Always Designing for People™

# Summary Plan Description

## 2026

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# General Information

This Summary Plan Description (SPD) represents a general explanation of the benefit plans provided for various associates of Automatic Data Processing, Inc. ("ADP, Inc." or the Company) under the Automatic Data Processing, Inc. Flex 2000 Plan (the Flex Plan), the Automatic Data Processing, Inc. Pension Retirement Plan (Pension Plan), and the Automatic Data Processing, Inc. Retirement and Savings Plan (401(k) Plan), as well as additional benefits available to certain associates of the Company.

If a question arises, the applicable underlying plan document will govern. This Summary Plan Description supersedes and replaces all previous materials distributed to the associates of Automatic Data Processing, Inc. and its participating affiliates. Nothing in this guide alters your at-will employment with ADP, which can be terminated by you or ADP at any time with or without notice.

Your total compensation package consists of two paychecks - the cash compensation you earn throughout the year and the "hidden paycheck." The second (hidden) paycheck represents the many benefits made available to you that will protect you financially and enhance the quality of your life.

## ADP Summary Plan Description

ADP and its participating affiliates (ADP) provide its associates with a comprehensive benefit program. These benefits represent an important and integral part of your total compensation package and include the following:

- Health Care Benefits such as Medical, Prescription Drug, Vision, and Dental Benefits as well as ADP contributions to Flexible Spending Accounts and Health Savings Accounts
- Survivor and Income Continuation Benefits, such as Life Insurance, Disability Income Program, Business Travel Accident Insurance, and Personal Accident Insurance
- Retirement Benefits, such as Pension, 401(k), and Stock Purchase benefits

Your ADP Summary Plan Description is designed to provide an easy reference to this comprehensive benefit program. It explains in detail specific aspects of the total program.

Because your benefits are so important, we suggest that you familiarize yourself with the information contained in this SPD and keep it handy for reference purposes. For assistance, please contact Global HR Shared Services at 1-877-237-4711 or submit a case.

Under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), "grandfathered health plans" that were in existence when the law was passed are exempt from complying with certain requirements. Previously, the Medical Plan was considered a grandfathered health plan. However, effective January 1, 2012, the Medical Plan no longer maintained its grandfathered status.

**PLEASE NOTE**: The terms and provisions of the applicable plan documents (e.g., policy contracts) control in the event there is a conflict with this SPD and the plan documents. The Plan Administrator has the discretionary authority to interpret and apply the terms and provisions of the plan document and to resolve all discrepancies or ambiguities in plan terms. You may contact Global HR Shared Services to obtain a complete copy of the plan document.

## Important Resources

| | |
|---|---|
| **ADP Benefits Enrollment System** | Log on to 2026 Benefits Enrollment on the Associate Portal |
| **Global HR Shared Services**<br>• Health care benefits (health, life, disability and other flexible benefits)<br>• Enrollment Questions | Click here to submit inquiries to Global HR Shared Services or use the HR chat Ask A.V.A.<br><br>Phone: 1-877-237-4711<br>Fax: 1-855-565-2122 |
| **Pension Service Center** | Phone: 1-844-237-7367<br>www.myplansconnect.com/adppension |
| **401(k) Service Center** | Phone: 1-877-401-5237<br>www.401kadp.com |

## Health & Welfare / Insurance

| Benefit | Carrier | Phone | Website |
|---|---|---|---|
| **Auto & Home** | Farmers GroupSelect, Liberty Mutual, Travelers and Progressive | 1-800-662-6840 | voluntarybenefits-adp.com |
| **Backup Child and Adult Care** | Bright Horizons | 1-877-242-2737 | backup.brighthorizons.com<br>To Register:<br>(Username: ADP Password: ADPBH) |
| **Basic Life** | MetLife | 1-800-638-6420 | www.metlife.com/mybenefits<br>The telephone number and website are for beneficiaries and associates seeking terminal illness benefits under the Basic Life plan, and have already filed a claim |
| **COBRA** | HealthEquity COBRA Services | 1-855-556-5737 | mybenefits.wageworks.com |
| **Commuter Spending Account** | HealthEquity Member Services | 1-866-346-5800 | my.healthequity.com |
| **Critical Illness** | Aetna<br>Group #802798 | 1-800-662-6840 | voluntarybenefits-adp.com |
| **Dental** | Aetna<br>Group #800201 | 1-800-843-3661 | www.aetna.com |
| **Diabetes Management** | Livongo | 1-800-945-4355 | www.join.livongo.com/ADP/begin |
| **Employee Assistance Program (EAP)** | LifeCare | 1-866-608-8368 | http://member.lifecare.com<br>Registration code: ADPLIFECARE |
| **Fertility and Adoption/Surrogacy** | WIN | 1-833-439-1518 | managed.winfertility.com/adp<br>Password: WINADP |

| Benefit | Carrier | Phone | Website |
|---|---|---|---|
| **Flexible Spending Accounts** | HealthEquity Member Services | Phone: 1-866-346-5800 Fax: 1-877-353-9236 | my.healthequity.com |
| **Group Universal Life** | MetLife | 1-800-662-6840 | voluntarybenefits-adp.com |
| **Health Savings Account** | HealthEquity Member Services | 1-866-346-5800 Fax: 1-877-353-9236 | my.healthequity.com |
| **Legal Services Plan** | MetLife Legal Plans | 1-800-662-6840 | voluntarybenefits-adp.com |
| **Long Term Disability** | MetLife's Disability Contact Center | 1-800-300-4296 | www.metlife.com/mybenefits The telephone number and website are for inquiries regarding your established specific claim |
| **Medical – Aetna** | **Aetna** Group #800201 **Network**: Aetna Choice POS II (Open Access) | Option 1 and CDHP with HSA: 1-800-829-3685 | www.aetna.com |
| | 24 Hour Nurse Line | 1-800-556-1555 | N/A |
| | Aetna Enhanced Maternity Program | 1-800-272-3531 | N/A |
| | Hospital Pre-Certification/ Medical Management Programs | 1-888-632-3862 | N/A |
| | Mental Health (In Network) | 1-800-424-4047 | N/A |
| | Teladoc | 1-855-835-2362 | www.teladoc.com/aetna |
| | TDD Line | 1-800-628-3323 | |
| **Medical – UnitedHealthcare (UHC)** | **UnitedHealthcare** Group #700563 **Network**: UnitedHealthcare Choice Plus | Option 1: 1-866-633-2474 CDHP with HSA: 1-800-864-9427 | www.myuhc.com |
| | Advocate4Me Program | Same numbers as above | N/A |
| | Maternity Support Program | Phone number on your ID card | www.myuhc.com/maternity |
| | Mental Health | 1-800-888-2998 | www.myuhc.com |
| | Out-of-Network Prior Authorization | Phone number on your ID card | N/A |
| | Virtual Care Services | N/A | www.myuhc.com |

| Benefit | Carrier | Phone | Website |
|---|---|---|---|
| **Medical – HMOs** | HMOs | Refer to SBCs (see right) | Refer to the Summaries of Benefits and Coverage (SBCs) on the 2026 Benefits Enrollment page of the ADP Associate Portal |
| **Personal Accident Insurance** | National Union Fire Insurance Company of Pittsburgh, PA (an AIG company) | 1-877-237-4711 | N/A |
| **Pet Insurance / Pet Discount** | Nationwide / Pet Assure | 1-800-622-6840 | voluntarybenefits-adp.com |
| **Prescription Drug** | **Express Scripts** (Aetna and UHC Option 1 and CDHP with HSA) | 1-877-723-4797 | www.express-scripts.com |
| | Price A Medication | | www.express-scripts.com/adp |
| | TDD Line | 1-800-759-1089 | |
| **Vision** | VSP | 1-800-877-7195 | www.vsp.com |
| **Voluntary Wellness Program** | Personify Health | 1-833-984-2247 | Existing Members: https://app.personifyhealth.com/ First Enrolling: join.personifyhealth.com/adp |

## Retirement and Savings

| Benefit | Vendor | Phone | Website |
|---|---|---|---|
| **401(k) Plan** | ADP Retirement Services | 1-877-401-5237 (need 4-digit PIN) | www.401kadp.com |
| **401(k) Investment Advice** | Edelman Financial Engines | 1-844-861-0028 | www.401kadp.com (access Edelman Financial Engines tile from home page) |
| **Pension Plan** | LifeWorks | 1-844-237-7367 | www.myplansconnect.com/adppension |

## Other Programs

| *Program* | Phone | Website |
|---|---|---|
| **ADP Ethics Hotline** | 1-800-273-8442 | N/A |
| **ADP Leaves Administrator** | 1-866-381-2857 | N/A |
| **ADP Stock Purchase (Fidelity)** Inquiries/Specific Account Information | 1-800-544-9354 | N/A |
| **ADP Tuition Assistance** | 1-866-317-3409 | https://associateportal.adp.com//benefits/educational_assistance/tuition_assistance_program |

| Program | Phone | Website |
|---|---|---|
| **AIG Travel Guard Personal VIP Assistance –** Travel Assistance Program | 1-877-244-6871 (US & Canada) 1-715-346-0859 (International) | N/A |
| **College Coach (Bright Horizons)** | 1-888-527-3550 | https://passport.getintocollege.com |
| **Financial Wellness (Enrich)** | Chat feature located in bottom right corner of any Enrich page | Visit the Personify Health website and then access Enrich from the Benefits tab on the top menu bar. Existing Members: member.virginpulse.com First Enrolling: join.personifyhealth.com/adp |
| **REST (Real Estate Services Team Program)** | 1-866-896-7045 | https://associateportal.adp.com//benefits/additional programs/real estate services team rest# |
| **Student Loan Repayment with Tuition.io** | 1-855-353-9395 | adp.tuition.io/register |
| **Unify Credit Union** | N/A | www.unifyfcu.com |
| **Vengroff Williams & Associates, Inc. (Health Plan Subrogation*)** | 1-800-813-4054 | N/A |
| **Work Number Client Service Center** | 1-800-996-7566 (Voice) 1-800-424-0253 (TTY – Deaf) Monday – Friday, 7:00 a.m. – 8:00 p.m. (CST) | N/A |

*Reviews accident claims to ensure if a party other than ADP is responsible for health care claims, that party reimburses the ADP Medical Plan for what it paid out.

# Definitions

## Associates

The term "full-time associate" means regular associates scheduled to work at least 32 standard hours per week. The term "part-time associate" means regular associates scheduled to work at least 20 but less than 32 hours per week.

Associates not eligible for benefits include:

- Temporary associates, seasonal associates or independent contractors. Persons who are employed by the Company on a full or part-time basis, with the understanding that his or her employment will be terminated no later than upon completion of a specific assignment with ADP and retain his or her status as a temporary associate
- An individual designated by the Company as a worksite Associate without regard to any subsequent determination or characterization by the Internal Revenue Service or other government agency or court that such an individual is a common law employee of the Company
- An associate covered by a collective bargaining agreement unless such agreement expressly provides for coverage by the Plan
- An associate designated by the Company as a Leased Employee under Code Section 414(n) without regard to any determination or characterization by the Internal Revenue Service or other government agency or court
- A nonresident alien of the United States who does not receive earned income from sources within the United States
- Any person excluded from coverage under the Medical Plan and one or more of the Medical Plan's participating benefits as part of an employment contract or agreement

## Dependents

The term "spouse" means anyone to whom you are legally married. Those who are legally separated are not eligible for ADP benefits – see the Eligibility section of this SPD. ADP will recognize a spouse from a legal common law marriage only if all the following criteria are satisfied:

- The associate's common law marriage must be established in a state that recognizes common law marriage, and the associate and the common law spouse must satisfy all criteria required to establish a common law marriage in that state
- The associate and his or her common law spouse must cohabitate in a state which recognizes common law marriage
- The associate and his or her common law spouse must "hold themselves out as husband and wife" They must tell the world that they are husband and wife through their conduct, such as the woman's assumption of the man's surname
- The associate and his or her common law spouse must file their federal income tax return as married filing jointly or married filing separately

The term "domestic partner" applies to same-sex and opposite-sex partners and means:

- A domestic partner who entered into a civil union with the associate; or
- A domestic partner who is registered in a domestic partnership; or
- A domestic partner who meets the following criteria:
  - both the associate and domestic partner are at least age 18;
  - neither the associate nor domestic partner is the legal spouse of another person;
  - neither the associate nor domestic partner is currently part of a domestic partnership or civil union with another person;
  - the associate and domestic partner are not related by blood to a degree of closeness that would prohibit marriage in the state in which they reside;
  - the associate and domestic partner are in an exclusive, committed relationship that is intended to be permanent, and have been in such relationship for at least six* consecutive months
  - the associate and domestic partner share a mutual obligation of support and responsibility for each other's common welfare; and
  - the associate and domestic partner share a principal residence and intend to do so permanently

Note that some states recognize civil unions and domestic partnerships as marriages. Refer to the ADP Domestic Partner Benefits Policy located on the Associate Portal under Benefits for benefit. *The Accidental Death & Dismemberment (AD&D) and Personal Accident Insurance (PAI) Policies require 12 consecutive months.

The term "child(ren)" means children to the end of the month in which they reach 26 years of age who are

- Your biological children
- Children of your eligible domestic partner or spouse
- Any legally adopted children or children placed with you for adoption for whom the ADP associate has financial responsibility as established by a pre-adoption court decree
- Adopted or foster children provided the ADP associate has a higher adjusted gross income than any natural parent, is older than the adopted or foster child, and no natural parent is claiming the child as a dependent for tax purposes
- Children for whom the ADP associate has been named legal guardian and is required to provide medical care, but only as long as the ADP associate remains the legal guardian in accordance with State law
- The term "child(ren)" also includes your dependent children age 26 or older and currently covered under the Flex Plan that are physically or mentally disabled and are financially dependent upon the associate. (Onset of disability must be prior to age 26 and dependent has been continuously covered under an ADP health plan or other health plan since becoming disabled.) This is subject to the medical carrier's approval by completing the Incapacitated Dependent Information form within 31 calendar days of the date their coverage would end.

Note: The child must be unmarried to be eligible for Personal Accident Insurance (PAI).

Associates may at times have primary responsibility for the support and maintenance of individuals other than their spouse/domestic partner or natural children (e.g., grandchildren, younger brother or sister). The individual must be a child in accordance with the age guidelines for covered dependent children under the Plan.

Adult dependents (other than spouses or eligible domestic partners) as defined by the Plan are not eligible dependents under the Plan. If an associate has assumed a legal obligation for such a dependent and the dependent currently resides in the associate's home, they should complete the Dependent Child Eligibility Questionnaire. Be sure to include supporting documentation with the questionnaire showing the individual's dependency upon the associate (i.e., custody paper, court orders, etc.). The completed forms must be sent to Global HR Shared Services for Plan review. You can fax the completed forms to 855-565-2122.

## Eligibility

### Medical, Prescription Drug, Dental, Vision, Flexible Spending Accounts (FSA), Long Term Disability (LTD), and Business Travel Accident (BTA)

All regular full-time and part-time associates are eligible for medical (1), prescription drug, dental, vision, FSA, and BTA coverage on their first day of employment and are eligible for LTD on their first day actively at work or upon approval of their application. Part-time associates must work on average 20 standard hours per week to be eligible.

- If you elect the CDHP with HSA Medical Plan option, you will be eligible to participate in a Limited Purpose Health Care FSA instead of the Health Care FSA.
- Spouses and children are eligible for medical, prescription drug, dental, vision, Health Care FSA and the Limited Purpose Health Care FSA. If you are legally separated or divorced, your spouse is not eligible. If a divorce decree or legal declaration requires an associate to provide continuation coverage in excess of, or contrary to, the terms of COBRA or this Plan, the Flex Plan will only be obligated to comply with the continuation of coverage provisions required by COBRA and this Plan.
- Domestic partners and their children are eligible for medical, prescription drug, dental, and vision benefits. Domestic partners and their children are eligible for coverage under the Health Care FSA and the Limited Purpose Health Care FSA if the domestic partner and their children are tax dependents under the Internal Revenue Code (the "Code").
- Children under age 13 are eligible for Dependent Care FSA if all other criteria are satisfied.
- Health Care FSA and Limited Purpose Health Care FSA can reimburse eligible medical expenses of tax code dependents.

(1) Part-time associates who will not be age 65 or greater anytime during the calendar year are eligible for CDHP with HSA or HMO Medical Plan options but not Medical Option 1.

### Basic Life and Accidental Death & Dismemberment Insurance (Life and AD&D)

All regular full-time associates are eligible on their first day actively at work. Spouses, domestic partners and children are eligible dependents for Accidental Death & Dismemberment Insurance.

### Personal Accident Insurance (PAI)

All regular full-time associates are eligible on the later of their first day actively at work or the effective date of the policy after the associate enrolls. Eligible dependents are spouses, domestic partners and children.

### Employee Assistance Program (EAP)

All regular full-time and part-time associates, including those who work less than 20 hours per week, are eligible on their first day of employment. Eligible dependents include associates' household members.

### 401(k)

All regular full-time and part-time associates, including those who work less than 20 hours per week, are eligible.
**Associates cannot participate in the ADP 401(k) Plan if they fall into any of the following categories:**

- Any associate covered by a collective bargaining agreement, unless such agreement expressly provides for such person's coverage under the 401(k) Plan
- Any individual designated by ADP or any affiliate (in accordance with their respective standard personnel practices) as a leased associate, independent contractor or consultant, regardless of whether such person may thereafter be held to be a common law employee of any employer by a court, the Internal Revenue Service or any other relevant, federal, state or local governmental authority or agency

- Any individual who is otherwise a "leased employee" (within the meaning of Section 414(n)(2) of the Internal Revenue Code (the "Code"))
- Nonresident alien of the United States who does not receive earned income from sources within the United States
- Any associate excluded from benefit coverage as part of an employment contract or agreement
- Any temporary associate. "Temporary associates" are persons who are employed by the Company on a full or part-time basis, with the understanding that his or her employment will be terminated no later than upon completion of a specific assignment. A temporary associate may be offered and may accept a new temporary assignment with ADP and retain his or her status as a temporary associate
- Any worksite associate. A "worksite associate" is any individual designated by ADP or a participating affiliate in accordance with standard payroll practice, as an associate or co-employee of a corporation or other entity that is not a member of the ADP's controlled group
- Any associate covered by any other qualified savings plan sponsored by the Company or any of its subsidiaries or any other affiliate
- Any associate whose home country is not the United States

## Pension

The Plan was closed to new participants effective January 1, 2015, and was frozen as of July 1, 2020. Participants retain their accrued benefits as of June 30, 2020, with no future accruals due to pay and/or service. Account balances will continue to earn interest based on the 10-year treasury rate for September of the preceding year.

The following individuals are not eligible to participate in the Pension Plan:

- An associate who at the time was covered by a collective bargaining agreement, unless such agreement expressly provides for such person's coverage under the Pension Plan
- Any employee who is first hired by an employer on or after January 1, 2015
- Any individual designated by ADP or any affiliate (in accordance with their respective standard personnel practices) as a leased associate, independent contractor or consultant, regardless of whether such person may thereafter be held to be a common law employee of any employer by a court, the Internal Revenue Service or any other relevant, federal, state or local governmental authority or agency
- Any individual who is otherwise a "leased employee" (within the meaning of Section 414(n)(2) of the Internal Revenue Code (the "Code"))
- Any nonresident alien of the United States who does not receive earned income from sources within the United States (within the meaning of Section 861(a)(3) of the Code)
- Any associate excluded from benefit coverage as part of an employment contract or agreement
- Any associate of the subsidiaries or any non-participating affiliate or its subsidiaries
- Any temporary associates. "Temporary associates" are persons who are employed by the Company on a full or part-time basis, with the understanding that his or her employment will be terminated no later than upon completion of a specific assignment. A temporary associate may be offered and may accept a new temporary assignment with ADP and retain his or her status as a temporary associate
- Any worksite associate. A "worksite associate" is any individual designated by ADP or a participating affiliate, in accordance with standard payroll practice, as an associate or co-associate of a corporation or other entity that is not a member of ADP's controlled group
- Any associate whose home country is not the United States

## Leaves of Absence (LOA)

Associates on an ADP approved leave of absence may continue their current coverage, except for Dependent Care Flexible Spending Accounts, provided they continue to make all required associate contributions. Failure to pay the required contributions may result in termination of coverage. You may also be required to repay the Flex Plan for claims paid on your behalf while you were not covered.

Associates on a paid leave will continue to have contributions deducted from their paycheck. Associates who elect to continue coverage while on an unpaid leave will be direct-billed by ADP for their contributions. Any contributions not paid by direct bill will be reconciled upon the associate's return from LOA and deducted from their pay.

## Enrollment

Your eligibility for the various benefit programs is based on the type of benefit and whether you are a full-time or part-time associate. The following chart outlines the eligibility requirements and effective date of coverage for each benefit.

## Eligibility and Effective Dates of Coverage

| Benefit | Full-Time | Part-Time | Eligible Dependents | Initial Effective Date of Coverage (1) | Effective Date for Qualified Event (2) |
|---|---|---|---|---|---|
| **Health Care**– Including:<br>• Medical<br>• Prescription Drug<br>• Dental<br>• Vision | Yes | Yes | Yes | 1st day of employment | Date of Event |
| **Flexible Spending Accounts**<br>• Health Care<br>• Limited Purpose Health Care<br>• Dependent Care | Yes | Yes | N/A | 1st day of employment | Date of Event |
| **AD&D** | Yes | No | Yes | 1st day actively at work | Date of Event |
| **Basic Life Insurance** | Yes | No | No | 1st day actively at work | Date of Event |
| **Long Term Disability** | Yes | Yes | N/A | 1st day actively at work or upon approval of application | Date of Event |
| **Business Travel Accident** | Yes | Yes | Yes | 1st day actively at work | Date of Event |
| **Personal Accident Insurance (PAI)** | Yes | No | Yes | Later of the 1st day actively at work or the policy effective date after the associate enrolls | Date of Event |
| **Employee Assistance Program (EAP)** | Yes | Yes | Yes | 1st day of employment | Date of Event |
| **401(k)** | Yes | Yes | N/A | 1st day of employment | N/A |

(1) Associate coverage is effective on the date a new associate begins active employment provided the associate does not opt out of coverage within the initial 31-day eligibility period. After 31 calendar days, unless you have a qualified life change or in the case of the Medical, Dental or Vision Plan, experience a Special Enrollment event or a SCHIP or Medicaid Enrollment Event, you will not be able to enroll until the next annual enrollment. Coverage for dependents that the associate enrolls in the Flex Plan at the same time the associate enrolls is effective on the same date as the associate's coverage.

(2) Refer to chart on Qualified Life Changes. If you have a qualified life change or experience a Special Enrollment event (Medical, Dental or Vision Plan only), you must enroll within 31 calendar days from the date of the change or event (within 60 days for the birth or adoption of a child). If you have a SCHIP or Medicaid Enrollment Event (Medical Plan only), you have to enroll within 60 calendar days from the date of the change or event. Coverage for dependents who are enrolled in the Medical Plan during their qualified life change window will become effective as follows:

- For a spouse, the date of the marriage
- For a domestic partner, the earliest date that the individual meets the definition of "domestic partner" set forth in the ADP Domestic Partner Benefits Policy
- For a newborn, the date of birth
- For an adopted child, the date of adoption or placement for adoption
- For any other child, the date the child becomes a dependent

If an associate is required by a qualified medical child support order, as defined under ERISA Section 609, to provide coverage for the associate's children, these children will be enrolled pursuant to the order. The Company has sole authority to determine whether a court order meets the requirements of Section 609. Associates may request a copy of the Company's policy on the requirements for a valid qualified medical child support order. If a qualified medical child support order is approved and the associate is not enrolled in the Medical Plan, the associate must enroll at the same time.

**Note**: Plan benefits are paid for newborns and children placed for adoption, but the associate is required to enroll the dependent child within 60 calendar days of birth or placement and to pay any extra amount required under the Flex Plan for dependent coverage. No one can be covered more than once under this Plan as both an associate and a dependent, or as a dependent of more than one associate.

### Contributions

Associate contributions to cover a domestic partner and/or the children of a domestic partner will be the same as covering a spouse and children, although there may be additional tax ramifications to the associate which will be taken on an after-tax basis for domestic partners and children who are not tax dependents under the Code. Refer to the "Taxation of Health Care Benefits" section of the ADP Domestic Partner Benefits Policy located on the Associate Portal under Benefits.

## FLEX Benefits - How it Works

FLEX Benefits allows you to custom tailor a benefit package that is most appropriate and economical for you and your family by giving you benefit choices. You have at least two different medical options and three different dental options. You may cover only yourself by choosing Single coverage or also cover dependents by choosing Associate Plus Spouse/Domestic Partner, Associate Plus Child(ren) or Associate Plus Family coverage.

### Enrollment

Since the Medical, Prescription Drug, Vision and Dental Plans are part of FLEX Benefits, you have choices about your coverage. Medical, vision, dental coverage and Flexible Spending Account elections are totally independent of one another; i.e., you can enroll for the dental option of your choice, even if you do not enroll for medical or vision coverage.

### FLEX Web Enrollment

You may make your benefits election on ADP's Benefits Enrollment System on the Associate Portal. It is fast, easy to use and has all the information you need to make informed decisions about your benefits.

### Annual Enrollment

For current associates there is an annual enrollment period for FLEX Benefits in the fall of each year for benefits effective January 1 of the following year. Elections remain in effect through December 31 of that following year.

You may review your current benefit coverage on the ADP Benefits Enrollment System or by calling Global HR Shared Services at 877-237-4711 or submit a case. The annual enrollment period is the time to review your benefits and decide whether to continue your coverage as is or to make changes.

### Failure to Enroll During Annual Enrollment

If you do not enroll by the deadline, you will automatically be assigned the same benefit coverage in effect prior to the enrollment period (except for your FSA and HSA elections). New or newly eligible associates working 32 or more hours per week will automatically be assigned to the following:

- Associate Only Medical coverage under the Aetna Choice POS II Option 1 if age 65 or older, Aetna CDHP with HSA Option 1 if under 65, Triple-S HMO if in Puerto Rico and Kaiser HI HMO if in Hawaii
- Long Term Disability*
- Basic Life
- Accidental Death & Dismemberment
- Business Travel Accident*
- Employee Assistance Program*

*Associates working 20 or more hours per week are also automatically enrolled in Long Term Disability, Business Travel Accident and the Employee Assistance Program. No other coverage will be provided unless you make an active election.

You may enroll on the ADP Benefits Enrollment System by logging onto the Associate Portal at https://associateportal.adp.com/. Your elections must be made within 31 calendar days from the date of hire. In addition, you can provide coverage to your eligible dependents by selecting Associate Plus Spouse/Domestic Partner, Associate Plus Child(ren) or Associate Plus Family Coverage.

**Reminder:** If you acquire a new dependent, such as getting married or a new baby, you must enroll the new dependent within 31 calendar days of acquiring the dependent (60 days for the birth or adoption of a new child).

If you are recently divorced or terminated a domestic partnership, you must remove your ex-spouse(s)/domestic partner from benefit coverage within 31 calendar days after your divorce or termination of domestic partnership. It is your responsibility to update your dependent information. Continuation coverage will be offered to qualified beneficiaries in accordance with COBRA. If a divorce decree or legal declaration requires the associate to provide continuation coverage in excess of, or contrary to, the terms of COBRA or this Flex Plan, the Flex Plan will only be obligated to comply with the continuation of coverage provisions required by COBRA and this Flex Plan. Domestic partners and their children are not qualified beneficiaries for COBRA purposes but will be offered COBRA Coverage Equivalent as discussed in this SPD.

If your dependent does not qualify as a dependent eligible for tax-favored medical benefits under the Internal Revenue Code, the fair market value of the coverage provided to that dependent will be taxable under federal income tax rules. Please contact your tax advisor if you have any questions about whether your dependent qualifies as a dependent under the Internal Revenue Code.

Please complete the Incapacitated Dependent Information form if your eligible dependent is physically or mentally disabled or incapable of earning their own living, based on the guidelines for an eligible dependent. The associate will need to complete the Subscriber Form and the dependent's physician will need to complete the Physicians Statement. The completed forms must be sent to Global HR Shared Services for Plan review.

**Important Note:** When you enroll your eligible dependents for coverage, you will be required to certify that each person meets the definition of an eligible dependent as described in the Definitions Section of this document. Enrolling individuals who do not qualify for dependent coverage under the ADP health plans (Medical, Dental and Vision) is considered fraudulent and may result in retroactive cancellation of coverage, recovery of claim payments and disciplinary actions up to and including termination of employment. If you are unsure about whether a family member meets the definition of an eligible dependent under one of the ADP health plans, contact Global HR Shared Services.

As part of the initial enrollment, you will be required to provide proof of the common law marriage or domestic partnership (if applicable). Proof of the common law marriage may be provided in the form of a written declaration or administrative order from the state in which the common law marriage was established (for those states that issue such documentation). In addition, the associate and his or her common law spouse must produce his or her most recent federal income tax return indicating that the associate and his or her common law spouse filed either as "married filing jointly" or as "married filing separately." ADP retains the right to request proof of an associate's filing status at any time. The associate must also produce, if such exists, any evidence of an agreement to be married. Proof of the domestic partnership may be provided in the form of an executed Certification of Domestic Partnership along with any accompanying requested support, or a copy of the domestic partnership registration or certificate of civil union. For assistance, please contact Global HR Shared Services at 877-237-4711 or submit a case.

Associates may at times have primary responsibility for the support and maintenance of individuals other than their spouse/domestic partner or natural children (e.g., grandchildren, younger brother or sister). To be eligible for medical, prescription drug, vision, or dental coverage under the Flex Plan such individual must be a child in accordance with the age and other guidelines for covered dependent children under the Flex Plan. Adult dependents (other than spouses, common law spouses, and domestic partners) as defined by the Flex Plan are not eligible dependents under the Flex Plan. If an associate has assumed a legal obligation for such a dependent and the dependent currently resides in the associate's home, they should complete the Dependent Child Eligibility Questionnaire. Be sure to include supporting documentation with the questionnaire showing the individual's dependency upon the associate (e.g., custody paper, court orders, etc.). The completed forms must be sent to Global HR Shared Services for Plan review.

### Enrollment – 401(k) Plan

Each eligible associate may become a participant in the Plan at any time by calling the ADP 401(k) Service Center at 1-877-401-5237 or logging onto www.401kadp.com. Your decision to participate is completely voluntary. However, as discussed below, new ADP associates, including rehired associates, will be automatically enrolled in the Plan if no active election is made within their initial 60-day period of employment. Further details regarding automatic enrollment can be found within the 401(k) section of this document.

As an eligible associate, you will have certain enrollment decisions such as:

- Choosing what percentage of your pay to save;
- Deciding whether your contributions will be Before-Tax Contributions, Roth Contributions, After-Tax Contributions, or any combination of the three;
- Choosing your investment options; and
- Naming your beneficiary

### Automatic Enrollment

New ADP associates, including rehired associates, will be enrolled in the 401(k) Plan automatically. Unless you elect otherwise, after you have completed 60 days of employment, ADP will automatically begin deducting 3% from your paycheck on a pre-tax basis. This money will be deposited into your 401(k) Plan Before-Tax Contribution account and will be invested in the JPMorgan SmartRetirement investment fund that corresponds with your approximate retirement date. Deductions will begin within approximately two paychecks after you have completed 60 days of employment.

## Making Changes (Medical, Dental, Vision, Flexible Spending Accounts (FSA) and Personal Accident Insurance (PAI))

IRS regulations state that your FLEX benefits must remain in effect until December 31 of each year, unless you have a qualified life change that is consistent with the change in your enrollment.

### Qualified Life Changes

During the year, changes can be made to your Medical, Dental, Vision, FSA and PAI Plans under the following conditions as defined by federal law:

- Birth, adoption, or death of a dependent, or newly acquired legal responsibility for a dependent
- Marriage, entry into a domestic partnership, divorce, annulment, legal separation (requires a court decree), or death
- Dependent no longer eligible
- Certain changes in employment status that affect benefits eligibility for an associate, spouse/domestic partner, or dependent, such as commencement or termination of employment, reduction or increase in hours of employment by the associate, spouse/domestic partner or dependent, including a change from part-time to full-time or full-time to part-time, a strike or lockout, commencement or return from an unpaid leave of absence
- A change in the eligibility conditions of the Medical Plan, or the employee benefit plan of the employer of an associate's spouse/domestic partner or dependent, affecting the eligibility of the associate, spouse/domestic partner or dependent under the Plan or the employee benefit plan
- Entitlement to or loss of Medicaid or Medicare coverage
- A change in residence or work location, but only to the extent that the change requires new elections under the Medical, Dental or Vision Plans
- Spouse/domestic partner or dependent children moving to the United States from another country (this does not include a move to another country if ADP's coverage could offer benefits)
- Special enrollment under HIPAA is a qualified life change for the Medical, Dental or Vision Plan
- Qualified Medical Child Support Order (QMCSO) is a qualified life change for Medical, Dental and Vision Plans. The QMCSO information is available on request

The law requires that your enrollment changes must be consistent with your qualified life change. ADP will advise you if your request for an enrollment change is not consistent with these rules. If you should terminate employment and return to work within 31 calendar days, your elections prior to termination of employment will be automatically reinstated unless you can show that a qualified life change has occurred. You may change only your coverage category. Your benefit option cannot change unless you are in an HMO and move out of the HMO service area or a DMO and move out of the DMO service area.

If you elect to reduce your FLEX benefits under a Health Care, Limited Purpose Health Care, or Dependent Care FSA based on a qualified life change, the following rules apply:

- Your total benefits election for that FSA for the Flex Plan year may not be reduced to an amount less than the amount reimbursed from that FSA as of the date of the change in election
- Your benefits election for that FSA for the remaining portion of the Flex Plan year will be determined by adding the balance in that FSA (including a positive or negative account balance) as of the date of the change in election to the total pre-tax contributions you are scheduled to make to that FSA for the remainder of the Flex Plan year
- If a life change occurs at the end of the plan year that permits changes to your FSA there must be enough net pay available and enough payrolls in that year that the life event occurred in order for ADP to honor the change. For example, a birth that occurs on December 26 would allow an associate 60 days to add the baby to their medical coverage and this life event would normally permit an increase to HCFSA. However, there are no bi-weekly pay periods remaining in the plan year for us to honor the increase in FSA
- If you have a question or need assistance in completing your election, please contact Global HR Shared Services at 877-237-4711 or submit a case.

## Special Enrollment Period under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Special Enrollment Period under HIPAA applies only to the Medical, Dental or Vision Plan and is treated as a qualified life change when:

1. An associate and his or her dependents lose other health insurance coverage if:
    - You or a dependent had other health insurance coverage at the time coverage under the group health plan was previously offered, and
    - You previously declined coverage under the Medical, Dental or Vision Plan, and either
        - Your other coverage was COBRA coverage that has been exhausted, or
        - Your other coverage was not COBRA coverage, and the other coverage was terminated because of a loss of eligibility for that coverage (such as a result of divorce, death, termination of employment or other factors identified in IRS regulations), or employer contributions towards the other coverage were terminated
2. An associate who is eligible, but has not enrolled in the Plan may enroll when he or she gets married/enters into a domestic partnership or upon the birth, adoption or placement for adoption of a child, even if the new dependent does not enroll for coverage
3. An associate who has enrolled, gets married/enters into a domestic partnership or upon the birth, adoption, or placement for adoption of a child. The spouse/domestic partner may enroll at the time of marriage/domestic partnership or upon the birth, adoption or placement for adoption of a child, even if the child does not enroll for coverage
4. A child becomes a dependent as a result of marriage/domestic partnership, birth, adoption, or placement for adoption, but only if you enroll or are already enrolled

Your life event election must be completed within 31 calendar days from the date of the life event (within 60 days for birth or adoption, to add the child) on the ADP Benefits Enrollment System. If the election is not completed within that timeframe, you will need to wait until the next annual enrollment period or, if earlier, the occurrence of another qualified life change. The coverage effective date for life events is the date of the qualified life change (e.g., marriage date or child's birth date). In addition, you will be required to provide written validation of the life event, effective date and dependent eligibility to Dependent Verification Services within 31 calendar days of your election. For FSA life changes that permit an enrollment or increase, only eligible charges incurred on or after the date of the life event may be claimed.

For further details regarding a life change and the current deadline extension, please contact Global HR Shared Services at 877-237-4711, or submit a case.

## Special State Children's Health Insurance Program (SCHIP) or Medicaid Enrollment Events

If (i) you or your dependent(s) lose coverage under a State Children's Health Insurance Program (SCHIP) or Medicaid or (ii) you or your dependent(s) become eligible for premium assistance from the State toward coverage in the Medical Plan, you have a SCHIP or Medicaid Enrollment Event. To take advantage of this special enrollment you must notify the Flex Plan within sixty (60) calendar days of the date you either lose coverage under SCHIP or Medicaid, or you gain eligibility for State premium assistance in the Medical Plan. For further details regarding a loss of coverage or premium assistance eligibility, please contact Global HR Shared Services at 877-237-4711, or submit a case.

## Qualified Life Change (Medical, Dental, Vision)

| Life Event | Medical | Dental | Vision |
|---|---|---|---|
| **Marriage/Entry into Domestic Partnership** | Enroll<br>Add Spouse/DP/Dependent<br>Opt Out | Enroll<br>Add Spouse/DP/Dependent<br>Opt Out | Enroll<br>Add Spouse/DP/Dependent<br>Opt Out |
| **Divorce or Legal Separation/Termination of Domestic Partnership** | Enroll<br>Delete Spouse/DP | Enroll<br>Delete Spouse/DP | Enroll<br>Delete Spouse/DP |
| **Birth or Placement for Adoption** | Enroll<br>Add Spouse/DP/Dependent | Enroll<br>Add Spouse/DP/ Dependent | Enroll<br>Add<br>Spouse/DP/Dependent |
| **Involuntary Loss of Group Coverage** [1] | Enroll<br>Add Spouse/DP/Dependent | Enroll<br>Add Spouse/DP/Dependent | Enroll<br>Add<br>Spouse/DP/Dependent |
| **Death of Dependent** | Enroll<br>Delete Dependent | Enroll<br>Delete Dependent | Enroll<br>Delete Dependent |
| **Gain of Coverage Elsewhere** | Opt Out<br>Delete Dependent | Opt Out<br>Delete Dependent | Opt Out<br>Delete Dependent |
| **Dependent No Longer Eligible** | Delete Dependent | Delete Dependent | Delete Dependent |
| **Job Relocation or Move** | HMO Participants change if moving out of current HMO Service area | DMO Participants change only if there are no DMO providers in the area | No Changes |
| **Change from Part-time without Benefits to Full-time or Part-time with Benefits** | Enroll | Enroll | Enroll |
| **Change from Full-time or Part-time with Benefits to Part-time without Benefits** | Terminate Coverage | Terminate Coverage | Terminate Coverage |
| **Beginning Unpaid Leave of Absence** | Terminate Coverage | Terminate Coverage | Terminate Coverage |
| **Returning from Unpaid Leave** | Reinstate Coverage | Reinstate Coverage | Reinstate Coverage |
| **Loss of Coverage under a State Children's Health Insurance Program or Medicaid** | Enroll | Not Applicable | Not Applicable |
| **Eligibility for State Premium Assistance** | Enroll | Not Applicable | Not Applicable |

[1] Loss of coverage due to annual enrollment elections will result in a life event; loss due to nonpayment of premium or other voluntary means will not. Loss of coverage refers to coverage at the top of the column.

## Qualified Life Change (PAI, FSA)

| Life Event | Personal Accident Insurance | Dependent Care FSA [1] | Health Care FSA | Limited Purpose Health Care FSA |
|---|---|---|---|---|
| **Marriage/Entry into Domestic Partnership** [2] | Add Spouse/DP | Increase<br>Decrease (If spouse/DP is not employed) | Increase | Increase |
| **Divorce or Legal Separation/ Termination of Domestic Partnership** | Delete Spouse/DP | Enroll if former spouse/DP was caregiver | Decrease [3] | Decrease [3] |
| **Birth or Placement for Adoption** | Add Dependent | Enroll<br>Increase | Enroll<br>Increase | Enroll<br>Increase |
| **Involuntary Loss of Coverage** [4] | Enroll<br>Add Spouse/ DP/Dependent | Enroll<br>Increase | Enroll<br>Increase | Enroll<br>Increase |
| **Death of Dependent** | Change Category<br>Delete Dependent | Enroll/Increase<br>(If death of caregiver)<br>Else Decrease/Opt Out | Increase<br>Decrease [3] | Increase<br>Decrease [3] |
| **Gain of Coverage Elsewhere** | No Changes | No Changes | No Changes | No Changes |
| **Dependent No Longer Eligible** | Delete Dependent | Decrease<br>Opt Out | No Changes | No Changes |
| **Job Relocation or Move** | No Changes | Opt Out<br>(if spouse/DP loses employment or dependent care cost increases) | No Changes | No Changes |
| **Change from Part-time without Benefits to Full-time or Part-time with Benefits** | Enroll | Enroll | Enroll | Enroll |
| **Change from Full-time or Part-time with Benefits to Part-time without Benefits** | Terminate Coverage | Terminate Coverage | Terminate Coverage | Terminate Coverage |
| **Beginning Unpaid Leave Of Absence** | Terminate Coverage | Terminate Coverage | Suspend Payment | Suspend Payment |
| **Returning from Unpaid Leave** | Reinstate Coverage | Enroll<br>Reinstate Deduction | Reinstate Deduction | Reinstate Deduction |

[1] If your cost of dependent care changes or your dependent care provider changes you might be able to change your dependent care FSA. Please contact Global HR Shared Services at 877-237-4711 or submit a case.
[2] A domestic partner is not considered a spouse under federal law, so a domestic partner's medical expenses are not eligible for tax-free reimbursement under the Health Care FSA or Limited Purpose Health Care FSA unless the domestic partner is a tax dependent under the IRS Code. Dependent care expenses for the child of an employee's domestic partner who is not also a child of the employee ordinarily will not qualify for reimbursement from a DC FSA. This is because such a child is unlikely to be the employee's qualifying individual except in very limited circumstances.
[3] If you have a life event that allows a decrease in your Health Care FSA or Limited Purpose Health Care FSA, please contact Global HR Shared Services at 1-877-237-4711 or submit a case.
[4] Loss of coverage due to annual enrollment elections will result in a life event; loss due to nonpayment of premium or other voluntary means will not. Loss of coverage refers to coverage at the top of the column.

**Note: Do not remove a dependent's coverage at annual enrollment in anticipation of a qualified life change**. Wait until the event happens, e.g., the divorce is legally approved, otherwise the dependent will not be eligible for COBRA.

### Your Share of the Cost

The associate contribution toward the cost of each type of coverage is fixed for each calendar year. Medical and dental costs vary according to the option selected. You will be notified of any change in costs during the annual enrollment period. Contributions for medical, dental, vision and personal accident insurance coverage are made via payroll deductions on a pre-tax basis. The current contribution amounts are shown in each section. Contribution amounts for Plan coverage provided to domestic partners and their children are made on an after-tax basis, unless the domestic partner or child is a tax dependent under the Code as set forth in a Declaration of Tax Status form executed by the associate and provided to the Plan Administrator.

## When Coverage Begins

For most coverages (see Eligibility and Effective Dates of Coverage chart earlier in this section), associate coverage is effective on the date a new associate begins active employment provided the associate does not opt out of coverage within the initial 31-day eligibility period.

After 31 calendar days, unless you have a qualified life change or experience a Special Enrollment event (Medical, Dental, or Vision Plan only) or, in the case of the Medical Plan, a SCHIP or Medicaid Enrollment Event, you will not be able to enroll until the next annual enrollment. If you have a qualified life change or experience a Special Enrollment event (Medical, Dental, or Vision Plan only), you must enroll within 31 calendar days from the date of the change or event (within 60 days for the birth or adoption of a child to add the child). If you have a SCHIP or Medicaid Enrollment Event (Medical Plan only), you have 60 calendar days from the date of the change or event to enroll. Coverage for dependents that the associate enrolls in the Flex Plan at the same time the associate enrolls is effective on the same date as the associate's coverage. Coverage for dependents who are enrolled within 31 days of the qualified life change (60 days for birth or adoption) will become effective as follows:

- For a spouse, the date of the marriage
- For a domestic partner, the earliest date that the individual meets the definition of "domestic partner" set forth in the ADP Domestic Partner Benefits Policy
- For a newborn, the date of birth
- For an adopted child, the date of adoption or placement for adoption
- For any other child, the date the child becomes a dependent

If an associate is required by a qualified medical child support order, as defined under ERISA Section 609, to provide coverage for the associate's children, these children will be enrolled pursuant to the order. The Company has sole authority to determine whether a court order meets the requirements of Section 609. Associates may request a copy of the Company's policy on the requirements for a valid qualified medical child support order. If a qualified medical child support order is approved and the associate is not enrolled in the Medical Plan, the associate must enroll at the same time.

Plan benefits are paid for newborns and children placed for adoption, but the associate is required to enroll the dependent child within 60 calendar days of birth or placement and to pay any extra amount required under the Flex Plan for dependent coverage.

If you are adding a dependent, you must provide documentation to Dependent Verification Services (DVS) within 31 calendar days of initial enrollment. Until then, your dependent's coverage will be pended. If insufficient documentation to substantiate eligibility is received, that dependent's request for coverage will be denied.

## Claiming Benefits

### How to File a Claim for Benefits

| Network Providers | Non-Network Providers |
|---|---|
| **In the Medical Aetna Choice POS II / UnitedHealthcare Choice Plus, Dental PPO and DMO Networks:** | **For Out-of-Network and Out-of-Area Claims** |
| • The provider generally files in-network claims<br>• Any balance due to the provider will be indicated on the Explanation of Benefits in the section marked "Patient Responsibility" | • You need to fill out the claim form<br>• Have the hospital, doctor, surgeon or dentist complete the appropriate portions of the form, or attach their itemized billing statement<br>• Attach all bills and other supporting documents<br>• Itemized bills must show the patient's name, nature of condition, diagnosis, service or treatment, amount of charge or fee, and the name of the individual or facility providing the service<br>• Send a claim and supporting documents to the Claim Administrator |

**Other Important Facts**

- Timeliness of filing claims is important
- You generally have two years from the date of service to submit medical expense claims incurred for the Medical Option 1 and CDHP with HSA. This rule does not apply to the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account. HMO claim filing deadlines vary so check with your HMO. All benefits are paid directly to you unless you assigned your benefits.

## Non-Duplication of Benefits

Associates with dependents who have primary coverage under another plan should fully understand the non-duplication provision. There may be no additional benefit from having coverage from an ADP-sponsored plan. This includes both the Medical and Dental ADP sponsored plans.

If you or any of your eligible dependents have coverage under any group plan, the benefits under this Plan are coordinated with the benefits of the other plan. When benefits are coordinated, the plan that pays first is called "primary" and the other plan(s) are called "secondary." The primary plan pays first. ADP's Medical and Dental Plan is the primary plan for you, an ADP associate. The only exception is when the other group plan does not have a coordination of benefits provision. In that case, the other plan will be considered primary and pay first.

Generally, the primary plan for your dependent children is the plan that covers the parent with the earlier birthday in the calendar year. (This is known at the "Birthday Rule.") For example, if one parent's birthday is in May, and the other's birthday is in June, the plan of the parent with the May birthday will be primary for the dependent children. The actual year of birth does not matter. There are additional guidelines concerning dependents in the case of divorce or separation. Contact the appropriate claims office for additional information.

If a participant has primary coverage under another group plan and is also covered under the ADP Medical or Dental Plan, the ADP Medical or Dental Plan will coordinate benefits up to, but not more than, the amount this Plan would normally pay. This means that if the other Plan payment is the same as or more than this Plan would pay, no additional benefits are available under this Plan.

**For example**:

| Non-Duplication of Benefits | | | | |
|---|---|---|---|---|
| Charge | Primary Carrier's Coverage | Primary Carrier's Payment | ADP's Plan Coverage/ Allowance | ADP's Plan Payment |
| $100 | 80% | $80 | 60% | $0 (secondary plan allowance minus primary carrier's payment) |
| $100 | 70% | $70 | 80% | $10 (secondary plan allowance minus primary carrier's payment) |

If both plans have benefit maximums (e.g., Chiropractic Annual Maximum) and the benefit maximum was met under the other plan, the ADP Medical Plan's benefit maximum will be its benefit maximum minus the amount/visits covered by the primary carrier.

**For example**:

| Non-Duplication of Benefits | | | | |
|---|---|---|---|---|
| Total Annual Charges | Primary Carrier's Annual Maximum | Primary Carrier's Payment | ADP's Plan Annual Maximum | ADP's Plan Payment |
| $4,000 | $1,500 | $1,500 @ 80% co-insurance or $1,200 | $2,500 | $1,300 ($2,500 minus $1,200) |
| ***In this example, assume ADP deductible has been met and charges are within the usual & prevailing range**. | | | | |

If the participant is covered under any group plan, including Medicare/Medicaid or a Health Maintenance Organization (HMO), in addition to coverage under the ADP Medical Plan and if all of the requirements of the other plan were not met (e.g., approved providers, second surgical opinion, etc.), the ADP Medical Plan's payment will be limited to what it would have paid had the other plan's requirements been met.

**For example:**

| Non-Duplication of Benefits | | | |
|---|---|---|---|
| Charge | Primary Carrier's Coverage/Payment | ADP's Plan Carrier's Coverage | ADP's Plan Payment |
| $100 | 60% or $60 for not following procedures. Payment would have been $80 | 80% of $80 | $0 (secondary plan will not reimburse penalty) |

## Rights of Subrogation and Reimbursement

### Coverage for Injuries Caused by You or Other Parties

One of the ways ADP keeps health care costs down is to make sure that another insurance company or another party pays their share of expenses when they are liable. ADP uses Vengroff, Williams & Associates, Inc. (VWA), a specialist in the field of subrogation services, to assist ADP in identifying third party claims. VWA will review certain health care claims when there is an indication that an injury may have been the result of an accident. If your or your dependent's injuries were caused by another person's actions, your health plan may be entitled to recover medical, dental and prescription drug expenses from another insurance company or third party.

To receive coverage, you must notify the Flex Plan that your illness or injury was caused by yourself, or another party and you must follow special Plan rules.

## Right of Subrogation

Subrogation means the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Plan's right of subrogation provides that if an injury or illness is your or someone else's fault, the Flex Plan has the right to recover expenses it pays for that illness or injury directly from any of the sources of payment listed later in this section.

To exercise its right of subrogation, the Flex Plan or the Plan Administrator (or any party designated by the Plan Administrator) may, in its discretion:

- Place a first-dollar equitable lien or constructive trust for 100% of the benefits paid by the Flex Plan against any responsible party or other third-party recovery you receive to the extent the Flex Plan paid benefits for the sickness or injury
- Bring an action on its own behalf or on your behalf against any responsible party or third party involved in the sickness or injury to recover 100% of the benefits paid by the Flex Plan, or
- Suspend the payment of any Flex Plan benefits pending receipt from you of any acknowledgement, agreement, authorization, waiver or release it considers necessary to exercise its rights or privileges under the Flex Plan

## Right of Reimbursement

If you receive any payment from a responsible party or third party (through a judgment, settlement or otherwise) when an injury or illness is your or someone else's fault, you must pay the Flex Plan back first, in full, for 100% of any medical, prescription drug or dental expenses the Flex Plan has paid to you or on your behalf. You must pay the Flex Plan back to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for medical, prescription drug or dental expenses. Furthermore, you must pay the Flex Plan back regardless of whether the responsible party admits liability and regardless of whether you have been made whole. In addition, you are responsible for payment of all of your attorneys' fees and court costs associated with any settlement or judgment you receive from a responsible party or third party, not the Flex Plan. If any money is left over, you may keep it.

If you do not repay the Flex Plan within seven (7) days after you receive a settlement or judgment from a responsible party or third party, the Flex Plan requires you to pay interest in the amount of one- and one half-percent (1.5%) of the total amount of benefits paid per month. In addition, the Flex Plan will not pay any attorneys' fees or costs associated with a lawsuit without the written permission of the Plan Administrator or any entity designated by the Plan Administrator.

## Sources of Payment

The Flex Plan's sources of payment through subrogation or reimbursement are as follows:

- Money from a responsible party or third party that you, your dependents, your guardian or other representatives or beneficiaries receive or are entitled to receive
- Any constructive trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your dependents, your guardian or other representatives or beneficiaries receive
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable

## Your Responsibilities

You have the duty to cooperate fully with the Flex Plan, the Plan Administrator and any party designated by the Plan Administrator if the Flex Plan's rights of subrogation or reimbursement are asserted, including the execution and delivery of any documents the Flex Plan may require or to appear in court for a deposition or testimony, if necessary.

### Enforcement by the Flex Plan

The Flex Plan may enforce its rights of subrogation or reimbursement by requiring you, your dependents, your guardian or other representatives or beneficiaries to present a claim/lawsuit to any of the sources of payment listed previously to recover expenses that you or they may be entitled to. The Flex Plan, the Plan Administrator and any entity designated by the Plan Administrator may suspend payment of future Flex Plan benefits if you do not cooperate and comply with its rights of subrogation and reimbursement, or if you take any action that prejudices the Plan's rights of subrogation and reimbursement.

The Flex Plan's rights of subrogation and reimbursement for 100% of all benefits paid, first-dollar, will not be reduced by any equitable defenses that may be raised by you or the third party responsible for your injury or illness, including but not limited to liability or other insurance covering the third party; any common fund doctrine; contributory or comparative negligence doctrine or statute; uninsured or underinsured motorist rules or statutes; medical payment; personal injury protection insurance; or no-fault insurance.

If the Flex Plan has not yet paid benefits relating to an injury or illness that was caused by you, a responsible party or a third party, the Flex Plan may reduce or deny future benefits relating to that injury or illness on the basis that you, your dependents, your guardian or other representatives or beneficiaries received compensation from the responsible party or third party. In addition, any amount due the Flex Plan under its rights of subrogation or reimbursement may be offset at the Plan Administrator's discretion against any other present or future medical and/or dental expense benefits payable to you or your dependents or beneficiaries.

The Flex Plan has the right to file suit against you to recover 100% of its reimbursement right, and you will be required to pay the Flex Plan's attorneys' fees and court costs related to any such suit.

The Flex Plan is *not* required to pay medical or dental expenses for any past illnesses or injuries that are settled (through a judgment, settlement or otherwise). And the Flex Plan's rights of subrogation and reimbursement apply even if the original illness or injury happened before your coverage under the Flex Plan commenced.

### Additional Information

Vengroff, Williams and Associates, Inc. has been designated by the Plan Administrator as the Flex Plan's third-party recovery provider. Any questions related to your duties and responsibilities under the Flex Plan's subrogation and reimbursement rights may be directed to the Plan Administrator or Vengroff, Williams and Associates, Inc. by telephone at 800-813-4054.

## Payment of Benefits and Recovery of Overpayments

### Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with Aetna or UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were provided and were medically appropriate. To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement but directs that your benefit payment should be made directly to the provider, Aetna or UnitedHealthcare may in their discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Automatic Data Processing (ADP) Inc. reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Automatic Data Processing (ADP) Inc. (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan).

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

### Form of Payment of Benefits – UnitedHealthcare

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value. If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

### Refund of Overpayments – UnitedHealthcare

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

### Recovery of Overpayments – Aetna

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment; any future benefit payment made to or on behalf of a Plan Participant. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna as the Plan's third-party administrator. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

## When Your Coverage Terminates

Your coverage will generally end the earlier of the following:

- The date your employment with ADP ends (coverage terminates on the latter of your last day worked or the day before severance pay begins)
- The date you are no longer eligible
- The date you act fraudulently or make an intentional misrepresentation of a material fact
- The date your election of no coverage is effective due to a qualified life event or annual enrollment.
- The date you stop paying required contributions, if any, or
- The date the Flex Plan terminate

Coverage for your dependents will end on the earlier of:

- The date a dependent is no longer eligible
- The date your coverage ends, or
- The date your election to cancel coverage for your dependent is effective due to a qualified life event or annual enrollment

Continuation coverage will be offered to qualified beneficiaries in accordance with COBRA. If a divorce decree or legal declaration requires the associate to provide continuation coverage in excess of, or contrary to, the terms of COBRA or this Plan, the Flex Plan will only be obligated to comply with the continuation of coverage provisions required by COBRA and this Flex Plan. Domestic partners and their children are not qualified beneficiaries for COBRA purposes but will be offered COBRA Coverage Equivalent as discussed in this SPD.

## Extended Benefits

### Medical

If coverage terminates while you or your dependents are totally disabled, benefits for that injury or sickness will be payable as if coverage had not terminated until the earlier of:

- The date you or your dependents are no longer disabled
- The end of the year following the year during which termination occurred
- The date you or your dependents become covered under another group plan

### Dental

If coverage terminates while you or your dependents are undergoing dental treatment which began while covered and this treatment is a continuation of a "course of dental treatment," benefits will be payable as if coverage had not terminated until the earlier of:

- Two months, or
- The period of time covered by the "Pre-Treatment Estimate". However, if the person becomes covered under another group dental plan, any benefits payable under this Plan will be reduced by any benefits payable under the other plan
- Under the DMO the extension period is 30 calendar days and only for the following services:
  - An appliance or alteration of one for which an impression was made while the person was a covered person
  - A crown, bridge or gold restoration for which the tooth was prepared while the person was a covered person
  - Root canal therapy for which the pulp chamber was opened while the person was a covered person

## Continuation of Coverage

### COBRA/COBRA Coverage Equivalent

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continuation of group health coverage under the Flex Plan beyond the date coverage would otherwise end for associates and their eligible dependents in certain situations. Although domestic partners are not considered eligible under COBRA, the Automatic Data Processing, Inc. Flex 2000 Plan will offer domestic partners and their children the option to continue medical, dental and vision coverage under certain circumstances, or "qualifying events." This coverage continuation is called COBRA Coverage Equivalent. Your rights to continue coverage in each of these circumstances are described below.

You may have other options available to you when you lose group health coverage under the Flex Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as your spouse's/domestic partner's plan), even if that plan generally doesn't accept late enrollees.

| Summary of Coverage Options under COBRA / COBRA Coverage Equivalent | |
|---|---|
| **Qualifying Event** | **Maximum Continuation Period for a Dependent** |
| The associate loses coverage because of reduced work hours | 18 months |
| Employment terminates | 18 months |
| The associate, spouse or domestic partner is disabled — as defined by the Social Security Act — at the time of a qualifying event or at any time during the first 60 days of COBRA or COBRA Coverage Equivalent | 29 months |
| The associate dies | 36 months |
| The spouse's or domestic partner's eligibility ends because the marriage, civil union or registered domestic partnership ended | 36 months |
| Dependent coverage ends because associate elects Medicare | 36 months |
| The child no longer qualifies as an eligible dependent for coverage under the Flex Plan | 36 months |

### What is COBRA/COBRA Coverage Equivalent?

Under COBRA/COBRA Coverage Equivalent, you may elect to continue the medical, prescription drug, dental, and vision coverage in effect for you and your dependents on the date your coverage ends. You may also elect to continue your Health Care FSA or Limited Purpose Health Care FSA coverage until the end of the year in which the qualifying event occurs. (**Note:** If you are covered for medical, dental, vision and/or the Health Care or Limited Purpose Health Care FSA on the date your coverage ends, you may select which benefits you want to continue.)

A qualified beneficiary who elects COBRA/COBRA Coverage Equivalent continuation coverage must pay the entire cost of the coverage plus a reasonable administration fee. COBRA/COBRA Coverage Equivalent coverage will end if the qualified beneficiary fails to make timely payment of contributions or premiums or for other reasons set forth below. If an annual enrollment period occurs during your COBRA/COBRA Coverage Equivalent coverage period, you have the same enrollment rights under the health care plan as an active associate. Because COBRA/COBRA Coverage Equivalent rules are complicated, if you have any questions about eligibility, please contact Global HR Shared Services at 877-237-4711 or submit a case.

### How Long Does COBRA/COBRA Coverage Equivalent Continuation Coverage Last?

The length of time that COBRA/COBRA Coverage Equivalent coverage lasts depends on the qualifying event. Generally, COBRA/COBRA Coverage Equivalent coverage will last either 18, 29 or 36 months after the qualifying event, determined as follows:

### Continuation for up to 18 Months

COBRA/COBRA Coverage Equivalent coverage will last for up to 18 months from the qualifying event for you and your covered dependents if your coverage ends because:

- Your employment ends; or
- Your work hours are reduced to below the minimum required number of standard hours per week

### Continuation for up to 24 Months

If your employment ended because you elected early retirement under the ADP Voluntary Early Retirement Program, your continuation coverage, in lieu of the COBRA terms above, is subject to the terms set forth in the document, "ADP's Voluntary Early Retirement Program – Important Information Regarding Electing Health Care Continuation Coverage".

### Continuation for up to 29 Months

COBRA/COBRA Coverage Equivalent coverage will last for up to 29 months from the qualifying event if you, your spouse or domestic partner is determined by the Social Security Administration to be disabled at any time before the 60th day of COBRA/COBRA Coverage Equivalent continuation coverage and you notify the Plan Administrator in a timely manner. In this case, you may elect to extend the first 18 months of COBRA/COBRA Coverage Equivalent continuation coverage by an additional 11 months for all enrolled dependents or for the disabled person only.

The Social Security disability must have started at some time before the 60th day of COBRA/COBRA Coverage Equivalent continuation coverage and must last at least until the end of the first 18 months of COBRA/COBRA Coverage Equivalent continuation coverage. You or the disabled dependent must notify the COBRA/COBRA Coverage Equivalent Administrator within 60 days of the Social Security Administration's determination of disability and before the end of the first 18 months of COBRA/COBRA Coverage Equivalent continuation coverage.

The COBRA/COBRA Coverage Equivalent Administrator must also be notified if there is a final determination by the Social Security Administration that the person is no longer disabled. The notice must be provided within 30 days after the final determination. The coverage will end on the first of the month that starts more than 30 days after the determination.

### Continuation for up to 36 Months

COBRA/COBRA Coverage Equivalent continuation coverage will last for up to 36 months from the qualifying event for your covered dependents if their coverage ends because:

- You and your spouse are legally separated or divorced, or your marriage is annulled
- Your civil union or domestic partnership is terminated (not a COBRA event but covered under COBRA Coverage Equivalent)
- You die while employed at ADP
- Your dependent child no longer qualifies as an eligible dependent for coverage under the Flex Plan

If your family experiences another qualifying event during the first 18 months of COBRA/COBRA Coverage Equivalent continuation coverage (such as your death, divorce or child ceasing to be an eligible dependent), your dependent(s) can get additional months of COBRA/COBRA Coverage Equivalent continuation coverage, up to a maximum of 36 months from the initial qualifying event.

In addition, if you are entitled to Medicare prior to a qualifying event involving termination of employment or reduction in hours, your dependent(s) are entitled to COBRA/COBRA Coverage Equivalent coverage for the longer of 18 months from the initial qualifying event, or 36 months from the date of your Medicare entitlement date. Medicare entitlement means that you are enrolled in either Medicare Part A or B.

### When COBRA/COBRA Coverage Equivalent Ends

COBRA/COBRA Coverage Equivalent continuation coverage will end upon the first of these events to occur:

- The cost of COBRA/COBRA Coverage Equivalent continuation coverage is not paid on time
- The Plan is terminated, and no other group health plan is offered by ADP
- The end of the 18, 29 or 36-month period of COBRA/COBRA Coverage Equivalent continuation coverage
- You or your eligible dependents first become entitled to Medicare after electing COBRA/COBRA Coverage Equivalent continuation coverage
- You or your eligible dependents first become covered under another group health plan after electing COBRA/COBRA Coverage Equivalent continuation coverage

### Special Rules on Medicare Entitlement

Medicare entitlement means the individual is enrolled in either Medicare Parts A or B.

- If an associate or dependent is Medicare entitled prior to loss of coverage due to the associate's termination of employment or reduction in hours, the Medicare entitled individual may elect COBRA/COBRA Coverage Equivalent continuation for 18 months
- If an associate is Medicare entitled prior to loss of coverage due to the associate's termination of employment or reduction in hours, the COBRA/COBRA Coverage Equivalent qualified beneficiaries of the Medicare entitled associate may elect coverage for the longer of 18 months from the associate's loss of coverage, or 36 months from the date of the associate's Medicare entitlement date
- If an associate or dependent does not apply for Medicare coverage when they become eligible, claims will be processed as if they had enrolled. The Medicare eligible individual must apply for Medicare Part A, Part B and Part D to have complete coverage
- If an associate or dependent becomes entitled to Medicare while receiving COBRA continuation coverage, the COBRA continuation coverage will terminate

### When is COBRA/COBRA Coverage Equivalent Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA/COBRA Coverage Equivalent Administrator has been notified that a qualifying event has occurred. When the qualifying event is termination of employment, reduction in hours of employment or death of the associate, ADP will notify the COBRA/COBRA Coverage Equivalent Administrator of the qualifying event. For other qualifying events, including divorce or legal separation and a dependent child ceasing to be eligible for coverage as a dependent, you must notify the COBRA/COBRA Coverage Equivalent Administrator within 60 days after the qualifying event occurs. Failure to notify the COBRA/COBRA Coverage Equivalent Administrator within this 60-day period will result in your losing the right to elect COBRA/COBRA Coverage Equivalent continuation coverage.

### How is COBRA/COBRA Coverage Equivalent Coverage Provided?

Once the COBRA/COBRA Coverage Equivalent Administrator receives notice that a qualifying event has occurred, COBRA/COBRA Coverage Equivalent continuation coverage will be offered to each of the qualified beneficiaries. Although each qualified beneficiary has an independent right to elect COBRA/COBRA Coverage Equivalent continuation coverage, you may elect COBRA/COBRA Coverage Equivalent coverage on behalf of your covered spouse/domestic partner and children. You will receive a COBRA/COBRA Coverage Equivalent election notice from the COBRA/COBRA Coverage Equivalent Administrator, and the election notice will specify the premiums you will be required to pay for COBRA/COBRA Coverage Equivalent continuation coverage. You have 60 days to elect COBRA/COBRA Coverage Equivalent continuation coverage after the later of the date of the qualifying event or the date you receive the COBRA/COBRA Coverage Equivalent election notice. Failure to return your COBRA/COBRA Coverage Equivalent election notice to the COBRA/COBRA Coverage Equivalent Administrator within this 60-day period will result in your losing the right to elect COBRA/COBRA Coverage Equivalent continuation coverage.

### How Much Does COBRA/COBRA Coverage Equivalent Coverage Cost?

Each qualified beneficiary is required to pay the entire cost of COBRA/COBRA Coverage Equivalent continuation coverage. This cost will not exceed 102 percent (or, in the case of an extension due to a disability, 150 percent) of the cost to the Flex Plan (including both employer and associate contributions) for coverage of an associate who is not receiving COBRA/COBRA Coverage Equivalent coverage. The required payments for COBRA/COBRA Coverage Equivalent coverage will be described in the COBRA/COBRA Coverage Equivalent election notice you and your covered
dependents receive from the COBRA/COBRA Coverage Equivalent Administrator.

### Who is the COBRA/COBRA Coverage Equivalent Administrator?

The COBRA/COBRA Coverage Equivalent Administrator is HealthEquity, and their telephone number is 855-556-5737. If you or your dependents want to elect COBRA/COBRA Coverage Equivalent continuation coverage, you must complete and return the COBRA/COBRA Coverage Equivalent election notice to HealthEquity, INC., PO BOX 650650 Dallas, TX 75265-0650.

## Military Service

If you lose your health coverage (including coverage for enrolled dependents) under the Flex Plan because you are called into active duty with the U.S. armed services, you may elect to continue your coverage for a period of up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Health coverage under the Flex Plan includes medical, prescription drug, dental, vision and Health Care or Limited Purpose Health Care Flexible Spending Account coverage.

If you elect USERRA continuation coverage while you are in military service, you are responsible for paying the cost of coverage in a manner determined by the Plan Administrator. If you do not elect USERRA continuation coverage while you are in military service, any health coverage you had prior to your military service will be reinstated on your return to employment with ADP. Your coverage will be reinstated without any waiting periods, except to the extent that you did not fully complete any required waiting period prior to the start of your military service.

If you lose your health coverage under the Flex Plan because you are called into active duty with the U.S. armed services, you may also be eligible for continuation coverage under COBRA for the applicable COBRA continuation period (either 18, 29 or 36 months, depending on the reason for your loss of coverage). USERRA continuation coverage and COBRA continuation coverage run concurrently, and your COBRA rights generally are more extensive and favorable than your rights under USERRA. Please contact the Plan Administrator for more information regarding USERRA continuation coverage.

If you are a qualified reservist or national guardsman who is ordered or called to active duty for a period of at least 180 days (or an indefinite period), and meet certain criteria, you may request a distribution of all or a portion of your Health Care or Limited Purpose Health Care Flexible Spending Account balance. See Qualified Reservist Distribution section of the FSA SPD for more details.

## Extended Medical Benefit (EMB) Option

A totally disabled associate who loses coverage due to a termination of employment may elect to continue the same medical plan coverage he or she had when an active associate at ADP through COBRA or instead, elect the EMB Option. Eligible dependents of an associate who dies while employed at ADP may also have the option to continue coverage following the death of the associate through COBRA or instead, elect the EMB Option. EMB rates are lower than COBRA rates.

If you elect EMB, it runs concurrently with COBRA, so you would be giving up COBRA coverage and instead be electing the EMB Option. If, however, your EMB coverage ends earlier than when your COBRA coverage would end, ADP will allow you to re-elect COBRA, but only for the remaining time left on the COBRA period. For example, if you are eligible for EMB coverage for 12 months and COBRA for 18 months, after the 12 months of EMB you could elect COBRA for the remaining 6-month COBRA period. You must enroll within the period provided under COBRA. To enroll, contact the ADP Global HR Shared Services at 1-877-237-4711.

### When can I Change my Coverage?

You may drop coverage at any time. In addition, you may be able to change your election by adding or dropping a new dependent at any time in accordance with the qualified life change rules (the list is in the SPD) and during annual enrollment.

Important Note: If you do not elect the EMB Option at the time you are first eligible, or if you later terminate your EMB Option (prior to the date the Plan coverage ends), you may not re-enroll in the EMB Option.

### How do I Pay for Extended Medical Coverage?

When you enroll in the EMB Option (and any benefits you elected under COBRA) your payment must be received by the due date, (generally, the first of the month). If coverage terminates due to non-payment of premiums, it will not be reinstated.

ADP reserves the right to change the amount it contributes toward medical coverage and the type of coverage provided at any time.

## Extended Medical Option for Totally Disabled Participants

### Who is Eligible?

An associate must meet all of the following:

- Have been actively at work at ADP for a cumulative 12 months or more prior to onset of disability;
- Be a participant in the ADP Medical Plan at the time employment terminated;
- Be paid up to date on their active medical coverage contributions;
- Be totally disabled as established under the ADP Long Term Disability Plan or under another disability plan or the Social Security Administration on the date of termination of employment; and
- Is not eligible for Medicare

### What happens if I become Eligible for Medicare's Disability Coverage?

ADP medical benefits provided through Aetna, UnitedHealthcare, and Kaiser are coordinated with Medicare benefits. Medicare will become your primary coverage, and the ADP Medical Plan will only supplement Medicare. If you do not apply for Medicare disability coverage when you become eligible, claims will be processed as if you had enrolled. You must apply for Medicare Part A, Part B and Part D to have complete coverage. If you are enrolled in an HMO that does not provide secondary coverage after Medicare disability coverage is activated; you may elect to change to one of the plan options offered through Aetna or UnitedHealthcare to have access to secondary coverage as long as you continue to be eligible under the EMB plan. Please contact Global HR Shared Services at 1-877-237-4711 for assistance within 30 days prior to the effective date of your Medicare disability coverage.

### When do Extended Medical Benefits End for a Disabled Participant?

Extended medical benefits for a disabled participant end at the earlier of 18* months from your date of termination or when any of the following occur:

- You are no longer totally disabled as established under the ADP Long Term Disability Plan or under another disability plan or the Social Security Administration;
- You are eligible for Medicare;
- You do not make payment on time;
- You die;
- You become covered under another group plan; or
- The Plan ends

*If covered disability began prior to January 1, 2016, the 18-month limit does not apply.

### When do Extended Medical Benefits End for Dependents?

Extended medical benefits for dependents of a disabled participant end at the earlier of 18 months from your date of termination or when any of the following occur:

- Your coverage ends for any reason other than death;
- Your dependent is no longer eligible as defined by the Plan; or
- Your dependent becomes covered under another group plan

Note that should you die, your dependents may be eligible for up to an additional 18 months of COBRA from when their EMB coverage ends.

## Extended Medical Option for Survivors

### Who is Eligible?

A dependent must meet all of the following:

- Is a dependent of an associate who was actively at work at ADP for a cumulative 12 months or more before the associate's death;
- Is an eligible dependent as defined by the Plan and a participant in the ADP Medical Plan at the time the associate died;
- Is a dependent of an associate who was paid up to date on their active medical coverage contributions;
- Is not covered under any other group health plan; and
- Is not eligible for Medicare

### When do Extended Medical Benefits End?

Extended benefits end at the earliest of 18 months from the associate's date of death or any of the following occurrences:

- Payment is not made on time;
- The spouse remarries or the domestic partner enters into a new domestic partnership;
- A dependent becomes covered under another group plan;
- The dependent is eligible for Medicare
- The dependent is no longer eligible as defined under the eligibility definitions in this section;
- The Plan ends

## HIPAA Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. The Medical, Dental, Prescription Drug, Vision, EAP, Health Care Flexible Spending Account, and the Limited Purpose Health Care Flexible Spending Account coverages under the Flex Plan are covered by the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), the Flex Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law. A description of the Flex Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Flex Plan's Notice of Privacy Practices, which can be accessed on the Flex Plan's website at https://associateportal.adp.com/.

# Medical Benefits

## Affordable Care Act Changes

Under the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA"), "grandfathered health plans" that were in existence when the law was passed are exempt from complying with certain requirements. Effective January 1, 2012, the Medical Plan[1] no longer maintained its grandfathered status.

Since 2019, individuals are not subject to a federal penalty for failure to maintain individual health insurance. However, some states and the District of Columbia have implemented a state-based individual mandate and penalty for noncompliance. Also please note that because of the ACA reporting requirements, we require you to provide the social security number for any dependent who is age 1 year or older and is enrolled in an ADP medical plan. If you have questions, please contact Global HR Shared Services at 1-877-237-4711.

Under the ACA, a non-grandfathered group health plan must ensure that any annual cost sharing imposed under the plan does not exceed certain out-of-pocket costs for essential health benefits. This means that the self-only annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage, or other than self-only coverage (e.g., associate + spouse/domestic partner, associate + child(ren) or family). For plan or policy years beginning in 2026, the maximum annual limitation on cost sharing is $10,600 for self-only coverage and $21,200 for other than self-only coverage.

## No Surprise Bill

### Emergency services

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Your coverage for emergency services will continue until your condition is stabilized and;

- Your attending physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care;
- You are in a condition to be able to receive from the out-of-network provider delivering services the notice and consent criteria with respect to the services; and
- Your out-of-network provider delivering the services meets the notice and consent criteria with respect to the services.

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the Options-At-A-Glance charts in this Medical SPD, for example Hospital Services *and precertification/prior authorization requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact Aetna or UnitedHealthcare member services or your network physician or-primary care-physician (PCP).

### Non-emergency services

If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the Emergency Room portions of the Options-At-A-Glance charts or contact your carrier's (Aetna or UnitedHealthcare) member services for more information.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by certain out-of-network providers
- Not available from a network provider
- Emergency services

Aetna and UnitedHealthcare will calculate your cost share for involuntary services in the same way as they would if you received the services from a network provider. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

[1]The Medical Plan is also referred to as the "Plan" throughout this section of the SPD.

### Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

### What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

### You are protected from balance billing for:

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center.

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

### You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in- network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Aetna, UnitedHealthcare, or the U.S. Department of Health and Human Services (HHS) No Surprises Helpdesk at 1-800-985-3059 to submit complaints regarding potential violations of the No Surprises Act. HHS will route complaints to the appropriate federal agency. We ask that you contact the carrier first to resolve the issue.

Individuals interested in obtaining information from the DOL concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the DOL's website (www.dol.gov/ebsa). Visit ww.cms.gov/nosurprises for more information about your rights under federal law, including information on the No Surprises Act and payment disputes.

**Patient Protection Notice**
The Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, the Claims Administrator designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our 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 the Claims Administrator at the number on the back of your ID card.

## Your Options

ADP offers several medical coverage options to each eligible associate. These options cover many of the same services; however, contributions, deductibles, co-payments, and annual out-of-pocket limits vary. It is important to carefully weigh the differences between each Medical Plan option to make sure your specific needs will be covered. **You will not be permitted to change options because your doctor drops out of your Medical Plan coverage option's network.**
Note: There is no pre-existing condition exclusion under the Medical Plan.

Refer to the 2026 Benefits Enrollment page under the Benefits section of the Associate Portal for the HMO / Aetna Choice POS II / UnitedHealthcare Choice Plus Benefit Summaries. The following are your medical plan options:

- Aetna Choice POS II or UnitedHealthcare Choice Plus network, referred to as Medical Option 1 (not available for part time associates under age 65 during the plan year)
- Consumer Driven Health Plan with a Health Savings Account (CDHP with HSA) Option 1 through Aetna Choice POS II or UnitedHealthcare Choice Plus network
- Consumer Driven Health Plan with a Health Savings Account (CDHP with HSA) Option 2 through Aetna Choice POS II or UnitedHealthcare Choice Plus network
- HMO (at some locations)
- No Coverage – offers full and part-time associates (scheduled to work at least 20 hours per week) the flexibility of taking no ADP medical coverage

Associates must make an active election or else they will end up with the default option. If no action is taken, you will default as follows:

- Full time associates (except those that reside in HI and PR) who **will not be** age 65 or above during the plan year – Aetna CDHP with HSA Option 1 medical plan (associate only coverage)
- Full time associates (except those that reside in HI and PR) that are or **will be** age 65 or above during the plan year – Aetna Choice POS II Option 1 medical plan (associate only coverage)
- Full time PR associates – Triple-S HMO (associate only coverage)
- Full time HI associates – Kaiser HI HMO (associate only coverage)
- Part time associates – no coverage

**Eligibility and Enrollment**
See Eligibility and Enrollment in the General Information Section.

### Things to Consider

- Are you willing to exclusively see doctors within an established network of providers (HMO) or do you need the flexibility to see other doctors that may be outside the network (Aetna Choice POS II / UnitedHealthcare Choice Plus)?
- Which plan provides the best coverage for any special medical condition you or your family members may have?
- Is it important that you be able to predict your health care expenses? HMOs generally do not require you to pay an annual deductible or a percentage of your expenses - you pay only a small copayment for services.
- The CDHP with HSA options have lower associate contributions and an ability to save for the future health care expenses in an HSA. However, they have a large upfront deductible so there is a tradeoff between possible short-term cash flow and possible long-term savings. Medicare eligible individuals are not eligible to make tax qualified contributions to the HSA.
- If you need to cover dependents that reside in another state, the Aetna Choice POS II / UnitedHealthcare Choice Plus plans offer the most flexibility. Many HMOs do not cover dependents residing out of the home area.

## Aetna Choice POS II / UnitedHealthcare Choice Plus Medical Option 1 and CDHP with HSA Options

### How the Aetna Choice POS II and UnitedHealthcare Choice Plus Work

Both the Aetna Choice POS II and UnitedHealthcare Choice Plus plans include doctors, nurses, clinics, hospitals, and other licensed sources of health care that have contracted with Aetna or UnitedHealthcare to provide services. You choose whether or not to use an Aetna Choice POS II / UnitedHealthcare Choice Plus network provider at the time you need medical services. You do not need to choose a primary care physician at enrollment.

Certain providers at a participating hospital may not be a part of the Aetna Choice POS II or UnitedHealthcare Choice Plus network. These providers can include Radiologists, Anesthesiologists, Pathologists, and Emergency Room Physicians. Services performed by a non-participating provider at an Aetna Choice POS II or UnitedHealthcare Choice Plus hospital are not considered in-network; however, they are payable at the network level based on billed charges or an amount negotiated by the Claim Administrator, or an amount permitted by law. See the information on the No Surprises Bill in this SPD.

Depending on the geographic area and the service you receive, you may have access through a UnitedHealthcare program to certain non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Expenses. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. If rates have not been negotiated then one of the following amounts applies based on claim type: 150% of published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, except for the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
- 70% of CMS for the same or similar physical therapy service from a freestanding provider

When a rate is not published by CMS for the service, UnitedHealthcare uses a third-party vendor that uses a relative value scale or similar methodology.

### Covered Expenses

Covered expenses are the negotiated rates for network providers and the usual and prevailing charges or an amount negotiated by the Claim Administrator, or an amount permitted by law for out-of-network providers for covered services and supplies listed in this Medical Plan Summary. The Claim Administrator, in its discretion, will calculate covered expenses following evaluation and validation of all provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural Terminology
- The methodologies as reported by generally recognized professionals or publications

The covered expenses must be incurred for the care of an accidental injury or sickness. A covered expense is incurred on the date that the covered service or supply is performed or given. A covered person and his or her physician decide on services and supplies, but the Medical Plan only pays for the covered services and supplies as determined by our Claim Administrator.

Covered services and supplies also include services and supplies that are part of an Alternate Care Proposal (ACP). An ACP is a course of treatment developed by the Claim Administrator and authorized by ADP as an alternative to the services and supplies that would otherwise have been considered covered services and supplies.

Unless the ACP specifies otherwise, the provisions of the Medical Plan related to benefit amounts, maximum amounts, co-payments, and deductibles will apply to these services.

Each covered person must satisfy certain copayments and/or deductibles before any payment is made for certain covered services and supplies. Then the Medical Plan pays the percentage of covered expenses shown in the Medical Options At-A-Glance Charts.

### Deductibles

The deductible is the amount of covered expenses the covered person must pay each calendar year before non-preventive care benefits are payable. After the deductible has been met, covered expenses are payable at the level shown on the applicable Medical Options-At-A-Glance Chart.

In Medical Option 1, the deductible applies to all covered expenses except prescription drugs (including diabetic supplies) and covered preventive services. In the CDHP with HSA options, the deductible applies to most covered expenses, including prescription drugs (except for some preventive medications including diabetic supplies); the deductible does not apply to covered preventive services. Where the deductible does not apply, coinsurance applies immediately, and the expenses do not go towards the deductible.

In Medical Option 1 and the CDHP with HSA options, the following items do not apply toward the satisfaction of the deductible:

- Expenses for services or supplies not covered by the Medical Plan
- Expenses for services or supplies in excess of the usual and prevailing fees or an amount negotiated by the Claim Administrator, or an amount permitted by law
- If the covered person has other health coverage and the Medical Plan is the secondary payer, amounts paid by the covered person as coinsurance under the primary plan
- The penalty for failure to obtain pre-certification/prior authorization

There are three major differences between the deductibles in Medical Option 1 and deductibles in the CDHP with HSA options.

- The first difference we mentioned – prescription drugs (except for some preventive medications) are subject to the CDHP with HSA option deductible and they are not under Medical Option 1.
- The second difference is that the CDHP deductible is much higher than the Medical Option 1 deductible. However, the CDHP with HSA options have the advantage of lower premium contributions and have a health savings account to which ADP contributes.
- The third difference is that in the CDHP with HSA Option 1, one or more family members combined must reach the family deductible limit before the plan will pay for non-preventive benefits for anyone in the family. So, in Medical Option 1, if you have Associate + Spouse/Domestic Partner, Associate + Child(ren), or Associate + Family coverage, you and each of your covered dependents could each satisfy the individual deductible ($800 in-network) and then the plan would pay for non-preventive benefits subject to coinsurance. In the CDHP with HSA Option 1, if you have Associate + Spouse/Domestic Partner, Associate + Child(ren) or Associate + Family coverage, even if you and one of your covered dependents reached the individual deductible ($1,850 in-network) the plan would not pay for non-preventive benefits until combined you reached the family deductible ($4,000 in-network). In the CDHP with HSA Option 2, the deductible works like Medical Option 1, but it is much higher. So, if you have Associate + Spouse/Domestic Partner, Associate + Child(ren) or Associate + Family coverage you and each of your covered dependents could each satisfy the individual deductible ($3,400 in-network) and then the plan would pay for non-preventive benefits subject to coinsurance.

Please also note that there is no cross application of the in-network and the out-of-network deductibles. They are separate from each other.

### Copayments and Coinsurance

In Medical Option 1 and the CDHP with HSA options, there are no copayments except for emergency room visits. Instead, you would pay coinsurance for non-preventive care which, if using a network provider of care, is a percentage of the network negotiated rate. Unless you are covered under an Aetna Passive Plan option, if you choose to use an out-of-network physician, you will be charged a higher percentage of the usual and prevailing fee or an amount negotiated by the Claim Administrator or an amount permitted by law plus the balance of the charges above the usual and prevailing fee.

### Example of Copayment, Coinsurance and Deductible Calculations

Assume you are in Medical Option 1, have Associate Only coverage, you need to go to the emergency room, and you incur $1,100 in covered charges. $800 of that $1,100 would be used to satisfy your annual deductible. Of the remaining $300 in charges, you would have to pay $200 to satisfy your emergency room copayment if you were not admitted. Of the remaining $100, you would have to pay 20% coinsurance ($20). Overall, you would be paying $1,020 out of your pocket and your annual deductible would be satisfied. Your deductible ($800), your coinsurance ($20) and your $200 emergency room copayment would count toward satisfying your $4,000 annual out-of-pocket maximum.

If you are in the CDHP with HSA Option 1, have Associate Only coverage, and you need to go to the emergency room prior to satisfying your deductible and incur $1,100 in covered charges, that $1,100 would come out of your pocket and would count towards satisfying your deductible. If you had already satisfied your deductible and incurred a $1,100 charge for emergency room services, you would pay the $200 emergency room copayment, if you were not admitted, plus 20% of the remaining $900 charge ($180) so you would be paying $380 that would be applied against your annual out-of-pocket maximum. If you had already satisfied your annual out-of-pocket maximum and incurred a $1,100 charge for emergency room services, you would pay nothing. Your $200 emergency room copayment and your coinsurance would be waived.

If you are in the CDHP with HSA Option 2, have Associate Only coverage, and you need to go to the emergency room prior to satisfying your deductible and incur $1,100 in covered charges, that $1,100 would come out of your pocket and would count towards satisfying your deductible. If you had already satisfied your deductible and incurred a $1,100 charge for emergency room services, you would pay the $200 emergency room copayment, if you were not admitted, plus 20% of the remaining $900 charge ($180) so you would be paying $360 that would be applied against your annual out-of-pocket maximum. If you had already satisfied your annual out-of-pocket maximum and incurred a $1,100 charge for emergency room services, you would pay nothing. Your $200 emergency room copayment and your coinsurance would be waived.

### Office Visits

In Medical Option 1 and the CDHP with HSA options, there are no office visit copayments. Instead, non-preventive care office visits are subject to the same coinsurance level as all other covered medical services. The coinsurance you pay (20%) is the same for network Primary Care Physician services (PCP) and Specialist Care Physician services (SCP). If you use a non-network provider of care, you will pay a 40% coinsurance level for a PCP or SCP. See the Medical Options-At-A-Glance summaries and the Definitions section of the SPD for further details.

### Non-Notification/No Prior Authorization Penalty

The non-notification penalty applies to covered expenses if Case Management/Pre-certification (Aetna)/Personal Health Support (UHC) is not notified as required by nonparticipating providers. Participating providers are required to provide notification for you or your dependent. Contact your claims administrator 24 hours prior to an inpatient stay.

### Out-of-Pocket Feature

Covered expenses are payable at the percentage shown in the Medical Options-At-A-Glance summaries until any out-of-pocket maximum has been reached during a calendar year. Then, covered expenses are payable at 100% of usual and prevailing fees or an amount negotiated by the Claim Administrator, or an amount permitted by law for the rest of that year.

All covered expenses that the covered person pays count toward the out-of-pocket maximums. Once you reach your out-of-pocket maximum, all covered expenses are paid at 100% of the usual and prevailing fee or an amount negotiated by the Claim Administrator or an amount permitted by law. If you receive your services out-of-network, you would still be responsible in general for charges above 150% of CMS rates for Medicare for eligible expenses or an amount negotiated by the Claim Administrator or an amount permitted by law. You would pay 100% of any charges above the eligible amounts and those payments are not applied against your out-of-pocket maximum.

The following out-of-pocket expenses will not count toward the out-of-pocket maximum for Medical Option 1 or the CDHP with HSA options and will apply even after the applicable out-of-pocket maximum has been reached:

- Non-notification penalty
- Expenses for services or supplies not covered by the Medical Plan
- Expenses for services or supplies in excess of the usual and prevailing fees or an amount negotiated by the Claim Administrator or an amount permitted by law

### Network Individual Out-of-Pocket Maximum

In Medical Option 1 and the CDHP with HSA Option 2, when the network individual out-of-pocket maximum is reached for any one covered person in a calendar year, network covered expenses are payable at 100% for that same person for the rest of that year. In the CDHP with HSA Option 1, for anything except single coverage one or multiple family members combined must reach the family out-of-pocket limit before the plan will pay covered benefits at 100% for anyone in the family. Specific limitations apply for some services, including chiropractic and fertility benefits. See the section "Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus Plan" for details.

### Non-Network Individual Out-of-Pocket Maximum

In Medical Option 1 and the CDHP with HSA Option 2, when the non-network individual out-of-pocket maximum is reached for any one covered person in a calendar year, non-network covered expenses are payable at 100% for that person for the rest of that year. In the CDHP with HSA Option 1, for anything except single coverage, there is no individual out-of-pocket maximum. One or multiple family members combined must reach the family out-of-pocket limit before the plan will pay covered benefits at 100% for anyone in the family. Specific limitations apply for some services, including chiropractic and fertility benefits. See the section "Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus Plan" for details.

**Note:** Once the out-of-pocket maximum is satisfied, eligible expenses will be covered generally at 150% of CMS rates for Medicare or an amount negotiated by the Claim Administrator, or an amount permitted by law. The amount(s) above usual and prevailing fee or an amount negotiated by the Claim Administrator, or an amount permitted by law will be the responsibility of the covered person. Please also note that there is no cross application of the in-network and the out-of-pocket maximums. They are separate from each other.

### Claims

All claims for benefits must be submitted within two years from the date of service.

### Medicare and the Medical Plan

Medicare is a health care program provided under Social Security. Before you reach your 65th birthday, contact the Social Security Administration office for information about how to enroll in Medicare. If an associate enrolls in Medicare, the ADP Plan will continue to be the primary carrier unless the associate advises Global HR Shared Services in writing that they have elected to have Medicare as their primary coverage. In that case, the associate will not be able to use the ADP Plan as a secondary coverage and must cancel their coverage under ADP's Plan. If you enroll in coverage through COBRA, Medicare will be primary.

The ADP Plan will also be the primary plan to Medicare in these dependent coverage situations:

- Medicare-eligible dependents of an active ADP associate
- Medicare-eligible retired spouse of an active ADP associate

Note: once a domestic partner is Medicare-eligible, the ADP Medical Plan will be secondary to Medicare.
If you are interested in Medicare, you can contactMedicare.Gov

### Early Medicare (pre-65)

If you or an eligible dependent become eligible for early Medicare (before age 65) due to total disability and while covered under the ADP Plan for active associates, the ADP Plan will be primary to Medicare. Note: once a domestic partner is Medicare-eligible, the ADP Medical Plan will be secondary to Medicare.

If you have Medicare because of End Stage Renal Disease (ESRD), the ADP Plan will be primary to Medicare for the first 30 months after you become eligible for Medicare and thereafter, Medicare will become primary to the ADP Plan.

If you do not apply for Medicare when you are eligible, claims will be processed as if you had enrolled in Medicare when the ADP Plan is secondary to Medicare. You must apply for Medicare Part A and Part B to have complete coverage.

## Managed Aetna Choice POS II / UnitedHealthcare Choice Plus Option 1 and CDHP with HSA Options

### Aetna Choice POS II or UnitedHealthcare Choice Plus

Associates have the option to elect either the Aetna Choice POS II or the UnitedHealthcare Choice Plus Plan option, depending upon your home zip code.

The benefit plan design and contributions are the same for both networks. However, the Claim Administrator will be different - either Aetna or UnitedHealthcare - and there will be a different network of participating hospitals, doctors, labs and other providers for each. Additionally, the list of procedures and treatments requiring pre-certification/prior authorization and the payment rules for certain non-participating mental health providers will vary between plan administrators. Visit the Aetna web site at http://www.aetna.com or the UnitedHealthcare web site at http://www.myuhc.com for a list of participating providers or contact Global HR Shared Services. For assistance, please contact Global HR Shared Services at 877-237-4711 or submit a case.

Please note that if your doctor leaves either network, you cannot change your option due to IRS guidelines that regulate these Plans. You may only make a change to your network of providers outside of the Annual Enrollment period if you move outside the Aetna Choice POS II / UnitedHealthcare Choice Plus service area (or if you experience a different qualified change in status). You will not be permitted to alternate between the networks during the year.

The Medical Option 1 and CDHP with HSA options provide coverage through a network of physicians, hospitals and other health care providers, who have contracted with the plan to provide comprehensive, quality service at a discount. You have the flexibility each time you receive service to use an in-network provider or out-of-network provider. Under both options, when you use a provider in the Aetna Choice POS II / UnitedHealthcare Choice Plus network, you get the benefit of negotiated discounts. If you choose a provider outside the network, your out-of-pocket costs will be higher. All options protect you against unexpected medical expenses and provide you the freedom to choose any provider.

**Note:** Where a provider is not available within the network, or if an associate is traveling outside the network service area and a non-network provider is used, the passive benefit of 80% of eligible expenses in general, 150% of CMS rates for Medicare or an amount negotiated by the Claim Administrator or an amount permitted by law will apply to services of the non-network provider, subject to the in-network level deductible and out-of-pocket limits.

If an associate is traveling outside the U. S. and requires medical care, passive PPO benefits will apply. Associates enrolled in an HMO plan should contact the HMO for coverage information while traveling outside the country.

**Health Information/Nurseline Services**

Both Aetna and UnitedHealthcare provide health information services for associates and their families enrolled in Aetna Choice POS II and UnitedHealthcare Choice Plus Plans. The Aetna program is called Informed Health Line (800-556-1555). Among the Aetna services are:

- 24 hours a day / 365 days a year nurseline service which allows you to talk to a registered nurse to obtain information on a variety of health and wellness topics, as well as information that can help you choose care that is appropriate for your situation
- Access to on-line and audio health information libraries
- Advice on self-care measures and tips on communicating with your health care provider

The UnitedHealthcare program is Advocate4Me (Contact number on your ID card). After hours, you will be referred to the Virtual Visit number. The services in the Advocate4Me program include allowing participants to:

- Understand your benefits and claims
- Talk through your bill or payment
- Avoid overpaying, find the right care and cost options
- Maximize your health savings
- Take advantage of your plan's health and well-being benefits

This is a valuable resource that can assist you in making intelligent choices about your health care. Please refer to Important Resources in the General Information Section of this SPD.

In addition, Aetna offers Aetna members In Touch Care and United Healthcare offers Personal Health Support. Aetna's In Touch Care is a program that takes a more holistic approach to care in terms of mind, body and cultural values. Aetna looks at different data sources to determine the appropriate level of support and designates a single point of contact for your health care needs. An Aetna nurse will reach out to those identified as high priority. Those with more moderate risks may receive a call, an email or interact online. A single nurse point of contact serves as the primary care manager for all your health care needs and those of your covered family members too.

United Healthcare's Personal Health Support (PHS) is a program that includes messaging, education, care plans and goal tracking. Based on a member's needs, PHS provides decision support, disease and case management for more than 100 conditions —including a broad range of clinical programs, such as maternity, transplant resource and congenital heart disease resource services. If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The PHS Nurse will provide you with their telephone number, so you can call them with questions about your conditions, or your overall health and well-being. If you do not receive a call from a PHS Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

# Aetna Choice POS II & UnitedHealthcare Choice Plus Medical Options-At-A-Glance

| Aetna Choice POS II / UnitedHealthcare Choice Plus | Option 1 | |
|---|---|---|
| | **In-Network** | **Out-of-Network** [1] |
| **Office Visit** | | |
| Preventive | Paid by ADP | Not Covered |
| Primary Care Physician (PCP) [2] | You pay 20% [3] | You pay 40% [3] |
| Specialty Care Physician | You pay 20% [3] | You pay 40% [3] |
| **Annual Deductible** [4] | In-network & Out-of-network deductible **do not** cross apply, they are separate | |
| Associate Only | $800 | $2,000 |
| Associate + Spouse/Domestic Partner | $800 per person | $2,000 per person |
| Associate + Child(ren) | $800 per person/ $1,600 per family | $2,000 per person/ $5,000 per family |
| Associate + Family | $800 per person/ $1,600 per family | $2,000 per person/ $5,000 per family |
| **Annual Out-of-Pocket Limit** [5] | In-network & Out-of-network out-of-pocket maximum **do not** cross apply, they are separate | |
| Associate Only | $4,000 per person | $7,500 per person |
| Associate + Spouse/Domestic Partner | $4,000 per person | $7,500 per person |
| Associate + Child(ren) | $4,000 per person/ $8,000 per family | $7,500 per person/ $15,000 per family |
| Associate + Family | $4,000 per person/ $8,000 per family | $7,000 per person/ $15,000 per family |
| **Hospital Services** | | |
| Inpatient | You pay 20% [3] | You pay 40% [3] |
| Outpatient | You pay 20% [3] | You pay 40% [3] |
| **Urgent Care Centers** | You pay 20% [3] | You pay 40% [3] |
| **Teladoc (Aetna) or Virtual Care Services (UHC)** | You pay 10% [3] | Not Covered |
| **Emergency Room: urgent care** [6] | You pay $200 copayment plus 20% after deductible (copayment waived if admitted) | |
| **Emergency Room: non-urgent care** [6] | $200 copay plus 20% after deductible | $200 copay plus 40% after deductible |
| **Mental Health / Substance Abuse** | | |
| Outpatient | You pay 20% [3] | You pay 40% [3] |
| Inpatient | You pay 20% [3] | You pay 40% [3] |
| **Physical, Speech and Occupational Therapy** | You pay 20% [3] | You pay 40% [3] |
| **Chiropractor** | You pay 20% after deductible up to a maximum benefit of $2,500 per calendar year | You pay 40% after deductible up to a maximum benefit of $2,500 per calendar year |
| **X-Ray / Lab** | You pay 20% [3] | You pay 40% [3] |
| **Preventive Care (deductible waived)** | | |
| Routine Cancer Screenings [7] | Paid by ADP | Not Covered |
| 1 Routine Physical for Adults [8] | Paid by ADP | Not Covered |
| **Immunizations** [9] (through age 17) | Paid by ADP | Not Covered |
| **Well-Baby Visits** (through age 5) | Paid by ADP | Not Covered |
| **Well-Child Visits** (ages 6 through 17) – 1 visit per calendar year | Paid by ADP | Not Covered |
| **Lifetime Benefit Maximum** | None | |
| **Prescription Drug** | | |
| **Retail Network Pharmacy (up to a 30-day supply)** | **You Pay:** | |
| Generic Drugs | 25% (minimum $20, maximum $60) [10] | |
| Preferred Brand Drugs | 25% (minimum $45, maximum $110) [10] [11] | |
| Non-preferred Brand Drugs | 50% (minimum $110, maximum $240) [10] [11] | |
| **Mail Order / Home Delivery Service / Walgreens Smart90 Program (up to a 90-day supply)** | **You Pay:** | |
| Generic Drugs | 25% (minimum $40, maximum $140) [10] | |
| Preferred Brand Drugs | 25% (minimum $95, maximum $250) [10] [11] | |
| Non-preferred Brand Drugs | 50% (minimum $250, maximum $480) [10] [11] | |

1) For out-of-network services, you pay 40% of the eligible amount. The eligible amount is generally 150% of the Centers for Medicare and Medicaid Services "CMS" rates or an amount negotiated by the Claim Administrator, or an amount permitted by law. You pay 100% of any charges above the eligible amounts and those payments are not applied against your out-of-pocket maximum.
2) PCP includes General Practitioner, Family Practitioner, Internist, Pediatrician and OB/GYN.
3) Once the deductible is met, coinsurance applies until you reach the out-of-pocket maximum.
4) The deductible is waived for certain preventive medications.
5) The out-of-pocket maximum is for medical and prescription drugs combined. It includes deductible and emergency room copayments and excludes out-of-network amounts over the eligible amount.
6) See the No Surprise Bill section of the SPD.
7) Covered services for routine physicals include only age and gender appropriate clinical screenings and immunizations in accordance with guidelines followed by Aetna and UnitedHealthcare providers. If your physician indicates that you should have a screening sooner than the standard guideline because your physician deems you to be at a high risk for a condition, that screening will be paid by ADP (limit of one screening per year for each type of screening).
8) You can spread the physical over two visits, but you cannot duplicate services.
9) Well-child immunizations include the following: diphtheria, pertussis, tetanus, hemophilus influenza, oral polio, hepatitis A, hepatitis B, measles, mumps, rubella, chicken pox, meningitis and one tuberculosis skin test.
10) If the cost of the drug is less than the minimum copayment, you will only pay the cost of the drug.
11) If you purchase a brand name medication when a generic equivalent is available, you will pay your generic copayment plus the cost difference between the brand name and generic medication.

### Special features of your Plan:

- ADP will pay for smoking cessation medications subject to quantity duration limits. Some drugs are subject to prior authorization rules. Your doctor may be required to provide additional information before prescriptions for these medications can be filled. See the Prescription Drug Plan section of the SPD for a complete list.

- If you receive maintenance medications through a retail pharmacy, you will pay 100% of the cost of the medication after the third fill if you continue to fill a 30-day supply. Through the Smart90 Walgreens program, you can receive up to a 90-day supply of your maintenance medications directly at a Walgreens retail pharmacy. This program may be chosen in place of receiving maintenance medications through home delivery from Express Scripts. In summary, prescription medications that you take for more than 90 days are covered under the Plan if received through the Express Scripts mail service or through the Smart 90 Walgreens network.

# Aetna Choice POS II & UnitedHealthcare Choice Plus Medical Options-At-A-Glance

| Aetna Choice POS II / UnitedHealthcare Choice Plus | CDHP with HSA Option 1 | | CDHP with HSA Option 2 | |
|---|---|---|---|---|
| | In-Network | Out-of-Network [1] | In-Network | Out-of-Network [1] |
| **Office Visit**<br>Preventive<br>Primary Care Physician (PCP) [2]<br>Specialty Care Physician | Paid by ADP<br>You pay 20% [3]<br>You pay 20% [3] | Not Covered<br>You pay 40% [3]<br>You pay 40% [3] | Paid by ADP<br>You pay 20% [3]<br>You pay 20% [3] | Not Covered<br>You pay 40% [3]<br>You pay 40% [3] |
| **Annual Deductible** | In-network & Out-of-network deductible **do not** cross apply, they are separate | | In-network & Out-of-network deductible **do not** cross apply, they are separate | |
| Associate Only | $1,850 | $3,500 | $3,400 | $6,800 |
| Associate + Spouse/Domestic Partner | $4,000 [4] | $7,000 [4] | $3,400 per person, $6,800 per family | $6,800 per person, $13,600 per family |
| Associate + Child(ren) | $4,000 [4] | $7,000 [4] | $3,400 per person, $6,800 per family | $6,800 per person, $13,600 per family |
| Associate + Family | $4,000 [4] | $7,000 [4] | $3,400 per person, $6,800 per family | $6,800 per person, $13,600 per family |
| **Annual Out-of-Pocket Limit** [5] | In-network & Out-of-network out-of-pocket maximum **do not** cross apply, they are separate | | In-network & Out-of-network out-of-pocket maximum **do not** cross apply, they are separate | |
| Associate Only | $4,250 | $8,500 | $6,650 | $13,300 |
| Associate + Spouse/Domestic Partner | $8,000 [6] | $17,000 [6] | $6,650 per person, $13,300 per family | $13,300 per person, $26,600 per family |
| Associate + Child(ren) | $8,000 [6] | $17,000 [6] | $6,650 per person, $13,300 per family | $13,300 per person, $26,600 per family |
| Associate + Family | $8,000 [6] | $17,000 [6] | $6,650 per person, $13,300 per family | $13,300 per person, $26,600 per family |
| **ADP HSA Contribution** [7] | $600 Individual and $1,100 for Individuals with dependents | | $750 Individual and $1,500 for Individuals with dependents | |
| **Hospital Services**<br>Inpatient<br>Outpatient | You pay 20% [3]<br>You pay 20% [3] | You pay 40% [3]<br>You pay 40% [3] | You pay 20% [3]<br>You pay 20% [3] | You pay 40% [3]<br>You pay 40% [3] |
| **Urgent Care Centers** | You pay 20% [3] | You pay 40% [3] | You pay 20% [3] | You pay 40% [3] |
| **Teladoc (Aetna) or Virtual Care Services (UHC)** | You pay 10% [3] | Not Covered | You pay 10% [3] | Not Covered |
| **Emergency Room: urgent care** [8] | You pay $200 copayment plus 20% after deductible (copayment waived if admitted) | | You pay $200 copayment plus 20% after deductible (copayment waived if admitted) | |
| **Emergency Room: non-urgent care** [8] | $200 copay plus 20% after deductible | $200 copay plus 40% after deductible | $200 copay plus 20% after deductible | $200 copay plus 40% after deductible |
| **Mental Health / Substance Abuse**<br>Outpatient<br>Inpatient | You pay 20% [3]<br>You pay 20% [3] | You pay 40% [3]<br>You pay 40% [3] | You pay 20% [3]<br>You pay 20% [3] | You pay 40% [3]<br>You pay 40% [3] |
| **Physical, Speech and Occupational Therapy** | You pay 20% [3] | You pay 40% [3] | You pay 20% [3] | You pay 40% [3] |
| **Chiropractor** | You pay 20% after deductible up to a maximum benefit of $2,500 per calendar year | You pay 40% after deductible up to a maximum benefit of $2,500 per calendar year | You pay 20% after deductible up to a maximum benefit of $2,500 per calendar year | You pay 40% after deductible up to a maximum benefit of $2,500 per calendar year |
| **X-Ray / Lab** | You pay 20% [3] | You pay 40% [3] | You pay 20% [3] | You pay 40% [3] |
| **Preventive Care (deductible waived)**<br>Routine Cancer Screenings [9]<br>1 Routine Physical for Adults [10] | Paid by ADP<br>Paid by ADP | Not Covered<br>Not Covered | Paid by ADP<br>Paid by ADP | Not Covered<br>Not Covered |
| **Immunizations** [11] (through age 17) | Paid by ADP | Not Covered | Paid by ADP | Not Covered |
| **Well-Baby Visits** (through age 5) | Paid by ADP | Not Covered | Paid by ADP | Not Covered |
| **Well-Child Visits** (ages 6 through 17) – 1 visit per calendar year | Paid by ADP | Not Covered | Paid by ADP | Not Covered |
| **Lifetime Benefit Maximum** | None | | None | |

| Aetna Choice POS II / UnitedHealthcare Choice Plus | CDHP with HSA Option 1 | | CDHP with HSA Option 2 | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Prescription Drug** | | | | |
| **Retail Network Pharmacy (up to a 30-day supply)** | **After Deductible is Satisfied** [12] **You Pay:** | | **After Deductible is Satisfied** [12] **You Pay:** | |
| Generic Drugs | 25% (minimum $20, maximum $60) [13] | | 25% (minimum $20, maximum $60) [13] | |
| Preferred Brand Drugs | 25% (minimum $45, maximum $110) [13] [14] | | 25% (minimum $45, maximum $110) [13] [14] | |
| Non-preferred Brand Drugs | 50% (minimum $110, maximum $240) [13] [14] | | 50% (minimum $110, maximum $240) [13] [14] | |
| **Mail Order / Home Delivery Service / Walgreens Smart90 Program (up to a 90-day supply)** | **After Deductible is Satisfied** [12] **You Pay**: | | **After Deductible is Satisfied** [12] **You Pay**: | |
| Generic Drugs | 25% (minimum $40, maximum $140) [13] | | 25% (minimum $40, maximum $140) [13] | |
| Preferred Brand Drugs | 25% (minimum $95, maximum $250) [13] [14] | | 25% (minimum $95, maximum $250) [13] [14] | |
| Non-preferred Brand Drugs | 50% (minimum $250 maximum $480) [13] [14] | | 50% (minimum $250, maximum $480) [13] [14] | |

1) For out-of-network services, you pay 40% of the eligible amount. The eligible amount is generally 150% of the CMS rates for Medicare or an amount negotiated by the Claim Administrator, or an amount permitted by law. You pay 100% of any charges above the eligible amounts and those payments are not applied against your out-of-pocket maximum.
2) PCP includes General Practitioner, Family Practitioner, Internist, Pediatrician and OB/GYN.
3) Once the deductible is met, coinsurance applies until you reach the out-of-pocket maximum.
4) One or multiple family members combined must reach the family deductible limit before the plan will pay for non-preventive benefits for anyone in the family.
5) The out-of-pocket maximum is for medical and prescription drugs combined. It includes deductible and emergency room copayments and excludes out-of-network amounts over the eligible amount.
6) One or multiple family members combined must reach the family out-of-pocket limit before the plan will pay covered benefits at 100%.
7) ADP contributes per pay period to HSAs up to the listed limits for the year. Contributions are prorated for HSAs opened after January 1. You must elect to participate in the HSA to receive ADP's HSA contribution.
8) See the No Surprise Bill section of the SPD.
9) Covered services for routine physicals include only age and gender appropriate clinical screenings and immunizations in accordance with guidelines followed by Aetna and UnitedHealthcare providers. If your physician indicates that you should have a screening sooner than the standard guideline because your physician deems you to be at a high risk for a condition, that screening will be paid by ADP (limit of one screening per year for each type of screening).
10) You can spread the physical over two visits, but you cannot duplicate services.
11) Well-child immunizations include the following: diphtheria, pertussis, tetanus, hemophilus influenza, oral polio, hepatitis A, hepatitis B, measles, mumps, rubella, chicken pox, meningitis and one tuberculosis skin test.
12) The deductible is waived for certain preventive medications.
13) If the cost of the drug is less than the minimum copayment, you will only pay the cost of the drug.
14) If you purchase a brand name medication when a generic equivalent is available, you will pay your generic copayment plus the cost difference between the brand name and generic medication.

## Special features of your Plan:

- ADP will pay for smoking cessation medications subject to quantity duration limits. Some drugs are subject to prior authorization rules. Your doctor may be required to provide additional information before prescriptions for these medications can be filled. See the Prescription Drug Plan section of the SPD for a complete list.
- If you receive maintenance medications through a retail pharmacy, you will pay 100% of the cost of the medication after the third fill if you continue to fill a 30-day supply. Through the Smart90 Walgreens program, you can receive up to a 90-day supply of your maintenance medications directly at a Walgreens retail pharmacy. This program may be chosen in place of receiving maintenance medications through home delivery from Express Scripts. In summary, prescription medications that you take for more than 90 days are covered under the Plan if received through the Express Scripts mail service or through the Smart 90 Walgreens network.

| Aetna Choice POS II & UnitedHealthcare Choice Plus<br>Bi-Weekly Contributions Without Tobacco Surcharge | | | |
|---|---|---|---|
| **Coverage Tier** | **Option 1** | **CDHP with HSA Option 1** | **CDHP with HSA Option 2** |
| Associate Only | $231.39 | $71.20 | $37.76 |
| Associate + Spouse/Domestic Partner | $520.62 | $184.62 | $156.72 |
| Associate + Child(ren) | $462.77 | $164.11 | $139.10 |
| Associate + Family | $790.63 | $254.28 | $215.89 |

ADP will apply a $50 monthly tobacco surcharge for associates and covered spouses/domestic partners who certify as Tobacco Users. Associates who never completed a Tobacco certification will default to Tobacco User rates for 2026 Medical Plan contributions until they attest otherwise. Spouse/domestic partner's use of tobacco will affect this surcharge if they are covered under the Medical Plan. Tobacco use will be defined as follows:

- **Tobacco User:** In the previous six months, associate/spouse/domestic partner has used tobacco products **AND** has not completed the Personify Health Tobacco Cessation Program
- **Non-Tobacco User:** In the previous six months, associate/spouse/domestic partner has not used tobacco products **OR** has completed the Personify Health Tobacco Cessation Program

**Tobacco products include** Cigarettes, electronic cigarettes (e-cigarettes), vaping products, pipes, cigars, chewing tobacco, smokeless tobacco or other tobacco products.

An associate/spouse/domestic partner can avoid or eliminate the surcharge by completing the Personify Health Tobacco Cessation Coaching Program, which is available to associates at no cost, or by successfully quitting tobacco use for six consecutive months.

**If an associate/dependent completes the Personify Health Tobacco Cessation Program or successfully quits tobacco use for six consecutive months, the associate/dependent can attest to being a non-tobacco user to forego the surcharge.**

**Note:** Associates and dependents can attest to being a non-tobacco user at any time during 2026 by updating their Tobacco Use Certification through the **ADP Benefits Enrollment System**. Once updated, the change will be effective the next available pay cycle. Retroactive elections cannot be honored.

# Aetna Choice POS II Medical Options-At-A-Glance (Passive)

| Aetna Choice POS II | Option 1 [1] | CDHP with HSA Option 1 [1] | CDHP with HSA Option 2 [1] |
|---|---|---|---|
| **Office Visit**<br>Preventive<br>Primary Care Physician (PCP) [2]<br>Specialty Care Physician | <br>Paid by ADP<br>You pay 20% [3]<br>You pay 20% [3] | <br>Paid by ADP<br>You pay 20% [3]<br>You pay 20% [3] | <br>Paid by ADP<br>You pay 20% [3]<br>You pay 20% [3] |
| **Annual Deductible** | | | |
| Associate Only | $800 | $1,850 | $3,400 |
| Associate + Spouse/Domestic Partner | $800 per person | $4,000[4] | $3,400 per person/$6,800 per family |
| Associate + Child(ren) | $800 per person/$1,600 per family | $4,000[4] | $3,400 per person/$6,800 per family |
| Associate + Family | $800 per person/$1,600 per family | $4,000[4] | $3,400 per person/$6,800 per family |
| **Annual Out-of-Pocket Limit [5]** | | | |
| Associate Only | $4,000 | $4,250 | $6,650 |
| Associate + Spouse/Domestic Partner | $4,000 per person | $8,000 [6] | $6,650 per person/$13,300 per family |
| Associate + Child(ren) | $4,000 per person/$8,000 per family | $8,000 [6] | $6,650 per person/$13,300 per family |
| Associate + Family | $4,000 per person/$8,000 per family | $8,000 [6] | $6,650 per person/$13,300 per family |
| **ADP HSA Contribution [7]** | None | $600 Individual and $1,100 for Individuals with dependents | $750 Individual and $1,500 for Individuals with dependents |
| **Hospital Services**<br>Inpatient<br>Outpatient | <br>You pay 20% [3]<br>You pay 20% [3] | <br>You pay 20% [3]<br>You pay 20% [3] | <br>You pay 20% [3]<br>You pay 20% [3] |
| **Urgent Care Centers** | You pay 20% [3] | You pay 20% [3] | You pay 20% [3] |
| **Teladoc (Aetna) or Virtual Care Services (UHC)** | You pay 10% [3]. This amount is normally less than a PCP office visit | You pay 10% [3]. This amount is normally less than a PCP office visit | You pay 10% [3]. This amount is normally less than a PCP office visit |
| **Emergency Room: urgent care** | You pay $200 copayment plus 20% after deductible (copayment waived if admitted) | You pay $200 copayment plus 20% after deductible (copayment waived if admitted) | You pay $200 copayment plus 20% after deductible (copayment waived if admitted) |
| **Emergency Room: non-urgent care** | You pay $200 copayment plus 20% after deductible | You pay $200 copayment plus 20% after deductible | You pay $200 copayment plus 20% after deductible |
| **Mental Health / Substance Abuse**<br>Outpatient<br>Inpatient | <br>You pay 20% [3]<br>You pay 20% [3] | <br>You pay 20% [3]<br>You pay 20% [3] | <br>You pay 20% [3]<br>You pay 20% [3] |
| **Physical, Speech and Occupational Therapy** | You pay 20% [3] | You pay 20% [3] | You pay 20% [3] |
| **Chiropractor** | You pay 20% after deductible up to a maximum benefit of $2,500 per calendar year | You pay 20% after deductible up to a maximum benefit of $2,500 per calendar year | You pay 20% after deductible up to a maximum benefit of $2,500 per calendar year |
| **X-Ray / Lab** | You pay 20% [3] | You pay 20% (3) | You pay 20% [3] |
| **Preventive Care (deductible waived)**<br>Routine Cancer Screenings [8]<br>1 Routine Physical for Adults [9] | <br>Paid by ADP<br>Paid by ADP | <br>Paid by ADP<br>Paid by ADP | <br>Paid by ADP<br>Paid by ADP |
| **Immunizations [10]** (through age 17) | Paid by ADP | Paid by ADP | Paid by ADP |
| **Well-Baby Visit** (through age5) | Paid by ADP | Paid by ADP | Paid by ADP |
| **Well-Child Visits** (ages 6 through 17)<br>1 visit per calendar year | Paid by ADP | Paid by ADP | Paid by ADP |
| **Lifetime Benefit Maximum** | None | None | None |

| Aetna Choice POS II | Option 1 | CDHP with HSA Option 1 | CDHP with HSA Option 2 |
|---|---|---|---|
| **Prescription Drug** | | | |
| **Retail Network Pharmacy (up to 30-day supply)** | **You pay:** | **After Deductible [11] You pay:** | **After Deductible [11] You pay:** |
| Generic Drugs | 25% (minimum $20, maximum $60) [12] | 25% (minimum $20, maximum $60) [12] | 25% (minimum $20, maximum $60) [12] |
| Preferred Brand Drugs | 25% (minimum $45, maximum $110) [12] [13] | 25% (minimum $45, maximum $110) [12] [13] | 25% (minimum $45, maximum $110) [12] [13] |
| Non-Preferred Brand Drugs | 50% (minimum $110, maximum $240) [12] [13] | 50% (minimum $110, maximum $240) [12] [13] | 50% (minimum $110, maximum $240) [12] [13] |
| **Mail Order / Home Delivery Service / Smart90 Walgreens (up to 90-day supply)** | **You pay:** | **After Deductible [11] You pay:** | **After Deductible [11] You pay:** |
| Generic Drugs | 25% (minimum $40, maximum $140) [13] | 25% (minimum $40, maximum $140) [13] | 25% (minimum $40, maximum $140) [13] |
| Preferred Brand Drugs | 25% (minimum $95, maximum $250) [12] [13] | 25% (minimum $95, maximum $250) [12] [13] | 25% (minimum $95, maximum $250) [12] [13] |
| Non-Preferred Brand Drugs | 50% (minimum $250, maximum $480) [12] [13] | 50% (minimum $250, maximum $480) [12] [30] | 50% (minimum $250, maximum $480) [12] [13] |

1) For out-of-network services, you pay 20% of the eligible amount. The eligible amount is generally 150% of the CMS rates for Medicare or an amount negotiated by the Claim Administrator, or an amount permitted by law. You pay 100% of any charges above the eligible amounts and those payments are not applied against your out-of-pocket maximum.
2) PCP includes General Practitioner, Family Practitioner, Internist, Pediatrician and OB/GYN.
3) Once the deductible is met, coinsurance applies until you reach the out-of-pocket maximum.
4) One or multiple family members combined must reach the family deductible limit before the plan will pay for non-preventive benefits for anyone in the family.
5) The out-of-pocket maximum is for medical and prescription drugs combined. It includes deductible and emergency room copayments and excludes out-of-network amounts over the eligible amount.
6) One or multiple family members combined must reach the family out-of-pocket limit before the plan will pay covered benefits at 100%.
7) ADP contributes per pay period to HSAs up to the listed limits for the year. Contributions are prorated for HSAs opened after January 1. You must elect to participate in the HSA to receive ADP's HSA contributions.
8) Covered services for routine physicals include only age and gender appropriate clinical screenings and immunizations in accordance with guidelines followed by Aetna and UnitedHealthcare providers. If your physician indicates that you should have a screening sooner than the standard guideline because your physician deems you to be at a high risk for a condition, that screening will be paid by ADP (limit of one screening per year for each type of screening).
9) You can spread the physical over two visits, but you cannot duplicate services.
10) Well-child immunizations include the following: diphtheria, pertussis, tetanus, hemophilus influenza, oral polio, hepatitis A, hepatitis B, measles, mumps, rubella, chicken pox, meningitis and one tuberculosis skin test.
11) The deductible is waived for certain preventive medications.
12) If the cost of the drug is less than the minimum copayment, you will only pay the cost of the drug.
13) If you purchase a brand name medication when a generic equivalent is available, you will pay your generic copayment plus the cost difference between the brand name and generic medication.

### Special features of your plan:

- ADP will pay for smoking cessation medications subject to quantity duration limits. Some drugs are subject to prior authorization rules. Your doctor may be required to provide additional information before prescriptions for these medications can be filled. See the Prescription section of this SPD for a complete list.
- If you receive maintenance medications through a retail pharmacy, you will pay 100% of the cost of the medication after the third fill if you continue to fill a 30-day supply. Through the Smart90 Walgreens program, you can receive up to a 90-day supply of your maintenance medications directly at a Walgreens retail pharmacy. This program may be chosen in place of receiving maintenance medications through home delivery from Express Scripts. In summary, prescription medications that you take for more than 90 days are covered under the Plan if received through the Express Scripts mail service or through the Smart 90 Walgreens network.

| Aetna Choice POS II Passive<br>Bi-Weekly Contributions Without Tobacco Surcharge | | | |
|---|---|---|---|
| **Coverage Tier** | **Option 1** | **CDHP with HSA Option 1** | **CDHP with HSA Option 2** |
| Associate Only | $231.39 | $71.20 | $37.76 |
| Associate + Spouse/Domestic Partner | $520.62 | $184.62 | $156.72 |
| Associate + Child(ren) | $462.77 | $164.11 | $139.10 |
| Associate + Family | $790.63 | $254.28 | $215.89 |

ADP will apply a $50 monthly tobacco surcharge for associates and covered spouses/domestic partners who certify as Tobacco Users. Associates who never completed a Tobacco certification will default to Tobacco User rates for 2026 Medical Plan contributions until they attest otherwise. Spouse/domestic partner's use of tobacco will affect this surcharge if they are covered under the Medical Plan. Tobacco use will be defined as follows:

- **Tobacco User:** In the previous six months, associate/spouse/domestic partner has used tobacco products **AND** has not completed the Personify Health Tobacco Cessation Coaching Program
- **Non-Tobacco User:** In the previous six months, associate/spouse/domestic partner has not used tobacco products **OR** has completed the Personify Health Tobacco Cessation Coaching Program

**Tobacco products include** Cigarettes, electronic cigarettes (e-cigarettes), vaping products, pipes, cigars, chewing tobacco, smokeless tobacco or other tobacco products.

An associate/spouse/domestic partner can avoid or eliminate the surcharge by completing the Personify Health Tobacco Cessation Coaching Program, which is available at no cost through the ADP Voluntary Wellness Program, or by successfully quitting tobacco use for six consecutive months.

**If an associate/dependent completes the Personify Health Tobacco Cessation Program or successfully quits tobacco use for six consecutive months, the associate/dependent can attest to being a non-tobacco user to forego the surcharge.**

**Note:** Associates and dependents can attest to being a non-tobacco user at any time during 2026 by updating their Tobacco Use Certification through the **ADP Benefits Enrollment System**. Once updated, the change will be effective the next available pay cycle. Retroactive elections cannot be honored.

**Passive PPO Option 1 and CDHP with HSA options**

The Passive Options are only available to associates who reside outside of the Aetna Choice POS II and UnitedHealthcare Choice Plus managed care service areas. Passive benefits are available through Aetna only at this time. Under the Aetna Passive options, out-of-network benefits are paid at a higher level than the non-Passive Options (80% co-insurance vs. 60% subject to usual and prevailing (U&P) fee schedule) or an amount negotiated by the Claim Administrator, or an amount permitted by law. The deductible and out-of-pocket maximums are the same as the network benefit levels.

For associates traveling out of the country who require medical care, you will be eligible for Passive level benefits through either Aetna or UnitedHealthcare for covered expenses, i.e., 80% of usual and prevailing (U&P) fees or an amount negotiated by the Claim Administrator, or an amount permitted by law after the deductible has been satisfied. Prescription drugs are covered.

## Case Management/Prior Approval Program

The Case Management/Prior Approval Program is designed to encourage an efficient system of care for associates and their enrolled dependents by identifying and addressing certain covered health care needs, such as admission counseling, inpatient care advocacy and certain discharge planning and disease management activities. Aetna calls prior approval precertification and UnitedHealthcare refers to it as prior authorization. The Case Management/Prior Approval activities are not a substitute for the medical judgment of your physician. The ultimate decision as to what medical care associates or their dependents receive must be made by the associate and their physician.

Case Management/Prior Approval is triggered when the Claim Administrator receives notification of an upcoming treatment or service. The notification process serves as a gateway to Case Management/Pre-certification/Prior Authorization activities and is an opportunity for the associate to let the Claim Administrator know that they are planning to receive specific health care services.

The associate can expect to receive phone calls from the Claim Administrator when certain treatments are involved.

**When using a non-network provider, it is the associate's responsibility to obtain precertification/prior authorization for services prior to receiving them**. This obligation to obtain precertification/prior authorization is also applicable when a non-network provider intends to admit you to a network facility or refers you to Network providers.
**If an associate fails to follow the precertification/prior authorization requirements set forth in this section, a Penalty will be imposed**. This amount will not be counted when satisfying the out-of-pocket maximum or the annual deductible.

### How to Notify Case Management/Pre-Certification

Call the toll-free number shown on your ID card. Once you have obtained authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services subject to the authorization.

## When to Notify Case Management/Pre-Certification

### Hospital Pre-certification

If you or a participating member of your family is considering hospitalization, ADP's pre-admission review administrator must be contacted before admission. If you do not follow the pre-admission procedures or the administrator's recommendations, the benefit payable for hospital expenses is reduced by $500. The associate, a member of the associate's family, the doctor, or any designated individual may make the contact. The responsibility for making the contact is yours if using a non-network provider. The administrator determines the length of inpatient care that is eligible for benefits under the Medical Plan. This means that days not approved are not covered under the Medical Plan.

If you are hospitalized in an emergency situation, you must notify the administrator within two business days of the admission. By working with your doctor throughout your hospital stay, the administrator can make a sound recommendation on the length of stay that is eligible for benefits under the Medical Plan.

- For inpatient confinement, the covered person must notify Case Management/Pre-certification of the scheduled admission date at least five (5) working days before the start of the confinement. An admission date may not have been set when the confinement was planned. The covered person must call Case Management/Pre-certification again as soon as the admission date is set
- For outpatient services that require notification, the covered person must notify Case Management/Pre-certification at least five (5) working days before the service is given.

**Aetna Choice POS II –** Following is the list of Procedures and Treatments Requiring Pre-certification for the Aetna Choice POS II Coverage Option. This list can change so go to http://www.aetna.com/health-care-professionals/precertification/precertification-lists.html for the latest list.

- Fertility Services **(WIN: 1-833-439-1518)**
- **Clinical Trials and Investigational services** are generally not covered, but there are some exceptions regarding approved clinical trials for cancer or terminal illness
- **Inpatient Confinements:** Rehabilitation facility, Inpatient Hospice, maternity confinements, mental and nervous, skilled nursing facility, surgical and non-surgical
- **Gene-based cellular and other innovative therapies (GCIT)** - covered services include GCIT provided by a physician, hospital or other provider
- **Home Health Services**
- **Cosmetic and Reconstructive Procedures**
  - Blepharoplasty, Canthopexy, Canthoplasty
  - Breast reconstruction, breast enlargement
  - Breast reduction, mammoplasty
  - Excision of excessive skin due to weight loss
  - Gastroplasty, gastric bypass
  - Lipectomy or excess fat removal
  - Pectus excavatum, repair
  - Rhinoplasty, rhytidectomy
  - Sclerotherapy or surgery for varicose veins
  - Surgical treatment of gynecomastia
  - Tattoo removal, revision or application
  - Treatment of penile dysfunction
  - Any other cosmetic procedure
- **Selected Durable Medical Equipment**
  - Clinitron and electric beds
  - Customized braces
  - Electric and motorized wheelchairs and scooters
  - Limb and torso prosthetics
- **Neuropsychological Testing**
- **Other Surgery/Services**
  - Bunionectomy and hammertoe
  - Elective (non-emergent) transportation by ambulance, medical van or air ambulance
  - Investigative or experimental services
  - Laparoscopic infertility surgery
  - Management of the temporomandibular joint
  - Orthognathic surgery procedures, osteotomies and surgical
  - Sex reassignment surgery and surgery to change specified secondary sex characteristics
  - Uvulopalatopharyngoplasty
- **Private Duty Nursing Care**
- **Radiology Imaging:**
  - Precertification members with plans applicable to this precertification list when performed in any place of service except inpatient, emergency room and observation bed status
  - Through regional specific vendor (MedSolutions or CareCore National) where applicable, for computed tomographic (CT) studies, coronary CT angiography, MRI/MRA, nuclear cardiology, PET scans, diagnostic left and right heart catheterizations and echo stress tests
- **Transplantation**

**UnitedHealthcare (UHC) Choice Plus -** Following is the List of Procedures and Treatments Requiring prior authorization for the UnitedHealthcare Choice Plus Coverage Option. This list can change so go to coverage and benefits tab of www.myuhc.com to check for the latest list.

Covered Health Services which require prior authorization:

- Ambulance - non-emergent air and ground
- Bariatric Surgery
- Cellular & Gene Therapy
- Clinical trials
- Congenital heart disease surgery
- Durable Medical Equipment (DME) costs over $1,000, including DME for the management and treatment of diabetes
- Fertility Services **(WIN: 1-833-439-1518)**
- Gender Dysphoria Services – surgical and non-surgical treatment
- Genetic Testing
- Home Health Care – Private Duty Nursing, Skilled Nursing
- Hospice care – Inpatient Stay
- Hospital – Inpatient Stay . Maternity Delivery inpatient stay longer than 48 hours following vaginal delivery or 96 hours following cesarean section delivery
- Mental Health Services – Inpatient: including admission for services at a Residential Treatment facility
- Mental Health Services – Outpatient: Partial Hospitalization/Day Treatment; High Intensity Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.
- Substance-Related and Addictive Disorders Services- Inpatient: including admission for services at a Residential Treatment facility
- Substance-Related and Addictive Disorders Services- Outpatient: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing
- Neurobiological Disorders – Autism Spectrum Disorders - Inpatient: including admission for services at a Residential Treatment facility
- Neurobiological Disorders – Autism Spectrum Disorders - Outpatient: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; and Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA)
- Prosthetic Devices in excess of $1,000 in cost per device
- Reconstructive procedures
- Skilled Nursing Facility/Inpatient Rehabilitation
- Sleep Apnea and Sleep Studies
- Orthognathic Surgery including temporomandibular joint (TMJ) surgery
- Therapeutic Treatments – Outpatient Dialysis, IV infusion, and intensity modulated radiation therapy, and MR-guided focused ultrasound
- Transplantation Services

You may also be required to have an independent medical exam by a physician who is:

- Certified by an appropriate specialty board and
- Not in practice with the physician recommending the procedure or treatment

The results of the exam will help determine the necessity of the procedure or treatment. Expenses incurred for such exam will be payable at 100% with no calendar year deductible.

**Note:** You or the provider performing the procedure or treatment must call the toll-free number shown on your ID card to request certification.

### Benefits Reduced if Case Management/Pre-Certification/Prior Authorization Not Called

Benefits are reduced if the covered person does not call as required for certain non-Network services. A prior authorization penalty applies to each confinement, surgical procedure or treatment plan if services are medically necessary. The amount of the penalty is $500 per confinement or procedure. The amount of the penalty will never be more than the covered expense. No benefits will be paid if services are not medically necessary.

**A Covered Person Can Appeal a Review decision by Calling Case Management/Pre-certification**
If the covered person or the physician does not agree with the decision, it can be appealed. See complete details of the appeals process in the ERISA section of this SPD.

**Maternity Case Management**
Pregnancy is subject to the following prior authorization time periods:

A. **Prenatal Program** - Case Management/Pre-certification should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in the prenatal programs available through Aetna or UnitedHealthcare as described below.
B. **Inpatient Confinement for Delivery of a Child** - Case Management/Pre-certification must be notified only if the inpatient care for the mother or child is expected to continue beyond:
   - 48 hours following a normal vaginal delivery, or
   - 96 hours following a Cesarean section
   - For inpatient care (for either the mother or child) which continues beyond the 48/96-hour limits stated above, the Case Management/Pre-certification must be notified before the end of these time periods.
   - A shorter stay, if the attending physician with the consent of the mother, discharges the mother or newborn earlier. If the mother is discharged earlier, the plan will pay for 1 home visit after delivery by a healthcare provider.
C. **Non-emergency Inpatient Confinement without Delivery of Child** - Confinement during pregnancy but before the admission for delivery, which is not emergency care, requires notification as a scheduled confinement. Case Management/pre-certification must be notified prior to the scheduled admission.

**Aetna Enhanced Maternity Program 1-800-CRADLE (1-800-272-3531)**
This maternity program is available to ADP associates enrolled in the Aetna Choice POS II medical options.

- The Aetna Enhanced Maternity Program provides you with maternity health care information and guides you throughout your entire maternity journey – from family planning and fertility (ADP uses WIN) to postpartum care. It offers: Access to breastfeeding support services
- Access to Smoke-free Moms-to-be® smoking cessation program for pregnant women
- Care coordination by trained obstetrical nurses
- Care management resources such as high-risk member support, preeclampsia prevention and action for preterm labor symptoms
- Earlier and more comprehensive identification of pregnancies
- Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding
- Education on early labor symptoms and preterm labor, what to expect before and after delivery, newborn care and more
- Guided Genetic Health – counseling by phone, carrier screening and cost-effective genetic testing
- Outreach throughout the maternity journey
- Specialized information for dad or partner
- Web-based materials and access to program services through Women's Health Online
- Non-bias and cultural awareness training to their nurses

Another important feature, **Pregnancy Risk Assessment**, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary. If you have extra risks, you may also receive follow-up calls after your delivery, a screening for depression and extra support for lactation and breast feeding.

**United Healthcare Maven Maternity Support (www.myuhc.com/maternity)**
If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an obstetrics (OB) nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

## Medical Management Programs

**Case Management (Aetna) (1-800-648-4092)**
This program is available to associates and dependents enrolled in the Aetna Choice POS II and Passive PPO coverage options. Case Management focuses on improving health and wellness. Case Management is a process of identifying persons at high risk for problems associated with complex health care needs, assessing opportunities to coordinate care, and identifying treatment options to improve quality of care, quality of life, and control costs. Case Managers generally assist covered associates and dependents in managing their illnesses, coordinate a series of intensive interventions designed to alter the natural history of a specific illness and facilitate the accessibility of resources. By integrating the record of a covered associate's or dependent's contact with the medical delivery system, Case Managers can focus internal and external resources in an effort designed to improve the covered individual's clinical condition.

**Personal Health Support (UnitedHealthcare) (1-866-633-2474) for Option 1 and (1-800-864-9427) for CDHP**
United Healthcare's Personal Health Support (PHS) is a program that includes messaging, education, care plans and goal tracking. Based on a member's needs, PHS provides decision support, disease and case management for more than 100 conditions —including a broad range of clinical programs, such as maternity, transplant resource and congenital heart disease resource services. If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The PHS Nurse will provide you with their telephone number, so you can call them with questions about your conditions, or your overall health and well-being. If you do not receive a call from a PHS Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

This program is available through the UnitedHealthcare Choice Plus plan. Care Coordination is UnitedHealthcare's medical management program that focuses on high-risk individuals and by nurse outreach, works with those individuals by closing gaps in care. Individuals are identified through a variety of "gateways" including notification to the plan of hospital admissions, home health needs and durable medical equipment. Eligible individuals are also identified by incurred medical claims and the myuhc health assessment.

Once identified, a Care Coordination nurse makes an outbound call to the covered associate's or dependent's home to conduct an assessment of the covered person's health care needs. This call is the beginning of the relationship between the nurse and the covered person. Together, they work as a team to close gaps in care such as setting up regular physician appointments, medication management and education, questions to ask during physician visits, etc. The role of the nurse is to partner with the covered associate or dependent to manage the illness or condition.

### Diabetic Management (Livongo) (1-800-945-4355)

The Livongo for Diabetes program is available to individuals with type 1 or type 2 diabetes, not pre-diabetes, who are enrolled in the Aetna or UnitedHealthcare Option 1 or CDHP medical plan. The program provides:

- A cellular-enabled glucose meter that automatically uploads your blood glucose readings in real time to Livongo
- Unlimited strips and lancets at no cost to you
- Tips to help you stay on track - With each check of your blood glucose using the Livongo meter, you receive a personalized message to help you make choices about your diabetes. You can also view trends of past readings at any time on the meter or in your private account.
- Coaching anytime and anywhere - Livongo coaches are Certified Diabetes Educators who are available anytime via phone, text, and Livongo's mobile app to give you guidance on your nutrition and lifestyle questions.

If you have any questions about this program, please visit the Livongo website at join.livongo.com/ADP or call Livongo Member Support at **1-800-945-4355** and mention registration code **ADP**. You may cancel at any time for any reason.

### Fertility Benefits (WIN) (1-833-439-1518)

The Fertility Benefits program administered through WIN provides enhanced coverage for fertility-related medical services to associates and dependents enrolled in the Aetna or UnitedHealthcare Option or CDHP medical plan. The program can help you understand your fertility options, provide guidance and assist you in selecting the best course of treatment:

- 24/7 access to a WIN Nurse Care Manager to answer questions, provide education, and help ease the emotional strain related to fertility
- Guidance to help increase the efficient use of hormonal medications to avoid waste and the risks of over-stimulation
- Expertise in understanding complex information and decisions regarding infertility causes, testing, treatment options, and success rates and risks
- A mobile app to help you manage your benefits anytime, anywhere. Go to: https://managed.winfertility.com/adp. Use employer code WINADP when creating an account on the app.

Refer to the Fertility Benefits section for more details about what is covered.

## Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus Plans

### Abortion

Abortion, including abortion drugs dispensed by a provider (including a telemedicine provider), where permitted by state and local laws.

### Acupuncture

Acupuncture is covered up to 20 visits in a calendar year, when it is performed by a licensed provider (doctor of medicine, doctor of osteopathy, chiropractor or acupuncturist) as a form of pain control, in lieu of anesthesia, or for treatment of nausea because of chemotherapy, pregnancy or post-operative procedures.

### Allergy Testing & Treatment

Office visit and lab covered the same as any other covered medical reason and allergy injections are subject to coinsurance.

### Ambulatory Surgical Center Services

Include services that are given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

### Anesthetics

Charges of a physician or professional anesthetist for furnishing and administering anesthetics are covered.

### Autism Spectrum Disorder Services
Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavior Analysis) of Autism Spectrum Disorder when ordered by a physician, licensed psychologist, or licensed clinical social worker, as part of a Treatment Plan; and the covered child is diagnosed with Autism Spectrum Disorder.

Applied Behavior Analysis is an educational service that is the process of applying interventions:
- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

### Bariatric Surgery/Morbid Obesity Surgery
In-network benefit levels for an Aetna Bariatric Institute of Quality (IOQ) facility or a UnitedHealthcare Bariatric Center of Excellence (COE) only, including travel and lodging for IOQ facilities and COEs greater than 50 miles from patient's home. For Aetna members, services obtained from a facility that is an Aetna network facility, but not designated as a Bariatric IOQ facility, will be covered as out-of-network services and supplies. Out-of-network facilities will also be covered as out-of-network services and supplies. For UnitedHealthcare members, services obtained from a facility that is a Non-Bariatric COE is subject to out-of-network coverage levels.

Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurse help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence.

### Aetna – Morbid Obesity Surgery
Providers should call 888-632-3862 - Option #3 to pre-certify. Covered medical expenses include charges made by a hospital or a physician for the surgical treatment of morbid obesity of a covered person. Coverage includes the following expenses as long as they are incurred within a two-year period:
- One follow-up visit;
- One morbid obesity surgical procedure including complications directly related to the surgery;
- Pre-surgical visits; and
- Related outpatient services

Note: Obesity medications for those who meet the prior authorization criteria would be through Express Scripts.

This two-year period begins with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned. Complications, other than those directly related to the surgery, will be covered under the related medical plan's covered medical expenses, subject to plan limitations and maximums.

### Limitations
Unless specified above, not covered under this benefit are charges incurred for:
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in the Plan

### UnitedHealthcare – Morbid Obesity Surgery
Access UnitedHealthcare's (OptumHealth's) Bariatric Resource Services Centers of Excellence program at **1-888-936-7246**. All authorization information and enrollment for bariatric surgery must be initiated through OptumHealth's Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery should notify OptumHealth as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth at **1-888-936-7246** to enroll in the program.

The Plan covers surgical treatment of morbid obesity provided all of the following are true:

- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4
- You have a minimum Body Mass Index (BMI) of 40, or ≥ 35 with at least 1 complicating coexisting medical condition or disease present
- You must enroll in OptumHealth's Bariatric Resource Services (BRS) program
- You must use an OptumHealth Bariatric Center of Excellence (COE) to receive coverage at In-Network benefit level. If you use a non-COE, coverage will be at the Out-of-Network benefit level.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation
- 3-month physician or other health care provider supervised diet documented within the last 2 years
- One surgery per lifetime unless complications
- Excess skin removal is not covered, unless medically necessary

### Contraceptive Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs (through the prescription drug plan) and contraceptive devices prescribed by an in-network physician provided they have been approved by the Federal Drug Administration
- Related outpatient services such as consultations, exams, procedures and other medical services and supplies

### Convalescent Facility

Medically necessary services received in a convalescent, extended care, or skilled nursing facility. Benefits will be paid for up to 60 days in a calendar year. This benefit does not cover charges made for the treatment of drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation, and other mental disorder. Custodial care and non-skilled medical services are not covered.

Confinement in a convalescent facility is covered when:

- The confinement is recommended by a doctor and begins during a convalescent period
- The patient is under the continuing care of a doctor
- The patient receives necessary skilled nursing care, physical rehabilitation services, or both, and it is expected that the care received will improve the patient's condition and facilitate discharge

A convalescent facility, extended care facility or skilled nursing facility is eligible if the facility:

- Is recognized as a skilled nursing facility by Medicare
- Is licensed to provide inpatient skilled nursing and physical restoration services
- Is supervised by a doctor or RN
- Provides 24-hour care by a staff of licensed nurses under the direction of a full-time RN
- Keeps complete medical records on each patient
- Has a utilization review plan for each patient
- Makes charges to its patients
- Is not mainly a place for rest, the aged, drug addicts, alcoholics, custodial or educational care, or for care of mental retardation or mental disorders

### Durable Medical Equipment

Durable Medical Equipment means equipment, which meets all of the following:

- It is for repeated use and is not a consumable or disposable item
- It is used primarily for a medical purpose
- It is appropriate for use in the home

If more than one piece of equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment are:

- Appliances which replace a lost body organ or part or help an impaired one to work
- Bathroom equipment if it is primarily medical in nature, not normally of use in the absence of illness and injury and is necessary for daily activities related to health and personal hygiene.
- Equipment needed to increase mobility, such as a wheelchair
- Hospital-type beds
- Monitoring devices
- Orthotic devices such as arm, leg, neck, foot, cranial banding and back braces
- Respirators or other equipment for the use of oxygen

The Claim Administrator decides whether to cover the purchase or rental of the equipment. Repair or replacement of purchased equipment is covered, if it is needed due to a change in person's physical condition, or if it would cost less to replace than to repair or rent the equipment.

### Fertility Benefits

Coverage for fertility treatments is subject to enrollment in the fertility benefits program administered through WIN. All associates and dependents covered by the ADP Option 1 or CDHP with HSA Medical Plan are eligible for the program. You do not have to be infertile to be eligible for benefits. To enroll in the program, contact WIN at 1-833-439-1518.

Members will be required to consult with a Nurse Care Manager prior to treatment. The program can help you understand your fertility options, provide guidance and assist you in selecting the best course of treatment for you.

Benefits include:

- $20,000 lifetime medical benefit maximum per person
  - for eligible expenses related to a covered fertility treatment or procedure.
  - does not apply toward covered diagnostic consultations and testing necessary to diagnose infertility.
  - medical expenses related to fertility prior to January 1, 2020, will not count towards the lifetime limit.
- Prescription drug coverage for approved fertility medications, subject to your plan's regular coinsurance, while receiving the fertility medical benefits is provided through Express Scripts. Prescription drugs must be approved by WIN to be covered. Your covered fertility related prescription drug costs will not count against the $20,000 lifetime medical maximum.
- A mobile app to help you manage your benefits anytime and anywhere.

The Medical Plan will pay for eligible charges incurred up to a $20,000 lifetime maximum per person, by an associate or a dependent. Procedures included are non-experimental invitro fertilization, artificial insemination, gamete (GIFT), zygote (ZIFT) intrafallopian transfer, frozen embryo transfer (FET), and a 1-year elective oocyte (egg) or embryo cryopreservation (freezing) per retrieval. The purchase of donor eggs or sperm is not covered, but medical procedures typically covered by the plan that utilize donor eggs and sperms will be covered. Lab expenses associated with fertility are covered by the Plan and do not go toward the $20,000 lifetime maximum per person. Approved prescription drugs by WIN for the treatment of outpatient fertility are covered under the Aetna Choice POS II / UnitedHealthcare Choice Plus Prescription Plan through Express Scripts.

### Habilitation Therapy Services

Habilitation therapy services are services needed to keep, learn or improve your skills and functioning for daily living (e.g., therapy for a child who isn't walking or talking at the expected age).

- Services must be performed by a physician, licensed or certified physical, occupational or speech therapist, hospital, skilled nursing facility or hospice facility or a home healthcare agency.
- Outpatient physical, occupational, and speech therapies covered services include PT or OT if it is expected to develop any impaired function or speech therapy if it is expected or ST if it is expected to develop speech function that resulted from delayed development.

### Hearing Care

- **Cochlear Implants** - Covers expenses for unilateral or bilateral cochlear implant procedure for severe hearing loss or other medically indicated conditions. In addition to the surgical implant procedure, eligible expenses include the cochlear implant device (internal and external components) and auditory rehabilitation therapy following the implant procedure

**Hearing Aids** - Covered services are limited to charges for hearing aids required as result of an accident, illness or degenerative condition up to a maximum of $1,000 per device every 36 months. The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam
- A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- A written prescription or other order

Only those conditions and services determined to be medically necessary and appropriate by the Claim Administrator will be eligible under this benefit.

### Home Health Care

The following covered services must be given by a Home Health Care Agency:

- Physical, occupational, or speech therapy
- Temporary or part-time nursing care by or supervised by a registered graduate nurse (RN)
- Temporary or part-time care by a home health aide

Covered Services are limited to 50 visits each calendar year (each period of home health aide care of up to four hours in the same day counts as one visit). Each visit by any other member of the home health team will count as one visit.

### Hospice Care

Expenses for care incurred when a person or dependent has a life expectancy of 12 months or less as certified by their primary attending physician. Eligible expenses include room and board, social services, home health aides, nurses, consulting services, family counseling sessions, and bereavement counseling for up to three months. If the patient outlives the 12-month prognosis, the Plan may extend this benefit.

### Hospital Services

- **Emergency Room** - Covered services only if it is determined that the services are covered health services and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services
- **Room and Board** - Covered expenses for a private room are limited to the regular daily charge made by the hospital for a semi-private room
- Other Services and Supplies

If the Claim Administrator, at its discretion, determines that a less intensive or more appropriate treatment could have been given, then no benefits are payable. To receive full benefits, you must call the number on your identification card for pre-certification.

### Infertility Services
Covered services include seeing a provider to diagnose and evaluate the underlying medical cause of infertility. Also, to do surgery to treat the underlying medical cause of infertility, e.g., endometriosis surgery or varicocele surgery. See fertility benefits listed earlier in this section.

### Infusion Therapy
Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. Covered services include infusion therapy you receive in an outpatient setting including but not limited to:
- A freestanding outpatient facility
- The outpatient department of a hospital
- A physician's office
- Your home from a home care provider

### IUD Device
Expenses for IUD for treatment of heavy menstrual bleeding and for birth control.

### Lab Tests and Allergy Tests for Diagnosis or Treatment
Medical services and supplies such as x-ray and laboratory fees, oxygen, radium, blood or blood plasma (that is not donated or otherwise replaced), rental of an iron lung and other such equipment, and prosthetic appliances (in some circumstances).

### Medical Transportation Services
Transportation by professional ambulance, other than air ambulance, to and from a medical facility is covered. Transportation by regularly scheduled airline, ground, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico, or Canada.

Emergency Ground Ambulance covered services include emergency transport to a hospital by a licensed ambulance:
- To the first hospital to provide emergency services
- From one hospital to another if the first hospital cannot provide the emergency services you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency ground ambulance is covered if it is:
- From a hospital to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a hospital if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to transport you safely and adequately to or from inpatient or outpatient treatment

### Mental Health and Substance Use Disorder
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. Inpatient care and partial hospitalizations must be pre-certified by Aetna or UnitedHealthcare. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:
- For UHC, there is a written treatment plan supervised by a physician or licensed provider and
- For Aetna and UHC, the Plan is for a condition that can favorably be changed

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office (subject to medical necessity) for the treatment of mental disorders as follows:
- Partial confinement treatment covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically directed intensive treatment of a mental disorder or substance abuse. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.
- Outpatient covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically directed intensive treatment.

The partial hospitalization would only be covered if you would need inpatient care if you were not admitted to this type of facility. Outpatient mental health treatment also includes electro-convulsive therapy (ECT) and substance use disorder injectables

### Nurse-Practitioner Services
Services of a licensed or certified Nurse Practitioner acting within the scope of that license or certification.

### Obesity Preventive Counseling
Up to age 22 – unlimited visits. Age 22 and over are eligible for 26 visits every 12 months, of which up to 10 may be used for healthy diet counseling.

### Obesity Treatment
Covered expenses include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:
- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Prescription drugs for the treatment through our Prescription Drug Plan
- Surgical treatment of obesity – see Bariatric Surgery

### Occupational Therapy
Services of a licensed occupational therapist provided the following conditions are met:
- The therapy must be ordered and monitored by a physician
- The therapy must be medically necessary for the care and treatment of an illness or injury
- The therapy must be given in accordance with a written treatment plan approved by a physician
- The therapist must submit progress reports at the intervals stated in the treatment plan
- The therapy must be expected to result in a significant, objective and measurable physical improvement in the covered person's condition within two (2) months of the start of the treatment

Therapy for autism or developmental delay for a dependent child is covered.

### Outpatient Surgery
Covered services include services provided and supplies used in connection with outpatient surgery performed in a surgery center or a hospital's outpatient department. Note: some surgeries can be performed safely in a physician's office. For those surgeries, the plan will pay for the physician services but not for a separate fee for facilities.

### Oral Surgery and Dental Services
Expenses for the treatment of the mouth, jaws, and teeth are covered medical expenses, but only those for:
- Services rendered, and supplies needed for the following treatment of or related to conditions of the:
  - Teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles, and nerves)
  - Dental related hospital and anesthesia services for children under the age of six are eligible where medically necessary

For these expenses, "physician" includes a dentist.

### Oral Surgical Services
Surgery needed to:
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- Cut out:
  - Cysts, tumors, or other diseased tissues
  - Teeth partly or completely impacted in the bone of the jaw (e.g., wisdom teeth)
  - Teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone
  - The roots of a tooth without removing the entire tooth
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth
- Treat a fracture, dislocation, or wound

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

**Note: Charges for oral surgery that are reimbursable (in whole or in part) under the Medical Plan are not eligible for benefits under the Dental Plan. Contact your medical plan's customer service unit (at the phone number on your ID card) to determine which plan covers your procedure.**

### Accidental Injury to Teeth

Dental work, surgery and orthodontic treatment needed to remove, repair, replace, restore, or reposition:

- Due to injury
- Natural teeth damaged, lost, or removed
- Other body tissues of the mouth fractured or cut

Any such teeth must have been:

- Firmly attached to the jawbone at the time of the injury
- Free from decay
- In good repair

The treatment must be done in the calendar year of the accident or the next one, if the following are installed due to such injury:

- Bridgework
- Crowns (caps)
- Dentures (false teeth)
- In-mouth appliances

Covered medical expenses include only charges for:

- An in-mouth appliance used in the first course of orthodontic treatment after the injury
- First denture or fixed bridgework to replace lost teeth
- First crown needed to repair each damaged tooth

Temporomandibular Joint Disorder (TMJ)
Covered medical expenses include only charges for:

- Mouth appliance/splint (limited to one)
- Physical therapy
- Surgery to alter the jaw, jaw joint or bite relationship by cutting procedure when appliance therapy alone cannot result in functional improvement
- Trigger point injections

Not included are charges for:

- Dental cleaning, in-mouth scaling, planing or scraping
- Myofunctional therapy (This is muscle training therapy or training to correct or control harmful habits.) for root canal therapy
- Non-surgical periodontal treatment
- Removal, repair, replacement, restoration or repositioning of teeth lost or damaged in the course of biting or chewing
- Repair, replacement, or restoration of fillings, crowns, dentures or bridgework
- Routine tooth removal (not needing cutting of bone)

### Organ/Tissue Transplants

Pre-certification must be obtained at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- Donor search
- Evaluation
- Organ procurement/tissue harvest
- Transplant procedure

Services and supplies for necessary organ or tissue transplants are payable under the Medical Plan.

### Donor Charges for Organ/Tissue Transplants
In the case of an organ or tissue transplant, donor charges are considered covered expenses ONLY if the recipient is a covered person under the Medical Plan. If the recipient is not a covered person, no benefits are payable for donor charges

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a covered service UNLESS the search is made in connection with a transplant procedure arranged by a Designated Transplant Facility

A Designated Transplant Facility is a facility that has entered into an agreement with Aetna or UnitedHealthcare for organ and tissue transplants. If a qualified procedure listed below is necessary and performed at a Designated Transplant Facility, the medical care and treatment and transportation and lodging provisions described below apply.

Qualified Procedures:
- Bone marrow/stem cell transplants
- Heart/lung transplants
- Heart transplants
- Kidney/heart, kidney/liver, kidney/lung, kidney/pancreas transplants
- Kidney transplants
- Liver transplants
- Lung transplants
- Pancreas transplants
- Other transplant procedures the Claim Administrator determines to be necessary provided the procedure is performed at a Designated Transplant Facility

### Medical Care and Treatment
The covered expenses for services provided in connection with the transplant procedure include:
- Follow-up care for a period up to one year after the transplant
- Hospital and physician fees
- Organ acquisition and procurement
- Pre-transplant evaluation for one of the procedures listed above
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search
- Transplant procedures

### Physician Services
See separate section that lists physician services.

### Physical Therapy
Services of a licensed physical therapist provided the following conditions are met:
- The therapy must be ordered and monitored by a physician
- The therapy must be medically necessary for the care and treatment of an illness or injury
- The therapy must be given in accordance with a written treatment plan approved by a physician
- The therapist must submit progress reports at the intervals stated in the treatment plan
- The therapy must be expected to result in a significant, objective and measurable physical improvement in the covered person's condition within two (2) months of the start of the treatment

Therapy for autism or developmental delay is covered.

### Preventive Services
See separate section that lists Preventive Health Care Benefits.

### Private Duty Nursing Care
Private Duty Nursing Care is pre-approved services of a nurse who is either a registered nurse (RN) or licensed practical nurse (LPN), and those of a licensed physical therapist. Private duty nursing is care given on an outpatient basis by a licensed nurse (RN, LPN, or LVN). The maximum number of 8-hour shifts per year is 70.

### Second Surgical Opinion
Covered the same as any other office visit.

### Smoking & Tobacco Use Cessation
Preventive counseling limited to 8 visits per 12 months.

### Speech Therapy
Speech therapy performed by a licensed speech pathologist for loss or impairment due to injury or illness. The Plan pays for charges for the diagnosis or non-surgical treatment by a physician for loss or impairment of speech, but only if the charge is made for:

- Diagnostic services rendered to find out if and to what extent the person's ability to speak is lost or impaired
- Rehabilitative services rendered that are expected to restore or improve a person's ability to speak
- The therapist must submit progress reports at the intervals stated in the treatment plan
- The therapy must be expected to result in a significant, objective and measurable physical improvement in the covered person's condition within two (2) months of the start of the treatment. This provision does not include charges for educational therapy or services that are developmental in nature, except as otherwise indicated

Therapy for autism or developmental delay is covered. Not covered are charges for:

- Diagnostic or rehabilitative services rendered before the person becomes eligible for coverage or after termination of coverage
- Special education for a person whose ability to speak is lost or impaired. This includes lessons in sign language

### Spinal Manipulations
The covered expenses for chiropractic services are limited to those services that are medically necessary and are subject to an annual maximum of $2,500 per covered individual per calendar year. Maintenance therapy is not covered.

### Teladoc (For Aetna members)
Teladoc provides access to a national network of board-certified doctors and pediatricians in the U. S. who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations. Teladoc does not replace existing primary care physician relationships, but supplements them as a convenient, affordable alternative for medical care. In-Network deductible and coinsurance apply to a fee that is normally less than the cost of a primary care physician consultation (more for behavioral health or dermatological services). The Plan will reimburse for Teladoc services which follow CMS (Centers for Medicare and Medicaid Services) guidelines.

### Telemedicine
UnitedHealthcare will cover telemedicine with member's individual providers for medical and mental health services at 20% after deductible for all options under the Medical Plan if provider is in the UHC network and 40% after deductible if provider is not in the UHC network. This is separate from UnitedHealthcare's virtual care services used by ADP members.

### Transgender Related Services

- Gender reassignment reversal
- Laboratory testing to monitor the safety of continuous hormone therapy
- Pre- and Post- surgical hormone therapy
- Psychotherapy for gender identity disorders and associated co-morbid psychiatric diagnoses
- Sex reassignment surgery/ies (See Transgender surgery under Physician Services)
- Surgery to change specified secondary sex characteristics, for comfort in the social role
- Voice modification lessons and therapy

**Transportation and Lodging**
Expenses for travel and lodging for patient and a companion, if covered services are not available from a network provider within 50 miles of your home, are covered as follows:

- Reasonable and necessary expenses for lodging and U.S. domestic travel (coach class air fare, train or bus travel)
  for the patient (while not confined) and one companion from the patient's home to receive covered services from a network provider
- Benefits are paid at a lodging per diem rate of up to $50 for one person or up to $100 for two people
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered up to the $100 per diem rate
- Travel and lodging expenses are only available if eligible health services are not available from a network provider within 50 miles from the patient's home
- There is a combined overall $10,000 limit for all transportation and lodging expenses incurred by the patient and eligible companion(s) per year
- You must complete a travel and lodging form from your insurance carrier

**Virtual Care Services (For UnitedHealthcare members)**
In-Network deductible and 10% coinsurance apply to a fee that is normally less than the cost of a primary care physician consultation. The Plan will reimburse for virtual care services which follow CMS (Centers for Medicare and Medicaid Services) guidelines. Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com and selecting 24/7 virtual visits in the virtual care category or by calling the telephone number on your ID card. Non-Network Benefits are not available.

**Walk-in Clinic**
Covered services include, but are not limited to, health care services provided through a walk-in clinic for:

- Scheduled and unscheduled visits for illnesses and injuries that are not emergency medical conditions
- Preventive care immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

**Wigs**
Prosthetic wigs prescribed by a physician required as a result of an injury or illness. Among the covered conditions is hair loss due to chemotherapy and alopecia areata. This is subject to the Claim Administrator's determination that a proposed course of treatment is medically appropriate and not experimental or investigational. Wigs for male pattern baldness are excluded. Benefits limits are $1,000 per year up to $2,500 per lifetime.

## Physician Services

**Medical Care and Treatment**

- Hospital, office and home visits
- Emergency room services

**Surgery** - Services for surgical procedures

**Reconstructive Surgery**

1. Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
   - Accidental injury
   - Birth defect
   - Sickness
   - Surgery to treat a sickness or accidental injury

2. Reconstructive breast surgery following a necessary mastectomy. Following a mastectomy, reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of all stages of mastectomy, including lymph edemas.
3. Transgender surgery
    - Sex reassignment surgery(ies), including:
        - Clitoroplasty
        - Complete hysterectomy
        - Labiaplasty
        - Metoidioplasty
        - Orchiectomy
        - Penectomy
        - Phalloplasty
        - Placement of testicular prosthesis
        - Salpingo-oophorectomy
        - Scrotoplasty
        - Urethroplasty
        - Tracheal shave
        - Vaginoplasty
        - Vaginectomy
        - Voice modification surgery
    - Genital surgery requirements:
        - A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
            - Persistent, well-documented Gender Dysphoria
            - Capacity to make a fully informed decision and to consent for treatment
            - Must be 18 years or older
            - If significant medical or mental health concerns are present, they must be reasonably well controlled
            - The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance
    - Surgery to change specified secondary sex characteristics, specifically:
        - Augmentation mammoplasty (including breast prosthesis if necessary) if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role
        - Bilateral mastectomy – For Female-to-Male patients below age 18, one year of testosterone treatment must be completed in addition to any other requirements
    - Note: for augmentation mammoplasty or bilateral mastectomy, you must provide the following documentation: A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
        - Persistent, well-documented Gender Dysphoria
        - Capacity to make a fully informed decision and to consent for treatment
        - If significant medical or mental health concerns are present, they must be reasonably well controlled.
        - The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance
4. Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury.

5. Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiological function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.
    - Surgery covered under the Medical Plan includes surgery to correct the function of a part of the body as a:
        - Reconstructive surgery to repair damage resulting from a disfiguring disease that occurred while covered under the Medical Plan
        - Result of an accidental injury sustained while a person is covered under the Medical Plan
        - Treatment of a condition that impairs the function of a body organ

### Assistant Surgeon Services
Appropriate reductions are applied to covered expenses for assistant surgeon services based on how the provider submits the claim. An assistant surgeon must be a physician. Surgical assistant's services are not covered. There may be circumstances where assistant surgeon billed charges may be reimbursed if member has obtained services in a network facility with a network surgeon, and assistant surgeon is out of network.

### Chiropractor
Covered expenses for chiropractic services are limited to services that are medically necessary and are subject to an annual maximum of $2,500 per covered individual per calendar year. Maintenance therapy is not covered.

### Multiple Surgical Procedures
Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered expenses for multiple surgical procedures are limited as follows: Covered expenses for secondary and subsequent procedures are limited to 50% of the covered expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.

### Other Physician Service Limitations
Services provided by a podiatrist may be limited. See "Expenses that are Not Covered under Aetna Choice POS II / UnitedHealthcare Choice Plus Plans" for details.

### Pregnancy Benefits
Benefits are payable for covered services and supplies for pregnancy given to the covered person while covered under the Medical Plan. Benefits for pregnancy are paid in the same way as benefits are paid for sickness. The child must be added to the plan within 60 days of birth or newborn expenses are ineligible.

Benefits are payable for at least:
- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery
- 96 hours of inpatient care for the mother and newborn child following a cesarean section

The hospital or other provider is not required to get authorization from the Claim Administrator for the time periods stated above. Authorizations are required for longer lengths of stay. Federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable).

Additional covered services and supplies specific to pregnancy are listed below.

### Birth Center Services
- Anesthetics
- Room and board
- Other services and supplies

### Nurse-Midwife's Services
The services of a licensed or certified nurse-midwife. A certified nurse midwife is an individual educated in the two disciplines of nursing and midwifery and is licensed/certified/registered by the state and is practicing within the scope of that license/certification/registration.

**Routine Well Baby Care**
The following services and supplies given during a newborn child's initial hospital confinement:

- Hospital services for nursery care
- Physician services
- Services of a surgeon for circumcision
- Other services and supplies given by the hospital

Patient responsibility will apply to anything outside of the normal pregnancy services/global pregnancy coverage.

## Preventive Health Care Benefits

Benefits are payable at 100% with no deductible for covered services and supplies for preventive health care benefits given to a covered person by a network physician while the person is covered under the Medical Plan. Preventive services rendered by a non-network provider are not eligible. (**Note**: If you are in the passive PPO, your preventive care benefits through a non-network provider are covered in general at 150% of CMS rates for Medicare or an amount negotiated by the Claims Administrator or an amount permitted by law. Refer to the Medical Benefits-At-A-Glance chart for details.)

Covered services and supplies include those specifically listed in this section. Please check with your carrier for details:

- **Breast feeding** interventions to support and promote breast feeding after delivery including lactation support and counseling and the cost for buying or renting breast feeding equipment (the physician, hospital, or durable medical equipment supplier must bill your medical carrier, you cannot purchase supplies at retail and send the receipt in for reimbursement). Rental or purchase of a breast pump is covered within 60 days prior to the estimated delivery date or after the delivery occurs.
- **Contraception Methods for Women with Reproductive Capacity:** Covers prescribed FDA approved contraception methods and sterilization procedures and patient education on them. This includes the Norplant device and administration. Specifically, women's contraceptives are covered as follows: Generic and single-source brand name (i.e., no generic equivalent) contraceptive medications for females when accompanied by a prescription and purchased through retail or mail order. Includes covered oral, transdermal, intrauterine, injectable contraceptives Plan B/Plan B one step, non-systemic contraceptives, devices and implants. All prescription contraceptives will be covered subject to the standard retail fill limits.
- **Counseling for:**
  - Alcohol misuse
  - Aspirin use for men and women of certain ages and cardiovascular risk factors
  - BRCA (counseling about genetic testing for women at higher risk) and testing for members who have a personal history of breast ovarian, tubal or peritoneal cancer or have family members with breast ovarian, tubal or peritoneal ovarian cancer. Covered expenses include charges made by a physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment
  - Breast cancer chemoprevention counseling (for women at higher risk)
  - Contraception methods for women with reproductive capacity (includes patient education)
  - Domestic Violence
  - Fluoride (prescription chemoprevention supplements for children without fluoride in their water source) and fluoride varnish for children under age 7
  - Folic acid supplements (for women of child-bearing ages)
  - HIV counseling for all sexually active women
  - Nutrition is covered for some diagnosis codes related to obesity, diabetes and cardiovascular conditions. For specifics, please reach out to your carrier, Aetna or UnitedHealthcare.
  - Obesity
  - Sexually transmitted infection (STI) prevention for all sexually active women
  - Tobacco use (including programs to help you stop using tobacco)
- **Counseling for children:**
  - Fluoride (prescription chemoprevention supplements for children without fluoride in their water source)
  - Obesity
  - Sexually transmitted infection (STI) prevention (For adolescents at higher risk)

- **COVID Vaccine**
- **Flu Shots**
- **Herpes Zoster Vaccine for Shingles for members age 50 and older**: If the Zostavax vaccine is purchased by the covered person, the vaccine is subject to benefits under the ADP Prescription Drug Plan and the physician services to administer the vaccine are subject to the medical benefit.
- **Immunization Vaccines for Adults:** Recommended ages and recommended populations and therefore doses vary. Immunizations include Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu shot) Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, and Varicella. Note most immunizations recommended for travel are not covered under this Preventive Healthcare Benefits section and therefore are subject to a deductible and coinsurance.
- **Inpatient Newborn Exam**: Hospital exam for discharge of newborn is covered.
- **Medications and Supplement**
  - Gonorrhea preventive medication for the eyes of all newborns
  - Iron supplements (for children ages 6 to 12 months at risk for anemia)
- **Routine Pap Smears**: One yearly screening is covered for associates/dependents as recommended by their physician.
- **Routine Physical Exams**: Adults may complete their physicals over two visits, but duplicate services (e.g., two blood sugar tests) will not be covered.
  - Covered services include age and gender appropriate clinical screenings, immunizations and lab/x-ray tests in accordance with guidelines followed by Aetna and UnitedHealthcare network providers. Preventive screenings prescribed by a network physician during a covered physical but performed at an offsite facility are covered at 100%. If your physician indicates that you should have a screening sooner than the standard guideline because your physician deems you to be at a high risk for a condition, that screening will be paid by ADP if done by an in-network physician.
- **Screenings for:**
  - Abdominal aortic aneurysm: one-time screening for men of specified ages who have ever smoked
  - Alcohol misuse
  - Blood pressure
  - Breast Cancer: mammograms: (American Cancer Society Guidelines) One baseline exam is covered for women ages 35 through 39. Thereafter, one exam every year is covered for women 40 and over. Additional breast cancer screenings and pathology evaluations are covered when further imaging is required to complete the screening process following a mammogram. Women defined as high-risk for breast cancer by their physician can be screened earlier or more frequently. Three-dimensional mammograms are also covered. Consult with your physician
  - Cervical cancer (for women under age 66)
  - Chlamydia infection (for younger women and other women at higher risk)
  - Cholesterol (for adults of certain ages or at higher risk)
  - Colon Cancers: (American Cancer Society Guidelines) One yearly fecal occult blood screening and one colonoscopy every ten years for associates/dependents age 45 and over. Deductible is waived; the plan pays 100% benefit. Men and women defined as high-risk for colon cancer by their physician can be screened earlier or more frequently. Cologuard, a noninvasive alternative to a colonoscopy, is also covered every 3 years to associates/dependents age 45 and over. You can get Cologuard AND a colonoscopy, subject to the frequency limits, if you want. Consult with your physician
  - Depression
  - Type 2 diabetes (for adults with high blood pressure)
  - Domestic violence screening (**Note**: The annual screening for interpersonal and domestic violence is not a service provided by mental health professionals. Mental health professional services are covered under Mental Health services)
  - Gonorrhea (for all women at higher risk)
  - Hepatitis B screening for any at-risk adolescents and adults
  - HIV (for everyone ages 15 to 65, and other ages at increased risk)

  - Human papillomavirus (HPV): One yearly screening is covered for women ages 30 and older. Women over 30 who have 3 consecutive negative screens and who do not fit the criteria for more frequent screening, may be tested every three years. Gardasil 9 is considered a medically necessary preventive service for members age 9 to 45.
    It is not medically necessary for members who have a three-dose series with Gardasil or Cervarix. If vaccination providers do not know or do not have available the HPV vaccine product previously administered, or are in settings transitioning to Gardasil 9, any available HPV vaccine product is considered medically necessary to continue or complete the three-dose series for females; Gardasil 9 is considered medically necessary to continue or complete the three-dose series for males
  - Lung cancer screening for adults ages 55 through 80 who have a 30-pack year smoking history (e.g., one pack per day for 30 years or two packs a day for 15 years)
  - Obesity
  - Osteoporosis (for women over age 60 depending on risk factors)
  - Prostate Cancer: One yearly screening is covered for associates/dependents age 40 and over
  - Syphilis (for adults at higher risk)
  - Tobacco use
- **Testing: BRCA** for members who have a personal history of breast and/or ovarian cancer or have family members with breast and/or ovarian cancer. Covered expenses include charges made by a physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.
- **Well-baby office visits** for covered dependents through age 5.
- **Well-child immunizations** for covered dependents through age 17. Covered immunizations include the following: chicken pox, diphtheria, haemophilus influenza type b, hepatitis A, hepatitis B, human papillomavirus (HPV,) influenza, measles, meningitis, mumps, oral polio, pertussis, pneumococcal (pneumonia), rotavirus, rubella, tetanus, and one tuberculosis skin test.
- **Additional Services for Pregnant Women**
  - Anemia screenings
  - Bacteria urinary tract or other infection screenings
  - Gestational diabetes screenings
  - Hepatitis B counseling (at the first prenatal visit)
  - Rh incompatibility screening, with follow-up testing for women at higher risk
  - Expanded counseling on tobacco use
  - Urinary tract or other infection screening
- **Covered Preventive Services for children**
  - Alcohol and drug use (for adolescents)
  - Autism screening service (for children at 18 and 24 months)
  - Behavioral issues
  - Cervical dysplasia (for sexually active females)
  - Congenital hypothyroidism (for newborns)
  - Developmental (screening for children under age 3 and surveillance throughout childhood)
  - Hearing (for all newborns)
  - Height, weight, and body mass index measurements
  - Hematocrit or hemoglobin
  - Hemoglobinopathies or sickle cell (for newborns)
  - HIV (for adolescents at higher risk)
  - Lead (for children at risk of exposure)
  - Lipid disorders (dyslipidemia screening for children at higher risk)
  - Medical history
  - Obesity
  - Oral health (risk assessment for young children)
  - Phenylketonuria (PKU) for newborns
  - Tuberculin testing (for children at higher risk of tuberculosis)
  - Vision
- **Other required preventive care**: Any other preventive care services required to be covered under rules adopted by federal regulators under the Affordable Care Act.

## Aetna Vision Discount

The Aetna Vision Discount Program is available to associates and dependents enrolled in an Aetna-administered coverage option at no additional cost. This program may help you and your family save on many eye care products, including eyeglasses and contact lenses, non-prescription sunglasses, contact lens solution and accessories. The Aetna Vision Discount Program is available at many optical centers nationwide such as most Pearle Vision Centers, Lens Crafters, Optical and others.

Call 1-800-793-8616 Monday - Saturday from 7:30 a.m. to 11:00 p.m. ET and Sunday from 11:00 a.m. to 8:00 p.m. ET for more information.

## Expenses that are Not Covered under Aetna Choice POS II / UnitedHealthcare Choice Plus Plans

There are services that are not covered under the Medical Plan as is normal for most group arrangements. The Medical Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with the following:

1. Services or supplies received before an associate or his or her dependent becomes covered under the Medical Plan.
2. **Allergy**: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity and urine auto injections.
3. **Biofeedback**
4. **Birth control pills** (unless as specified under Covered Services section of this SPD). However, birth control pills are covered under the ADP Prescription Drug Plan administered by Express Scripts. See the "Prescription Drug Benefit" section for covered expenses under that plan.
5. **Blood**: Blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, aphaeresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.
6. **Cosmetic surgery or treatment,** unless to correct the result of an accidental injury sustained while covered under the Medical Plan, to repair a birth defect or for reconstructive surgery to repair damage resulting from a disfiguring disease that occurred while covered under the Medical Plan. See the "Physicians Services" in the "Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus Plan" sections for limited coverage of reconstructive surgery.
7. **Court ordered** examinations or treatment in connection with legal proceedings unless such examinations or treatment otherwise qualify as covered services.
8. **Custodial care**: Services and supplies are considered custodial and not covered when they:
   - Are furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide therapeutic treatment. This includes room & board and other institutional care
   - Can safely and adequately be provided by persons without the technical skills of a covered health care provider (physicians, RNs)
   - Care meeting the above criteria is not covered regardless of:
     - Who recommends, provides or directs the care
     - Where the care is provided
     - Whether or not the patient or another caregiver can be or is being trained to care for him or herself
9. **Ecological or environmental medicine, diagnosis and/or treatment**: Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
10. **Education**, training and bed and board while confined in an institution for training, a place of rest, a place for the aged, or a nursing home.
11. **Educational testing, services or supplies**.

12. **Examinations** – any health examinations required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement:
    - Any special medical reports not directly related to treatment except when provided as part of a covered service
    - By any law of a government
    - For securing insurance, school admissions or professional or other licenses
    - To attend a school, camp, a sporting event, participate in a sport, or other recreational event
    - To travel
13. **Eyeglasses, contact lenses, eye refractions, and eye surgery** mainly to correct refractive errors, including any confinement, treatment, services or supplies given in connection with or related to the surgery.
14. **Fees** charged for completion of claim forms or missed appointments.
15. **Fertility Services** not covered under the Plan:
    - Medical services that are typically covered under the Plan (see the Fertility Benefits section) are no longer covered once an individual has reached the $20,000 medical fertility lifetime limit;
    - The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
    - Charges, greater than one year per retrieval, associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.);
    - Home ovulation prediction kits or home pregnancy tests
16. **Foot conditions** - Removal of corns, calluses or toenails, or for services for a weak, strained, flat, unstable, or imbalanced foot or for a metatarsalgia or bunion.
17. **Hearing aids in excess of what is included under "Hearing Care"** in the "Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus Plan" section above.
18. **Herbal medicine, holistic or homeopathic care**, including drugs.
19. **Home Delivery of a Child** – Planned deliveries at home and associated services are not covered.
20. **Home and Mobility** – Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as air conditioners, air purifiers, water purifiers, exercise equipment, equipment to aid sleeping or sitting, removal of potential sources of allergies or illness, stair-glides, elevators, wheelchair ramps, and transportation devices.
21. **Immediate family provided care.** Services, supplies, medical care or treatment given by one of the following members of the Associate's immediate family:
    - The associate's spouse/domestic partner
    - The child, brother, sister, parent, or grandparent of either the associate or the associate's spouse/domestic partner
22. **Investigational services or supplies**
    A charge for a service or supply is not covered to the extent that it is experimental, unproven or investigational. Charges in connection with such a service or supply are also not covered. A service or supply will be considered "experimental, unproven or investigational" if:
    - Services that are not consistent with conclusions of prevailing medical research which demonstrates that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:
        - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received)
        - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group)
    - The drug, medical service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of indications. This includes:
        - Any Phase I clinical trial or
        - Any Phase II clinical trial unless approved by the Claim Administrator
    - The prevailing opinion within the appropriate specialty of the US medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings

- In the case of a drug, device, or other supply that is subject to FDA approval: It does not have FDA approval
- The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval
- The provider's institutional review board requires that the patient, parent, or guardian give an informed consent stating that the service or supply is experimental or investigational
- This exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if the Claim Administrator determines that a covered person has a "life-threatening" sickness or condition (one which is likely to cause death within one (1) year in the absence of effective treatment) and the Claim Administrator determines that an experimental or investigational service meets the definition of a covered medical service under the plan for that sickness or condition. In making this determination, the Claim Administrator will obtain an evaluation by a panel of independent medical professionals. The panel will be selected by the Claim Administrator and include professionals who treat the type of disease involved. This exclusion will not apply with respect to drugs that:
  - Have been granted treatment investigational new drug (IND) or group c/treatment IND status, or
  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute if the Claim Administrator determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease

23. Those for or related to services, treatment, or training related to **learning disabilities or developmental delays**. This exclusion does not apply to:
    - Treatment of delays in development resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate)
    - Treatment of autism

    Refer to the "Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus Plan" section for benefit limits.
24. **Massage therapy** services.
25. **Membership costs** for health clubs, weight loss clinics and similar programs.
26. **Nutritional counseling**, special foods, baby foods (whether or not administered through a feeding tube), food supplements, liquid diets, diet plans or any related products are generally excluded. Obesity counseling is covered. Nutritional support that is taken orally is not covered. Nutritional support for permanent impairment of the gastrointestinal tract when administered by either enteral tube feeding or parenteral venous nutrition may be covered subject to medical necessity as determined by the Claim Administrator. Permanent impairment of the gastrointestinal tract is one that is expected to continue for three months or longer.
    - Enteral tube feedings are considered medically necessary for either (a) a permanent non-function or disease of the structures that normally permit food to reach the small bowel; or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the individual's overall health status. Parenteral nutrition is considered medically necessary only if adequate nutritional intake is not possible via enteral tube feeding.
    - Under Preventive Health Care Benefits, nutrition counseling is covered for some diagnosis codes related to obesity, diabetes and cardiovascular conditions. For specifics, please reach out to your carrier, Aetna or UnitedHealthcare.
27. **Occupational injury**, whether or not benefits are payable under Workers' Compensation or similar law. Occupational disease for which benefits are payable under Workers' Compensation or similar law.
28. **Personal convenience or comfort items** including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
29. **Private duty nursing** services while confined in a hospital or other health care facility.
30. Services for or related to the **removal of an organ or tissue from a person** for transplantation into another person, unless the transplant recipient is a covered person under the Medical Plan and is undergoing a covered transplant.
31. **Services and supplies**, which the covered person is not legally required to pay.
32. **Services not permitted under applicable state or local laws.** Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the plan will not cover such health care services in that state or locality. Note that in some cases the plan may provide travel benefits for services affected by this exclusion. For detailed information about these excluded services, contact your carrier's Member Services.

33. **Sexual dysfunction/enhancement** – Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire.
34. **Strength & Performance** – Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including exercise equipment, memberships in health or fitness clubs, training, advice or coaching.
35. Care or treatment to the **teeth, gums or supporting structures** such as, but not limited to periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak. See "Oral Surgery and Dental Services" in the "Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus Plan" section above for limited coverage of oral surgery and dental services.
36. **Telephone consultations** unless covered telemedicine
37. **Therapies** including – aromatherapy, bio-feedback, chelation therapy (except for heavy metal poisoning), educational therapy, gastric irrigation, hyperbaric therapy (except for the treatment of decompression or to promote healing of wounds), hypnotherapy (unless performed by a physician as a form of anesthesia in connection with covered surgery), Lovaas therapy; purging, recreational therapy, sensory or auditory integration therapy, sleep therapy.
38. **Vitamins** (See the "Prescription Drug" section for covered vitamins.)
39. Services given by **volunteers** or persons who do not normally charge for their services.
40. **Wigs**, toupees, hair transplants, or hair weaving except as outlined under "wigs" in the Covered Services section of the SPD. Any expenses for hair loss due to male pattern baldness.
41. Services or supplies for medical care paid for or expected to be paid for by any persons (or the insurers of such persons) considered to be responsible for the condition giving rise to the charges as a result of a judgment, settlement or otherwise.
42. Services that are in any way reimbursable through "No-Fault" automobile insurance. (In states with "No-Fault" automobile insurance, the auto carrier is considered primary and ADP's Plan is secondary.) If you do not choose to elect Personal Injury Protection (PIP) coverage through your auto carrier, then charges that would have been paid by the auto carrier will not be eligible for reimbursement.
43. Routine vision, hearing and dental exams. Any other preventive exams, tests and immunizations, except as described under the Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus plans.
44. Services furnished by a governmental facility or one operated by a governmental body.
45. Services or supplies not ordered by a physician or dentist or those not necessary for the care of the condition for which you are being treated.
46. Non-prescription or over-the-counter drugs, even though your doctor may list them on a prescription blank.
47. Chiropractic expenses in excess of the $2,500 calendar year maximum per covered individual. Maintenance therapy is not covered.
48. Services in conjunction with marriage, family, child, career, social adjustment, pastoral, or financial counseling. For Mental Health coverage see "Mental Health and Substance Abuse" in the "Covered Services in Aetna Choice POS II / UnitedHealthcare Choice Plus Plan" section above.
49. Services for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetics therapy; vision perception training; or carbon dioxide therapy.
50. Services or supplies furnished by a network provider in excess of such provider's negotiated charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

## Health Savings Accounts

**THIS SECTION DOES NOT APPLY TO ASSOCIATES ENROLLED IN MEDICAL OPTION 1 OR AN HMO**

If you elect coverage under the CDHP coverage options, you may also elect to establish a Health Savings Account (HSA).

The HSA described in this section is not an ERISA-covered benefit and is not established or maintained by ADP. Rather, the HSA is established and maintained by the HSA trustee.

**Important Note:**
This section is intended to provide a general discussion of Health Savings Accounts in order to facilitate your understanding of the personal tax consequences associated with your participation in the CDHP coverage option and your contributions (or receipt of Company contributions) to your HSA. It is not intended to provide you with personal tax or financial planning advice. The rules relating to HSAs are complicated and depend on factors unrelated to your Medical Plan participation (such as your enrollment in Medicare and your participation in other medical coverage through a spouse/domestic partner's plan).

It is recommended that you review your individual situation with your personal tax advisor or financial planner and/or the HSA provider. ADP will not be held responsible for any use/misuse of the information about HSAs provided in this SPD when making personal tax or financial planning decisions, including decisions made in connection with the preparation of your personal income tax return.
ADP and the Plan Administrator do not guarantee, and do not have any responsibility for, the tax, legal or other implications of an individual's participation in or contributions to an HSA.

### Why Have a Health Savings Account

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the CDHP medical plan option. An HSA is a bank account funded by you, your employer, or any other person on your behalf. The HSA offers a tax-advantaged way to pay for current and future eligible health care expenses for you and your tax-qualified dependents (as determined by the Internal Revenue Code). As such, IRS guidelines mandate that a Health Savings Account may only be offered alongside a qualified high-deductible Medical Plan option (such as our CDHP).

### Who Is Eligible to Open a Health Savings Account

Eligibility to participate in the HSA is linked to your enrollment in a CDHP medical plan option. An "eligible individual" means, with respect to any month, any individual who:

- Is covered under a high-deductible health plan (our CDHP) on the first day of such month
- Does not also have first-dollar coverage under any other health plan, including your spouse/domestic partner's plan (there are certain exceptions for plans providing certain limited types of coverage)
- Is not enrolled in Medicare, Medicaid or Tricare
- May not be claimed as a dependent on another person's federal tax return; or
- Does not participate in a full Health Care FSA. For associates enrolled in a CDHP option, ADP offers a Limited Purpose Health Care FSA that can be used to pay for dental and vision expenses and prescription and eligible over-the counter items for dental and vision care. Medical and prescription drug expenses incurred after you meet your CDHP deductible are also eligible for reimbursement through the Limited Purpose Health Care FSA.(See FSA Section of the SPD)

### Decide Whether to Open a Health Savings Account

If you enroll in a CDHP option, you will have the opportunity to set up an HSA. After you make your CDHP enrollment election, you can also elect to make before-tax contributions to your HSA.

### ADP will contribute to Your Health Savings Account during the Year

- ADP will contribute to your HSA depending upon the medical coverage level you choose: For the CDHP with HSA Option 1, ADP contributes $600 per year for an Individual and $1,100 per year for Individual with dependents (prorated for HSAs opened after January 1). For the CDHP with HSA Option 2, ADP contributes $750 per year for an Individual and $1,500 per year for Individual with dependents (prorated for HSAs opened after January 1). ADP's contributions will be divided and paid based on your payroll schedule (weekly, bi-weekly and monthly). To receive ADP's contribution to your HSA, you must:
- Have an HSA with HealthEquity sponsored through ADP
- Be enrolled in an ADP CDHP medical plan option through Aetna or UnitedHealthcare
- Not be a terminated associate
- Not have your ADP account closed by HealthEquity
- Not have reached or exceeded the annual HSA contribution limit

### Choose Your Health Savings Account Contribution for the Year

You can contribute to your HSA on a before-tax basis through payroll deductions. For 2026, the maximum HSA contribution is $4,400 for single coverage and $8,750 for all other coverage levels. These maximums include ADP's and your contributions combined, so the most you can contribute in 2026 for the CDHP with HSA Option 1 is $3,800 for single coverage and $7,650 for all other coverage levels and for the CDHP with HSA Option 2 you can contribute $3,650 for single coverage and $7,250 for all other coverage levels.

You can start, stop, or change your contributions anytime during the year by making the changes through ADP's Benefits Enrollment System. Any changes will take place as soon as administratively feasible. **If you are 55 and over (or will reach age 55 on or before December 31, 2026), you are eligible to make additional "catch-up" contributions of up to $1,000 for 2026. These catch-up contributions are not counted against the contribution limits.**

Your contributions will automatically be deducted from your pay in equal installments. In addition, you may make separate contributions to your account via personal check. Any other individual may contribute to your HSA as well. However, total contributions cannot be more than the annual maximum amounts described previously. If you contribute outside of your regular payroll deductions, you are responsible for ensuring that you do not exceed the contribution limits.

### Use Your Health Savings Account to Help Pay for Eligible Health Care Expenses

You can withdraw money in your HSA to pay for your annual deductible and other eligible health care expenses. Examples of eligible health care expenses (most are the same as for the Health Care Flexible Spending Account) include office visits, prescription drugs, surgery, dental expenses and vision expenses. For a complete list of eligible health care expenses, please see the IRS web site for information: https://www.irs.gov/forms-pubs/about-publication-502. Make sure you keep qualified medical receipts for all HSA withdrawals in case you are ever audited.

Any balance in your Health Savings Account will roll over from year to year and can be used toward future eligible health care expenses, including retiree medical premiums, such as Medicare Parts B, C, and D, but excluding Medicare Supplement plans (e.g., Medigap).

You can use your HSA to pay for things other than health care, but you'll pay taxes on the distribution (your contributions and any earnings) as well as an additional 20% penalty unless you're at least 65 years old or permanently disabled.
Because of the tax advantages offered by HSAs and the Health Care Spending Account when used for medical expenses, the government places certain restrictions on these types of benefit plans when offered together, as described below:

- If you enroll in the CDHP with HSA medical plan option and open a Health Savings Account for 2026, you cannot participate in a Health Care FSA. Instead, you can participate in a Limited Purpose Health Care FSA, which will be limited to dental and vision expenses. Medical and prescription drug expenses incurred after you meet your CDHP deductible are also eligible for reimbursement through the Limited Purpose Health Care FSA).

### Your Health Savings Account offers a Triple Tax Advantage

Your contributions are tax free when they go into the HSA (if you live in California or New Jersey, your contributions will not reduce your state taxable wages); the HSA grows tax-free with interest and the account funds are tax-free when they are used to pay for eligible health care expenses.

### Your Health Savings Account allows you to Invest in Mutual Funds

Your HSA will be through Health Equity. After your Health Savings Account reaches $1,000, you may start investing any of your account balance above the $1,000 in different investment choices. The fund choices support a range of investment objectives and time horizons, and you can invest in as many of the funds as you choose. There are additional fees associated with investing your Health Savings Account balance. For more information on your Health Savings Account investment options and the associated fees, please contact 1-866-346-5800.

### You Can Take Your Account with You to Help Pay for Future Expenses

Your HSA is portable and always belongs to you, even if you later enroll in a different ADP Medical Plan option, retire, or leave ADP. You can continue to withdraw funds from the account to cover eligible health care expenses, but you will need to be enrolled in a high-deductible medical plan option, like our CDHP options, to make new contributions.

### Keep Records

Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can exclude amounts distributed from your HSA from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. The IRS may request receipts during a tax audit. The Plan Administrator, ADP, and HSA Trustee will not verify that distributions from your HSA are for qualified health expenses, nor will they be responsible or liable if you misuse HSA funds. Please consult your tax advisor to determine how your HSA affects your unique tax situation.

## HMOs

### Health Maintenance Organizations

Health Maintenance Organizations (HMOs) offer an alternative to traditional medical coverage. When you enroll, you and each family member may be asked to select a Primary Care Physician (PCP) from the HMO's provider network. Your PCP coordinates all your health care needs and refers you to specialists, if necessary. If you visit a non-network provider or facility without prior approval from the HMO, you will be responsible for 100% of the cost of those services. The prescription benefit offered through the HMO is outlined in the HMO Benefit Summaries.

**Important Note:** If your HMO generally requires or allows the designation of a Primary Care Provider (PCP), you have the right to designate any PCP who participates in the HMO's network and who is available to accept you or your family members. If your HMO designates a PCP automatically, then until you make this designation, the HMO will designate one for you. If your HMO generally requires or allows the designation of a PCP for a child, you may designate a pediatrician as the Primary Care Provider. For information on how to select a PCP, and for a list of the participating PCPs in your HMO network, contact the Plan Administrator or your HMO provider.

You do not need prior authorization from your HMO provider, the Medical Plan, or from any other person (including a Primary Care Provider) to obtain access to obstetrical or gynecological care from a health care professional in your HMO's 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 the Plan Administrator or your HMO provider.

The HMO plans that you are eligible for are based on your home zip code. The objective of an HMO is to control medical costs by carefully managing care through a network of health care professionals and facilities that deliver a comprehensive range of health care services to enrolled associates and their dependents.

Advantages to enrolling in an HMO include:

- Centralized medical care, eliminating the need to find your own specialists
- Emphasis on preventive care, routine physicals, prenatal and well-baby care
- Fewer records to maintain and no medical claims to file
- Fixed monthly costs with minimal out-of-pocket expenses

The network of doctors available through the HMO may, or may not, include your current doctor. Be sure to contact the Plan Administrator for a copy of the HMO Provider Directory or check the Internet to see if your doctor is part of the HMO network. **If you are enrolled in an HMO and your doctor leaves the network, you cannot change your HMO election. This is not considered a qualifying life change.**

**Important Note:** If you elect medical coverage through an HMO option offered by ADP, you will receive a membership booklet from the HMO. Your HMO membership booklet includes important information describing the terms and conditions of benefits offered by the HMO including: the type and amount of covered benefits, the amounts you are required to pay for covered benefits, the limitations that may be applied to covered benefits, the benefits that are excluded from coverage, and the HMOs procedures for filing claims if a benefit is denied.

Your HMO membership booklet is part of this SPD, and you should keep both documents together in the same place. This SPD includes other important information, including information about your ERISA rights for medical benefits. Please note that all HMOs are subject to state regulation and if you have a complaint about an HMO, you can contact the state insurance department listed in your HMO booklet.

Remember that, even if you contact a state insurance department with a complaint, you still have ERISA rights. To the extent that the information in your HMO membership booklet conflicts with the information in this SPD, the information in this SPD will control. For HMO web addresses and plan details, see each HMO Benefit Summary.

### Things to Consider

If you are enrolled in an HMO and your doctor leaves the network, you cannot change your HMO election. This is **not** considered a qualifying life change.

Full and part-time associates (working at least 20 hours per week) may choose to opt out of the Medical Plan during annual enrollment or if you have a qualified life change. Enrollment changes must be consistent with your qualified life change.

## Definitions of Words and Terms

The following definitions are customized for the Medical Plan and are not applicable in other contexts.

**Annual Enrollment Period**: Is the period that associates can change benefit choices. ADP's Annual Enrollment is held in the fall for a January 1st effective date.

**Case Management**: Is used in situations where the patient will have a long recovery period, such as following a serious injury or illness, or in the case of high-risk pregnancy. It typically integrates care provided by all the players – the Plan, the Plan Administrator, the provider(s), the patient, and the family - in an effort to find the most appropriate treatment for that person.

**Claim Administrator**: ADP is self-insured and has contracted with the Claim Administrators, Aetna and UnitedHealthcare, to provide administrative services (claims processing, network contracting, etc.) for the Medical Plan and Dental Plan. In managed care areas, the Claim Administrator has contracted with providers for services at discounted fees.

**Coinsurance**: The percentage of covered costs that are paid by you including your deductible.

**Contracted or Network Provider**: A physician, hospital or provider of ancillary services who has a contract with ADP's Claim Administrator to provide their services at discounted rates.

**Copayment**: The flat dollar amount you pay for an emergency room visit in addition to your deductible. The copayment for an emergency room visit will be waived if you are admitted into the hospital.

**Custodial Care**: Care that helps a person meet the activities of daily living. This includes, but is not limited to, the following: help in walking; help in getting in or out of bed; help in bathing, dressing, feeding and using the toilet; housekeeping; preparation of special diets; and supervision of medical care which does not need the continuing attention of trained medical or paramedical personnel, and is usually administered by the person or a family member.

**Deductible**: The amount an individual or family must pay each calendar year from their own funds for all other covered medical costs before the plan will make any payment.

**Dependent Care Flexible Spending Account**: Is a voluntary, non-interest earning account that provides employees with a way to set aside pre-tax salary dollars to pay for dependent day care expenses that allow the associate to work (for example, elder care, after-school care, summer day camp).

**Health Care Flexible Spending Account**: Is a voluntary non-interest earning account that provides associates with a way to set aside pre-tax salary dollars to pay for unreimbursed health care expenses, such as medical, dental and vision deductibles and copayments.

**HMO (Health Maintenance Organization)**: Is a managed care medical service organization emphasizing preventive health care, which utilizes physicians and hospitals that have contracted with the HMO. Covered associates and dependents must use primary care providers to coordinate patient care and they have specific providers and facilities that they must use.

**Home Delivery Pharmacy**: Is a pharmacy designated as a primary distribution center for a mail service program. Using a mail-order pharmacy is beneficial if a covered person regularly takes medication for a chronic condition such as high blood pressure, diabetes, etc. Generally, covered associates and dependents may receive up to a 90-day supply of the maintenance medication for one co-payment.

**Limited Purpose Health Care Flexible Spending Account**: Is a voluntary non-interest earning account that provides associates enrolled in the CDHP with the HSA option to set aside additional pre-tax salary dollars to pay for non-reimbursable dental and vision expenses, such as deductibles and copayments. Medical and prescription drug expenses incurred after you meet your CDHP deductible are also eligible for reimbursement through the Limited Purpose Health Care Flexible Spending Account.

**Medically Necessary or Medical Necessity**: Any services and supplies provided for the prevention, evaluation, diagnosis or treatment of a specific illness, injury or condition and must be: ordered by a doctor or other health care provider; required for the treatment or management of a medical symptom or condition; the most efficient and economical service which can safely be provided to the patient; and provided in accordance with approved and generally accepted standards of medical or surgical practice.

The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.
Aetna and UnitedHealthcare each develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting their determinations regarding specific services. These clinical policies (as developed by Aetna and UnitedHealthcare and revised from time to time), are available to Covered Persons for Aetna members on www.aetna.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.aetna.com or for UnitedHealthcare members on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcare online.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered.

**Network**: A group of providers (physicians, hospitals and ancillary service providers) who contract with the Claim Administrator to provide their services for a discounted fee.

**Out of Area**: (PPO and CDHP participants only) Benefits are subject to the "out of area" levels when services are obtained in an area where no managed care provider is available or when the covered associate or dependent is outside of the country. See **Passive PPO and CDHP**. For associates traveling out of the country who require medical care, you will be eligible for Passive level benefits through either Aetna or UnitedHealthcare for covered expenses, i.e., 80% of usual and prevailing (U&P) fees or an amount negotiated by the Claim Administrator or an amount permitted by law after the deductible has been satisfied. Prescription drugs are covered.

**Out-of-Pocket Maximum**: The out-of-pocket maximum is the highest amount you would pay, including the deductible, copayments, and the coinsurance you pay over the deductible. Once you reach your out-of-pocket maximum, the plan pays up to 100% of most of your eligible expenses for the remainder of the year. Charges that exceed the usual and prevailing fee do not apply to the out-of-pocket maximum. The amount of your out-of-pocket maximum is based upon the option selected. The out-of-pocket maximum applies to you and all covered family members.

Some expenses do not apply to your out-of-pocket maximum including your payroll contribution for medical coverage, penalties and non-eligible expenses. Even if you reach your out-of-pocket maximum, you will continue to pay for the percentage not covered for hospital room and board, surgical, and related expenses because of your failure to comply with the pre-admission or pre-surgical review process.

**Passive PPO and CDHP**: These terms refer to the Aetna PPO and CDHP medical plan option offered to ADP associates living outside the ADP managed care service area. Passive PPO and CDHP plan options pay benefits at 80% of the usual and prevailing fee or an amount negotiated by the Claim Administrator or an amount permitted by law for non-preventive care and 100% of the usual and prevailing fee or an amount negotiated by the Claim Administrator or an amount permitted by law for preventive care. If you go to a managed care provider and you show your ID card, the network provider will charge you the discounted fee for service. You benefit by reduced fees.

**Physician**: A physician or surgeon, who is legally licensed to practice medicine, including licensed chiropractors. The following will be considered eligible providers of medical care if they are licensed to practice within the scope of their profession in the jurisdiction in which they practice or the state in which the services are rendered:

- Acupuncturists
- Inhalation Therapists
- Midwives
- Marriage, Family & Child Counselor
- Naturopaths
- Occupational Therapists
- Optometrists
- Osteopaths
- Podiatrists
- Professional Counselor
- Professional Nurse rendering psychotherapy
- Professional/Rural Nurses
- Psychiatric Mental Health Nurse
- Speech Pathologists

Covered associates and dependents can receive a discount on their medical services if they use a network provider. However, they can still use doctors outside of the network but will have more out-of-pocket expenses.

**Primary Care Physician (PCP)**: A physician who supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, an internist, a pediatrician or obstetrician/gynecologist.

**Shared Savings Program**: a program in which Aetna may obtain a discount to a non-Network provider's billed charges for certain out-of-network services not subject to a Medicare fee schedule. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by Aetna. In this case, the non-Network provider may bill you for the difference between the billed amount and the rate determined by Aetna. If this happens, you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by Aetna.

**Specialist (SCP)**: A physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine.

**Usual and Prevailing Fees (U&P)**: Guidelines used by the Claim Administrators to determine the maximum amount that will be paid for a medical or dental service. U&P fees are based on the amount of money charged by physicians, hospitals and other providers in a specified geographic area for a given service. Generally, for non-network providers, the Claim Administrators are using 150% of CMS rates for Medicare or an amount negotiated by the Claim Administrator, or an amount permitted by law. You pay 100% of any charges above the eligible amounts and those payments are not applied against your out-of-pocket maximum.

**Worksite Associate**: Any individual designated by ADP or a participating affiliate in accordance with standard payroll practice, as an associate or co-employee of a corporation or other entity that is not a member of the ADP's controlled group.

## Your Rights Under Federal Laws

### Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers (such as HMOs) generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, Federal law requires the Medical Plan to inform you that you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided under the Medical Plan in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Medical Plan. If you would like more information on these benefits, call your Plan Administrator.

### Mental Health Parity and Addiction Equity Act of 2008

Under the Mental Health Parity and Addiction Equity Act of 2008, mental health and substance abuse benefits must have parity with medical and surgical benefits. Treatment limitations and financial requirements related to mental health and substance abuse benefits must have parity with the most frequent or common medical and surgical limitations and requirements. The act also mandates parity for out-of-network coverage. Plans that cover out-of-network medical or surgical treatments must provide comparable coverage for out-of-network mental health and substance abuse benefits. The provisions of the act generally took effect for plan years beginning on or after January 1, 2010.

### Medicare Secondary Payer Disclosures

A new Medicare Secondary Payer law requires all medical carriers and group health plans to report participant information to the Centers for Medicare & Medicaid Services (CMS) on a quarterly basis. This information includes Social Security Numbers for you and your spouse/domestic partner age 55 and older (except in limited circumstances). Effective January 1, 2011, Social Security Numbers must be reported to CMS for you and your spouse/domestic partner age 45 and older, as well as for anyone covered under the group health plan (regardless of age) who is receiving dialysis or has had a kidney transplant. Thus, if the Plan does not have a Social Security Number on file for you, your spouse/domestic partner, or dependent, you may be asked to provide it to ADP or to the Claim Administrator for ADP to comply with this law.

# Your ERISA Rights

## General Information

ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Medical Plan.

## Plan Continuation

ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a plan, you will receive notice.

## Plan Document versus Guide

One of the primary purposes of the Summary Plan Description is to provide ADP associates and their covered dependents with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage and to have information concerning these Plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans and contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, or if there is a conflict between the Summary Plan Description and the legal Plan documents, the actual legal documents of the plans will rule.

## Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may charge a reasonable fee for the copies
- 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. A copy of this report is distributed annually and is also available on the web site https://associateportal.adp.com/

You have the right to continue health care coverage for yourself or your dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the Plan on rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. You may make a claim for medical benefits as described in the "Benefit Determinations and Appeals" section. Routine requests for information regarding your benefits under the Medical Plan and other similar inquiries will not be considered benefit "claims" that require processing under ERISA or the Medical Plan's claims procedures. If you wish to make a claim for Medical Plan benefits in accordance with your rights under ERISA, you must follow the procedures established by the plan.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules as described below in the "Benefit Determinations and Appeals" section.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after completing the Medical Plan's claim and appeal process, as outlined in the "Benefit Determinations and Appeals" section below. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after completing the Plan's claim and appeal process. **You may not start legal action against the Plan, the Plan Administrator, the Claim Administrator, your employer, or any other Plan fiduciary later than 90 days after the date you have completed the Plan's claim and appeal process (including external review by an independent third party, if available), and have received a final decision regarding your claim.**

## Benefit Determinations and Appeals

If you enrolled in an HMO option, please consult your HMO membership booklet for a description of the procedures for filing a claim for benefits or an appeal with the HMO. These benefit determination and appeal rules apply only to the PPO and CDHP options offered under the Medical Plan.

### Filing Health Claims under the Medical Plan

If you see a **network provider**, that office will usually send your Claim Administrator (Aetna or UnitedHealthcare) a detailed bill for your services. If you see an **out-of-network provider** or are in a plan that does not use a network of providers, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send your Claim Administrator the bill within 12 months of the date you received services, unless you are legally unable to notify your Claim Administrator. You must send the bill to your Claim Administrator with a claim form that you can either get online or contact your Claim Administrator to provide.

You may file claims for Medical Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from the Claim Administrator. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. To authorize an authorized representative to act on your behalf with respect to a benefit claim, you must submit a signed written request on a form approved by the Plan Administrator, which authorizes the representative to act on your behalf with respect to the benefit claim. You must sign and submit the approved form to the Plan Administrator and have such request approved prior to the authorized representative taking any action on behalf of your benefit claim, except as discussed below regarding Urgent Pre-Service Claim or Urgent Concurrent Care Determinations. Your assignment of benefits to a health care provider does not constitute a designation of an authorized personal representative for purposes of the Plan.

If you submit a pre-service request for benefits that names a specific claimant, condition, and service or supply for which approval is requested to a Medical Plan representative responsible for handling benefit matters, but which otherwise fails to follow the Medical Plan's procedures for filing pre-service or urgent care claims, you will be notified of the failure and of the proper procedures to be followed as soon as possible within 5 days (within 24 hours in the case of an urgent care claim). The notice may be oral unless you request written notification.

Claims will be processed in accordance with Medical Plan provisions. If your claim is denied, in whole or in part, you will receive a written notice of the denial from the Claim Administrator within the applicable time period described below. The notice will explain the reason(s) for the denial and the appeal procedures available under the Medical Plan. If you are not satisfied with the decision regarding your benefit coverage, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision.

You must act on your own behalf or through an authorized representative if you want to exercise your rights under the Medical Plan. If a person is not properly designated as the claimant's authorized representative under the Medical Plan, the Claims Administrator will not be able to deal with him or her in connection with the exercise of the claimant's rights. Additionally, your treating physician or other health care professional may act as your authorized representative in exercising your rights for an Urgent Pre-Service Claim or Urgent Concurrent Care Determination, as described below.

### Urgent Care Claim

If the Medical Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Medical Plan or your physician determines that it is an urgent care claim, you will be notified of the decision as soon as possible taking into account medical exigencies and not later than 72 hours after the claim is received. An " urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

### Other Claims (Pre-Service and Post-Service)

If the Medical Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim. For post-service claims you will be notified of the decision no later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Medical Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Medical Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

### Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Medical Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

### Filing an Appeal of an Adverse Benefit Determination for a Health Claim

As a participant under the self-insured ADP Medical Plan, you have the right to file an appeal if you are not satisfied with the outcome of the initial claim determination. You have the right to appeal a decision regarding any of the following:

- Benefit determination, including whether a service or supply is experimental or investigational or is medically necessary
- Certification of health care services
- Claim payment
- Eligibility for participation in the Medical Plan, if relating to a claim for benefits
- Plan interpretation
- Retroactive termination of your Medical Plan coverage

You may file an appeal in writing with the appropriate Claim Administrator at the address indicated below within 180 days of receipt of notice of the initial coverage decision:

**Aetna Medical Choice POS II Appeals**
Aetna
P. O. Box 14586
Lexington, KY 40512-4586

**UnitedHealthcare Medical Choice Plus Appeals**
UnitedHealthcare
Attn: Medical Choice Plus Claims
P. O. Box 30432
Salt Lake City, UT 84130-0432

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. Your appeal will generally be acknowledged within five working days of receipt. A representative at the Claim Administrator may call you or your health care provider to obtain medical records and/or other pertinent information to respond to your appeal.

You will be notified of the decision no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the Claim Administrator within 60 days of receipt of the level one appeal decision. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim or level one appeal. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Medical Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

The Claim Administrator will notify you of the decision on second level appeal not later than 15 business days (for pre-service claims) or 30 business days (for post-service claims) after the second appeal is received.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. The Member Services telephone number is on your identification card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Medical Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 business hours after the appeal is received. If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with the Claim Administrator. You will be notified of the decision not later than 72 business hours after the second appeal is received.

You have the right to receive, upon request and at no charge, the information used to review your second level appeal. The decision made on your second level appeal is final and binding. The Claim Administrator will have full power to administer and interpret the Medical Plan in all of its details and to apply the terms and provisions of the Medical to claim determinations, subject to applicable requirements of law. Benefits under the Medical Plan shall be paid only if the Plan Administrator or the applicable Claim Administrator decides, in its discretion, that the applicant is entitled to them.

### External Review

If your claim is denied or partially denied and you are not satisfied with the Claim Administrator's decision on final appeal, you may be able to request external review of your claim by an independent third party (referred to as an Independent Review Organization or External Review Organization), who will review the denial and issue a decision that is binding on you and the Medical Plan. Claim denials based on a determination that you are not eligible to participate under the terms of the Plan are not eligible for external review. Generally, you may not request external review of your claim until the administrative appeal rights described above have been exercised and exhausted in full. However, you may simultaneously request external review and internal appeal once your initial claim is denied, if waiting to complete an expedited urgent care appeal would seriously jeopardize your life or health or your ability to regain maximum function.

You or your authorized representative must make a request for external review within four months after date of receipt of the Claim Administrator's decision on final appeal. More information about the external review process will be provided with your notice of a claim denial or other adverse benefit decision.

You may not file an action at law or in equity for benefits under the Plan until the administrative appeal and external review (if applicable) rights described above have been exercised and exhausted in full, and the Plan benefits requested in your final appeal and external review (if applicable) have been denied in whole or in part.

### Deadline for Filing Lawsuits

Once you have exhausted your internal appeal and external review (if available) rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a) (1) (B) of ERISA. **You have 90 days from the date of receipt of a final decision after all appeals and reviews have been utilized and exhausted in which to file a lawsuit. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim. If you file a suit for benefits, the evidence that may be presented to the court will be strictly limited to the evidence timely presented to the Claim Administrator and any external reviewer, if applicable.**

### Plan Administrator

As the named fiduciary for the Plan, the Plan Administrator has the discretionary authority to determine eligibility under Plan terms, to interpret and apply the terms and provisions of the Plan, to resolve discrepancies and ambiguities, and to make final decisions on the appeal by a Plan participant of an initial claim denial. The Plan Administrator has delegated certain of its powers to the Claim Administrators. A decision made by the Plan Administrator or its delegate will be final and binding on all parties. Refer to the ERISA section for complete details.

### Administrative Details

The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

The Plan provides benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Medical Plan is a participating plan in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. In the event of a conflict between the Plan document, the SPD and the insurance contract, the terms and provisions of the insurance contract will control (if not inconsistent with ERISA or other applicable law), then the Plan Document and finally this SPD. |
| Plan Type | The Plan is a "welfare benefit plan" under Section 3(1) of the Employee Retirement Income Security Act of 1974. |
| Plan Administration, Funding & Claim Processing | The medical benefits are self-insured and claims are processed by the Claim Administrators identified below. Benefits are paid with associate and employer contributions. Associate contributions are applied first to the payment of Plan benefits.<br>Claim Administrators: Aetna Medical Claims, P.O. Box 981106, El Paso, TX 79998-1106.<br>For Member Services call 800-829-3685.<br>UnitedHealthcare, Medical PPO Claims, P.O. Box 740800, Atlanta, GA 30374-0800.<br>For Member Services call 866-633-2474.<br>The Plan Administrator is an administrative committee appointed by the Board of Directors of the Company. |
| VEBA Trust | The associate and employer contributions are deposited in the Automatic Data Processing, Inc. and Subsidiaries Employee Welfare Benefit Trust, a voluntary employees' beneficiary association established under Internal Revenue Code Section 501(c )(9).<br>The Trustees for the Trust are individuals appointed by the Company.<br>The Trustees are responsible for making payments from the Trust, including premiums for insurance plans, which are paid directly to the insurance carriers. In addition, all self-insured Plan benefits and related administrative expenses are paid directly from the Trust. |
| Plan Year (for Fiscal and Other Records) | January 1 to December 31 |
| Source and Method of Plan Financing | See the section entitled "Eligibility" and the Bi-Weekly Medical Contributions charts in this Section of the SPD |
| Plan Sponsor and Plan Administrator and Address | Automatic Data Processing, Inc.<br>One ADP Boulevard, M/S C237<br>Roseland, NJ 07068 Telephone: 973-974-5000<br>Identification Number: 22-1467904 |
| Agent for Service of Legal Process | Service of legal process may be made upon the Plan Administrator or any Trustee for the Trust |

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

### DOL Locations

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 866-444-3272 or online at www.dol.gov/ebsa.

# Prescription Drug

A separate Prescription Drug Plan[1] is included with the Aetna Choice POS II/UnitedHealthcare Choice Plus Medical Option 1 and Consumer Driven Health Plan (CDHP). The Prescription Drug Plan allows you to purchase your prescription drugs through local network pharmacies or a mail delivery program.

If you enroll in Aetna Choice POS II/UnitedHealthcare Choice Plus Medical Option 1 or CDHP, you are automatically enrolled in the Prescription Drug Plan administered by Express Scripts. The same eligibility requirements that apply under the Medical Plan options also apply to the Prescription Drug Plan. This document only pertains to prescription drug benefits administered by Express Scripts.

## If You are Enrolled in Medical Option 1:

There is no deductible, but there is a combined out-of-pocket maximum for your medical and prescription drug benefits. All covered prescription drug expenses that you and your dependents pay (i.e., copays and coinsurance) count toward the out-of-pocket maximum. Once the out-of-pocket maximum is met, the Prescription Drug Plan pays 100% for eligible prescription drug expenses. Refer to the "How it Works" section for more information about your cost of medications. Note: The out-of-pocket maximums do not cross-apply in medical Option 1. This means that in-network prescription drug expenses will not count toward your out-of-network limits and vice versa.

The combined medical and prescription drug out-of-pocket maximums are listed below:

| Out-of-Pocket Maximum | | |
|---|---|---|
| | In-Network | Out-of-Network |
| Associate | $4,000 | $7,500 |
| Associate + Spouse/ Domestic Partner | $4,000 per person | $7,500 per person |
| Associate + Child(ren) | $4,000 per person/ $8,000 per family | $7,500 per person/ $15,000 per family |
| Associate + Family | $4,000 per person/ $8,000 per family | $7,500 per person/ $15,000 per family |

For Passive Plan benefits please refer to the Aetna Choice POS II Medical Options At-A-Glance (Passive) chart in the Medical section of the SPD.

[1]The Prescription Drug Plan is also referred to as the "Plan" throughout this section of the SPD.

## If You are Enrolled in a CDHP Option:

You must meet the combined medical and prescription drug deductible before the Prescription Drug Plan begins to pay benefits other than for certain preventive drugs (refer to the "Preventive Medications Under the CDHP" section for details). Until then, you pay the full cost of the medication, which is discounted when you use an in-network pharmacy. Once you meet the combined deductible, you must pay coinsurance for medications as described in the "How it Works" section. All covered prescription drug expenses that you and your dependents pay (i.e., costs to satisfy the deductible and coinsurance) count toward your out-of-pocket maximum. Once the out-of-pocket maximum is met, the Prescription Drug Plan pays 100% for eligible prescription drug expenses.

The combined medical and prescription drug deductible and out-of-pocket maximums are as follows:

| Deductible (1) | CDHP with HSA Option 1 | | CDHP with HSA Option 2 | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Associate | $1,850 | $3,500 | $3,400 | $6,800 |
| Associate + Spouse/Domestic Partner | $4,000 (2) | $7,000 (2) | $3,400/ person $6,800/ family | $6,800/ person $13,600/ family |
| Associate + Child(ren) | $4,000 (2) | $7,000 (2) | $3,400/ person $6,800/ family | $6,800/ person $13,600/ family |
| Associate + Family | $4,000 (2) | $7,000 (2) | $3,400/ person $6,800/ family | $6,800/ person $13,600/ family |

| Out-of-Pocket Maximum | CDHP with HSA Option 1 | | CDHP with HSA Option 2 | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Associate | $4,250 | $8,500 | $6,650 | $13,300 |
| Associate + Spouse/Domestic Partner | $8,000 (3) | $17,000 (3) | $6,650/ person<br>$13,000/ family | $13,300/ person<br>$26,600/ family |
| Associate + Child(ren) | $8,000 (3) | $17,000 (3) | $6,650/ person<br>$13,000/ family | $13,300/ person<br>$26,600/ family |
| Associate + Family | $8,000 (3) | $17,000 (3) | $6,650/ person<br>$13,000/ family | $13,300/ person<br>$26,600/ family |

(1) The deductible is waived for certain preventive medications. In this case, coinsurance will immediately apply and these expenses will not count towards satisfying the deductible.
(2) One or multiple family members combined must reach the family deductible limit before the plan will pay non-preventive benefits for anyone in the family.
(3) One or multiple family members combined must reach the family out-of-pocket maximum before the plan will pay covered benefits at 100% for anyone in the family.

For Passive Plan benefits please refer to the Aetna Choice POS II Medical Options-At-A-Glance (Passive) chart in the Medical section of the SPD.

## How It Works

ADP's Prescription Drug Plan is a three-tier design to encourage the use of generics where available or preferred brand-name drugs if a generic is not available.

The cost of your medications will depend on whether you use generics, preferred brands, or non-preferred brands. The Prescription Drug Plan includes a formulary, which is a list of drugs that are preferred by the plan. This formulary includes a wide selection of drugs and has been reviewed by the Pharmacy and Therapeutic Committee, an independent committee of practicing physicians and pharmacists. The committee reviews and evaluates medications to ensure they are safe and effective as well as to ensure that clinical integrity is maintained in all therapeutic categories. Use of the formulary allows the plan to offer a wide variety of choices while helping to keep the cost of prescription drug benefits affordable.

### Retail Pharmacy (30-day supply)

To receive benefits under the Prescription Drug Plan, present your Express Scripts member ID card to a retail pharmacy in the network (a participating pharmacy). Your coinsurance will be a percentage of the prescription drug's total cost and will be subject to minimum and maximum amounts. (See the following chart.)

When you use this card to make purchases at a pharmacy in the Express Scripts retail pharmacy network, you may obtain up to a 30-day supply of the drug. You pay a coinsurance for each prescription. The amount of the coinsurance depends on whether the drug you receive is a generic, preferred brand or non-preferred brand drug.

If you purchase a brand-name drug (preferred or non-preferred) when a generic drug is available, you must pay more for the brand-name drug. By purchasing generic medications, your cost will always be less. For example**:**

- If you purchase a brand-name medication when a generic equivalent is available, you will pay your **generic coinsurance plus a penalty equal to the cost difference between the brand-name and generic medication**
- If you purchase a brand-name medication and there is no generic equivalent, you will pay your brand-name coinsurance
- Any time you purchase a generic medication, you will pay your generic coinsurance

If you use a non-participating pharmacy, you must pay the full cost at the time of purchase and then file a claim through the drug program for direct reimbursement. The appropriate coinsurance is deducted from your reimbursement. Reimbursement is limited to the amount that would have been paid to a participating pharmacy in the Express Scripts retail pharmacy network.

Express Scripts sends information directly to your home regarding the Prescription Drug Plan. You can search for a participating retail pharmacy located in your area by calling 877-723-4797 or accessing the web at www.express-scripts.com.

## Smart90 Walgreens (90-day supply)

Through the Smart90 Walgreens program, you can receive up to a 90-day supply of your maintenance medications directly at a Walgreens retail pharmacy. This program may be chosen in place of receiving maintenance medications through home delivery from Express Scripts.

## Express Scripts Pharmacy® (90-day supply)

The prescription mail order service is designed for associates and covered dependents who need maintenance or long-term medication. Through this service, you can receive up to a 90-day supply of medication sent conveniently to your home. Note that your doctor must indicate that it is for a 90-day supply with three fills. Visit Express Scripts online any time at www.express-scripts.com to find out how to get started, or you can call toll-free at 877-723-4797. For each 90-day supply of medicine, your coinsurance will be a percentage of the prescription drug's total cost and will be subject to minimum and maximum amounts.

| | When you use a Retail Network Pharmacy Up to a 30-day Supply | When you use the Express Scripts Pharmacy® or Smart 90/Walgreens Up to a 90-day Supply |
|---|---|---|
| **Generic Drugs** (1) | 25% of the prescription drug's total cost<br>No less than $20<br>No more than $60 | 25% of the prescription drug's total cost<br>No less than $40<br>No more than $140 |
| **Preferred Brand** (1) (2)<br>(only if generic is not available) | 25% of the prescription drug's total cost<br>No less than $45<br>No more than $110 | 25% of the prescription drug's total cost<br>No less than $95<br>No more than $250 |
| **Non-preferred Brand** (1)(2)<br>(only if generic is not available) | 50% of the prescription drug's total cost<br>No less than $110<br>No more than $240 | 50% of the prescription drug's total cost<br>No less than $250<br>No more than $480 |

(1) If the cost of the drug is less than the minimum coinsurance, you will only pay the actual cost.

(2) If you purchase a brand name medication when a generic equivalent is available, you will pay your **generic copayment plus the cost difference between the brand name and generic medication.**

You can determine if your brand medications are preferred by checking the Prescription Drug Plan's formulary guide provided by Express Scripts. You can check the most up-to-date costs and coverage information for preferred brand name and generic medications by visiting Express-Scripts online at www.express-scripts.com. If you are a first-time visitor to the site, take a moment to register. After you've logged in, select Price a Medication from the menu under 'Manage Prescriptions'.

### Specialty Medications

If you are currently taking a specialty medication, your prescription benefit entitles you to the enhanced services of Accredo, an Express Scripts **specialty pharmacy**. Specialty medications, normally administered by injection and often requiring refrigeration and special handling, are used to treat complex conditions such as hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis.

The Accredo Pharmacy works exclusively with specialty medications. Services available from Accredo Pharmacy include:

- 24/7 access to pharmacists for questions
- Expedited, scheduled delivery via UPS or a similar service
- Free supplies to administer your medication (needles, syringes)
- Personalized counseling and condition-specific education from registered nurses
- Refill reminder calls

Please note that certain specialty medications may no longer be covered when ordered through your current pharmacy. To get started with the **Accredo Pharmacy** today – or to confirm if your specialty medications will still be covered when obtained at your current pharmacy – call Express Scripts toll-free at 877-723-4797.

Copays for certain specialty medications may be set to the maximum of the current plan design or any available manufacturer-funded copay assistance. The financial assistance you receive to help cover some of your specialty medicine costs from Accredo will not count toward your annual deductible and/or out-of-pocket maximum. You'll still receive financial assistance, and this doesn't change the amount you pay for your medicine. However, only the amount you pay will be applied to your deductible and/or out-of-pocket maximum. You'll see this as an adjustment on your Explanation of Benefits (EOB).

For example, if your copay is $500 and you receive $450 in financial assistance, only the remaining $50 you pay out-of-pocket will be applied to your annual deductible and/or out-of-pocket maximum.

Financial assistance may also be known as copay assistance, variable copay, manufacturer coupons, discount programs and coupon programs.

### Fertility Drugs

If a member is starting fertility treatment, please contact WIN at 833-439-1518. Prescription drug coverage for approved fertility medications, subject to your plan's regular coinsurance, while receiving the fertility medical benefits, is provided through Express Scripts. Prescription drugs must be approved by WIN to be covered. Your covered fertility-related prescription drug costs will not count against the $20,000 lifetime medical maximum per person for eligible expenses related to a covered fertility treatment or procedure.

## Covered Prescription Expenses

The following are covered benefits unless listed under "Prescription Expenses that are NOT Covered" later in this section:

- Federal Legend Drugs - drugs, which under state or federal law require a prescription
- Insulin
- Legend vitamins
- Lupron (for men and women)
- Needles and Syringes
- Over-the-counter Diabetic Supplies (allowed up to 30 days or 100 units, whichever is greater)
- Contraceptives
- State Restricted Drugs, in accordance with the State's restrictions

Note: Any covered drugs available at retail and pre-packaged in a greater than 30-day supply are subject to the mail order coinsurance.

### Smoking Cessation

Please check with Express Scripts for coverage of smoking cessation medications including over the counter smoking cessation aids.

### Coverage Management or Prior Authorization Program

Some medications are covered only for certain uses or in certain quantities. Your Prescription Drug Plan sets all coverage parameters. For example, a drug may not be covered when it is used for cosmetic purposes. Also, the quantity covered may be limited to certain amounts over certain time periods. Certain drugs are subject to step therapy rules. Step therapy uses clinical logic to perform an automatic check of your medical profile and drug history to determine whether or not you have tried:

- a clinically appropriate and available generic or
- a lower cost drug before providing coverage of another brand alternative or
- if you have met other clinical criteria for coverage

In these cases, your doctor may need to provide more information for the medication to be covered. This program, the clinical basis of which was approved by an independent committee of physicians and pharmacists, ensures that your prescriptions are being covered in accordance with your Prescription Drug Plan.

Your network pharmacist will let you know if additional information is required. You or the pharmacist can then ask your doctor to call a special toll-free number. This call will initiate a coverage review that typically takes 1 to 2 business days. Once the review is complete, Express Scripts will notify you and your doctor of the decision. You are eligible to appeal any decision (see below). If you are in immediate need of medication that requires a review, you should discuss with your pharmacist or doctor other alternatives that can be used until a review and decision has been made. See the Urgent Care Claims section for details.

If you use a non-network pharmacy to fill a prescription, you are responsible for checking with Express Scripts to see if prior authorization is required. Failure to do so will result in the claim being denied if it required prior authorization. You should also check to see if your medication is subject to step therapy or quantity limits.

### RationalMed

RationalMed is a unique health and safety program that combines medical and prescription drug data to help identify patients at risk for drug-therapy related hospitalizations. It alerts the patient's physician(s) of a potential drug conflict, particularly where a combination of drugs is being used. This program enhances physician awareness and allows the physician to determine if alternative drug therapy or treatment is appropriate.

### Home Delivery Program

- The mail order feature is designed to help reduce the cost of prescription drugs whenever possible. If you receive maintenance medications through a retail pharmacy, you will pay 100% of the cost of the medication after the third fill if you continue to fill a 30-day supply. Through the Home Delivery Program, you can receive up to a 90-day supply of your maintenance medications delivered to your home. In summary, prescription medications that you take for more than 90 days are covered under the Plan if received through the Express Scripts mail service or through the Smart 90 Walgreens network.

| Where | When | Generic Drugs | Preferred Brand Name Drugs (No generic available) | Non-Preferred Brand Name Drugs (No generic available) |
|---|---|---|---|---|
| | | You Pay | You Pay | You Pay |
| **Participating Retail Pharmacy** | **First three times** you purchase each prescription drug | 25% of the medication's total cost per prescription filled (with $20 min/$60 max) for up to a **30-day supply** | 25% of the medication's total cost per prescription filled (with $45 min/$110 max) for up to a **30-day supply** | 50% of the medication's total cost per prescription filled (with $110 min/$240 max) for up to a **30-day supply** |
| **Participating Retail Pharmacy** | **Beginning with the fourth time** you purchase each prescription drug | 100% of the medication's total cost per prescription filled (with $20 min) for up to a **30-day supply** | 100% of the medication's total cost per prescription filled (with $45 min) for up to a **30-day supply** | 100% of the medication's total cost per prescription filled (with $110 min) for up to a **30-day supply** |
| **Express Scripts Pharmacy Home Delivery or Smart90 Walgreens** | Anytime you purchase a prescription drug | 25% of the medication's total cost per prescription filled (with $40 min/$140 max) for up to a **90-day supply** | 25% of the medication's total cost per prescription filled (with $95 min/$250 max) for up to a **90-day supply** | 50% of the medication's total cost per prescription filled (with $250 min/$480 max) for up to a **90-day supply** |

To determine whether your medications are included on the ADP Prescription Drug Plan maintenance drug list, go to www.express-scripts.com and select Price a Medication from the menu under 'Manage Prescriptions'" or call Express Scripts Member Services toll-free at 877-723-4797.

You may continue to get all short-term medications, such as antibiotics, at a retail pharmacy.

## Prescription Expenses That Are Not Covered

The following are excluded from coverage unless specifically listed as a benefit under "Covered Prescription Expenses" earlier in this section.

- Anti-dandruff preparations
- Compound medications considered experimental or investigational
- Contraceptive jellies, creams, foams, devices or implants
- Food supplements
- Mifeprex
- Non-Federal legend drugs
- Non-legend vitamins
- Therapeutic devices or appliances
- A prescription cannot be filled more than what is specified by the physician, or after one year from the original prescription. Note: Controlled substances can only be filled for up to 6 months or up to 6 fills as prescribed by your physician.
- Drugs labeled "Caution – Limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual
- Drugs whose sole purpose is to promote or stimulate hair growth (Propecia, Rogaine) or for cosmetic purposes (Avage, Botox cosmetic, Epiquin, Renova, Solage, Tri-Luma, Vaniqa)
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution, which operated on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Fertility drugs, once a member has reached the $20,000 lifetime fertility cap under the medical plan. You can work with WIN regarding discounts outside of ADP's Medical and Prescription Drug Plan

To confirm most recent drug coverage inclusion and exclusion, go to www.express-scripts.com and click "Price a medication" or call Express Scripts Member Services toll-free at 877-723-4797.

**Dispensing Limits:**

The amount of drug which is to be dispensed per prescription or filled in quantities prescribed up to a 30-day supply at a retail pharmacy and up to 90 days through the home delivery pharmacy/Smart90 Walgreens.

## Health Care Reform/Preventive Medications

The Prescription Drug Plan covers the following preventive medications (both prescription and over-the-counter (OTC) at a $0 coinsurance with no deductible for members enrolled in Medical Option 1 or the CDHP option. To receive these medications at a $0 coinsurance, you must have an authorized prescription for the product, and it must be dispensed by a participating mail or retail pharmacy:

- Aspirin – Generic OTC products with age limits, for persons under the age of 60
- Bowel preparation agents for screening for colonoscopies – generic drugs and over-the-counter preparations for persons age 45 through 75, limit two prescriptions every 365 days
- Breast cancer – certain cancer drugs, for asymptomatic persons, age 35 and older, with no previous diagnosis of breast cancer, but considered to be by use of a risk model to be a "high risk" for breast cancer
- Contraceptives – Generic and single-source brand name (i.e., no generic equivalent) contraceptive medications when accompanied by a prescription and purchased through retail or mail order. Includes covered oral, transdermal, intrauterine, injectable contraceptives Plan B/Plan B one step, non-systemic contraceptives, devices and implants. Opill, an over the counter (OTC) hormonal contraceptive, is also covered at zero cost share at the point-of-sale when prescribed by a health care provider. All prescription contraceptives will be covered subject to the standard retail fill limits. Members requesting brand name medications that have a generic alternative will be subject to pay the penalty between the brand and generic cost.
- Fluoride – A generic or OTC prescription product for children to prevent dental cavities - covered for persons 6 months old through age 5 years old
- Folic acid – Generic or OTC doses of 400 to 800 mcg/day for persons up to age 50
- HIV pre-exposure prophylaxis (PrEP)

- Smoking cessation products – prescription products covered for persons age 18 years and older under plan guidelines
- Statins – Generic low/moderate dose statins (cholesterol lowering drugs that help prevent heart attacks and strokes) for persons ages 40 to 75
- Vaccines – including the administration of the vaccine

## Preventive Medications under the CDHP

In addition to the prescription drugs that Health Care Reform requires to be available at $0 coinsurance, if you are enrolled in the CDHP option, the Prescription Drug Plan will waive the deductible (you must still pay the coinsurance) for certain preventive medications prescribed by a doctor, when you use an in-network pharmacy, including various types of:

- Agents for osteoporosis
- Cholesterol lowering agents
- Diabetes therapies
- Vitamins (geriatric, pediatric, and prenatal)

## Medicare Part D Creditable Coverage

Medicare prescription drug coverage is available to everyone eligible for Medicare through Medicare Part D prescription drug plans. ADP has determined that the prescription drug coverage under the Prescription Drug Plan is, on average for all participants, expected to pay as much or more than the standard Medicare prescription drug benefit. Therefore, because your existing drug coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a late penalty if you do not enroll in Medicare prescription drug coverage upon first becoming eligible for Medicare. You can choose to join a Medicare prescription drug plan later without incurring a penalty. If you decide to enroll in a Medicare Part D plan, you will still have prescription drug coverage under the Prescription Drug Plan as long as you elect medical coverage under Aetna Choice POS II/UnitedHealthcare Choice Plus Medical Option 1 or CDHP. Covered associates and dependents eligible for Medicare receive an annual creditable coverage notice that includes more information. For a copy of the notice, contact the Plan Administrator.

# Your ERISA Rights

### General Information

ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Plan.

### Plan Continuation

ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a plan, you will receive notice.

### Plan Documents versus Guide

One of the primary purposes of the Summary Plan Description known is to provide ADP associates and their covered dependents with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans and contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, or if there is a conflict between the Summary Plan Description and the legal Plan documents, the actual legal documents of the plans will rule.

## Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may charge a reasonable fee for the copies
- 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. A copy of this report is distributed annually and is also available on https://associateportal.adp.com/

You have the right to 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 may have to pay for such coverage. Review the Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

You may make a claim for prescription drug benefits as described in "Benefit Determinations and Appeals." Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered benefits "claims" that require processing under ERISA or the Plan's claims procedures. If you wish to make a claim for Plan benefits in accordance with your rights under ERISA, you must follow the procedures established by the Plan.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules as described below in the "Benefit Determinations and Appeals" section.

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court after completing the Plan's claim and appeal process, as outlined in the "Benefit Determinations and Appeals" section below. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after completing the Plan's claim and appeal process. **You may not start legal action against the Plan, the Plan Administrator, the Claims Administrator, your employer, or any other Plan fiduciary later than 90 days after the date you have completed the Plan's claim and appeal process (including external review by an independent third party, if available), and have received a final decision regarding your claim.**

## Benefit Determinations and Appeals

### Filing Prescription Drug Claims under the Plan

When you present a prescription to be filled at an in-network pharmacy, the pharmacy will submit a request for benefits on your behalf. If the Prescription Drug Plan approves payment for your medication or supplies, your benefit will be provided at the time your prescription is filled.

If you present a prescription to be filled at a non-network pharmacy, you are responsible for first checking the Plan requirements, e.g., to see if the prescription requires prior authorization or if there is a penalty for not using the generic version of the drug. You will have to pay for the claim in full and submit your claim by mail or fax to Express Scripts for claim processing. Express Scripts will send you an explanation of benefit (EOB) with a check for the portion of the claim paid by the Prescription Drug Plan.

Your Prescription Drug Plan also provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. Therefore, if your pharmacy informs you that your medicines or supplies are not covered by the Prescription Drug Plan, you may pay for the prescription out-of-pocket and submit a paper claim for Plan benefits. You must also submit a claim for Plan benefits if you fill your prescription at a non-participating pharmacy. If the Prescription Drug Plan requires advance approval of a service, supply or procedure before a benefit will be payable, you may also file a request for approval in writing. You may submit a formal claim for benefits by sending it to the Claims Administrator:

**Express Scripts**
P.O. Box 14711
Lexington, KY 40512
For Member Services, call 877-723-4797

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Express Scripts Solutions, Inc. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. You must act on your own behalf or through an authorized representative if you want to exercise your rights under the Prescription Drug Plan. In the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

If you submit a pre-service request for benefits that names a specific claimant, condition, and service or supply for which approval is requested to a Plan representative responsible for handling benefit matters, but which otherwise fails to follow the Prescription Drug Plan's procedures for filing pre-service or urgent care claims, you will be notified of the failure and of the proper procedures to be followed as soon as possible within 5 days (within 24 hours in the case of an urgent care claim). The notice may be oral unless you request written notification. Claims will be processed based on your Prescription Drug Plan benefit. You will receive an explanation of benefits within the applicable time period described below. If you are not satisfied with the decision regarding your benefit coverage, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision.

### Urgent Care Claims

If the Prescription Drug Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Prescription Drug Plan or your physician determines that it is an urgent care claim, you will be notified of the decision as soon as possible taking into account medical exigencies and not later than 72 hours after the claim is received.
An "urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but no later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but no less than 48 hours, to provide the information, and you will be notified of the decision no later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier). If you don't provide the needed information within the 48-hour period, your claim is considered "deemed" denied and you have the right to appeal as described below.

### Other Claims (Pre-Service and Post-Service)

If the Prescription Drug Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision no later than 15 days after receipt of the pre-service claim, provided you have submitted sufficient information to decide your claim. For all other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim, as long as all needed information was provided with the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Prescription Drug Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Prescription Drug Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier). If you don't provide the needed information within the 45-day period, your claim is considered "deemed" denied and you have the right to appeal as described below.

### Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Prescription Drug Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

### Filing an Appeal of an Adverse Benefit Determination for a Prescription Drug Claim

In the event you receive an adverse benefit determination (your claim is denied, in whole or in part) following a request for coverage of a prescription benefit claim (including a claim considered "deemed" denied because missing information was not timely submitted) and you are not satisfied with the decision, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to:

**Express Scripts**
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

You will be notified in writing of a decision regarding your appeal within 30 days (or within 15 days, in the case of a pre-service claim) of receipt of your written request for appeal. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to your appeal, the Plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. You have the right to receive, upon request and at no charge, access to or copies of all documents, records and other information relevant to your claim.

You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim). To initiate a second level appeal, you or your authorized representative (such as your physician) must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to:

**Express Scripts**
Attn: Appeals
PO Box 631850
Irving, TX 75063-0030

A decision regarding your request will be sent to you in writing within 30 days (or within 15 days, in the case of a pre-service claim) of receipt of your written request for second level appeal. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

**Filing an Urgent Appeal of an Adverse Benefit Determination (Expedited Review)**
You have the right to request an urgent appeal of an adverse benefit determination (including a claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim. To initiate an urgent claim or appeal request, you or your physician (or other authorized representative) must call l 800-753-2851 or fax the request to 1-888-235-8551. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your claim or appeal be considered for urgent processing. In the case of an urgent appeal (for coverage involving urgent care), you will be notified of the benefit determination within 72 hours of receipt of the claim. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to your appeal, the Plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to a full and fair impartial review of your claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your claim).

The Claims Administrator will have full power to administer and interpret the Prescription Drug Plan in all of its details, subject to applicable requirements of law. Benefits under the Prescription Drug Plan will be paid only if the Claims Administrator decides, in its discretion, that the applicant is entitled to them.

If you have exhausted your second level appeal (i.e., your "final adverse benefit determination"), you have the right to bring a civil action under ERISA section 502(a), but not later than 90 days after the date you have completed the Plan's claim and appeal process (including external review by an independent third party, if available), and have received a final decision regarding your claim. Instead, you may be eligible for an external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination and below.

### External Review

If your claim is denied or partially denied in your final adverse benefit determination and you are not satisfied with the Claims Administrator's decision on this final adverse benefit determination, you may be able to request external review of your claim by an independent third party, who will review the denial and issue a decision that is binding on you and the Prescription Drug Plan. Claim denials involving medical judgment or rescission are eligible for external review. Claims based purely on the terms of the Plan (e.g., the Plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim, and would thus not be eligible for external review.

You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal Plan claim review process described above. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed or faxed to:

**Express Scripts**
Attn: External Review Requests
P.O. Box 631850
Irving, TX 75063-0030.
Phone: 1 800 753 2851
Fax: 1 888 235 8551

### Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO, and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that your claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Claims Administrator for reconsideration. The IRO will review your claim within 45 calendar days and send you the Plan and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a), but not later than 90 days after you have received this final decision regarding your claim. If the IRO has determined that your claim does not involve medical judgment or rescission, the IRO will notify you in writing that your claim is ineligible for a full external review and you have the right to bring civil action under ERISA section 502(a) but not later than 90 days after you have received such notice.

### Urgent External Review

Once you have submitted your urgent external review request, your claim will immediately be reviewed to determine if you are eligible for an urgent external review. An urgent situation is one where, in the opinion of your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If you are eligible for urgent processing, your claim will immediately be reviewed to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you the Plan and Express Scripts written notice of its decision. If you are not satisfied or you do not agree with the decision, you have the right to bring civil action under ERISA section 502(a), but not later than 90 days after you have received this final decision regarding your claim.

### Deadline for Filing Lawsuits

Once you have exhausted your internal appeal and external review rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a)(1)(B) of ERISA. You have 90 days from the date of receipt of a final decision after all appeals and reviews have been utilized and exhausted. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim. If you file a suit for benefits, the evidence that may be presented to the court will be strictly limited to the evidence timely presented to the Claims Administrator and any external reviewer, if applicable.

### Administrative Details

The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished. The Plan provides benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Prescription Drug Plan is a participating plan in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. In the event of a conflict between the Plan document, the SPD and the insurance contract, the terms and provisions of the insurance contract will control first, then the Plan Document and finally the SPD. |
| Plan Type | The Plan is a "welfare benefit plan" under Section 3(1) of the Employee Retirement Income Security Act of 1974. |
| Plan Administration, Funding & Claim Processing | The prescription drug benefits are self-insured and claims are processed by the claims administrator identified below. Benefits are paid with associate and employer contributions. Associate contributions are applied first to the payment of plan benefits.<br><br>Claims Administrator:<br>Express Scripts Prescription Drug Benefits – PAID Prescriptions L.L.C.<br>P.O. Box 2187,<br>Lee's Summit, MO 64063-2187.<br><br>For Member Services, call 1-877-723-4797.<br>The Plan Administrator is the administrative committee appointed by the Board of Directors of the Company |
| VEBA Trust | The associate and employer contributions are deposited in the Automatic Data Processing, Inc. and Subsidiaries Employee Welfare Benefit Trust, a voluntary employees' beneficiary association established under Internal Revenue Code Section 501(c)(9).<br>The Trustees for the Trust are individuals appointed by the Company.<br>The Trustees are responsible for making payments from the Trust, including premiums for insurance plans, which are paid directly to the insurance carriers. In addition, all self-insured Plan benefits and related administrative expenses are paid directly from the Trust. |
| Plan Year (for Fiscal and Other Records) | January 1 to December 31 |
| Plan Sponsor | Automatic Data Processing, Inc. |

| Plan Number | Plan 503 |
|---|---|
| Source and Method of Plan Financing | See the section entitled "Eligibility" and the Bi-Weekly Medical Contributions charts in the Medical Plan Section of the SPDs |
| Plan Administrator and Address | **Automatic Data Processing, Inc.**<br>One ADP Boulevard, M/S C237<br>Roseland, NJ 07068<br>Telephone: 1-973-974-5000<br>Identification Number: 22-1467904 |
| Agent for Service of Legal Process | Service of legal process may be made upon the Plan Administrator or any Trustee for the Trust. |

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

### DOL Locations

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

# Dental Benefits

## Your Options

ADP offers you several options. You may select **Option 1, 2, or 3**, or choose no coverage at all.

**Option 1 – Aetna Indemnity PPO** - You can go to any dentist of your choice; however, there is a deductible for most services. If your dentist or specialist is a network provider, covered charges will be discounted. Show your ID card to obtain network discount. Your monthly contributions are higher than the other two dental options and Orthodontic services are available for dependent children only.

**Option 2 – Aetna Dental Preferred Provider Organization (PPO)** - (In-Network and Out-of-Network) - Provides the flexibility to see any dentist, however, services by a network dentist are at the contract rate and there are no deductibles. You will receive a higher level of benefit if you use a network dentist. The out-of-network plan has a deductible, lower coinsurance and an annual maximum amount. Therefore, your out-of-pocket costs will be higher.

This Option allows you the flexibility to receive care from any provider you choose. Each time you receive services, you may choose to see an in-network dentist or an out-of-network provider. However, if you choose to visit a network provider and show your Aetna Dental ID card, services are at the contract rate. Eligible expenses out-of-network are based on Aetna's usual and prevailing fee schedule. Orthodontic services are available for dependent children only.

**Option 3 – Aetna Dental Maintenance Organization (DMO)** - When you choose this option, you and/or each member of your family must select a primary dentist from the DMO's network of participating dentists. Each covered family member may select a different primary dentist from the DMO network of participating dentists. This dentist coordinates all your dental needs and refers you to specialists if necessary. You can change your dentist by calling the number on your ID card by the 15th of any month. The change in your dentist will become effective on the first day of the following month. A new DMO ID card will be sent to you. You can access Aetna's provider search by going to www.aetna.com and click on "Find a Doctor" to find a participating dentist in your area.

Additionally, Option 3 includes Orthodontia benefits based upon the dentist's usual and prevailing fee for both adults and dependent children.

**Your covered expenses will be covered as out-of-network expenses if you do not obtain services and supplies from your Primary Care Dentist (PCD) or if you obtain services without a referral from your PCD, even if you choose a provider in the DMO network. If you visit a dentist other than the dentist listed on your DMO ID card, without prior approval, your covered expenses will be covered as out-of-network expenses. The plan covers out-of-network services and supplies, but your out-of-pocket expenses may be higher.**

Before selecting the DMO, contact the DMO provider to ensure availability. You will not be allowed to leave the DMO because a particular provider is not available. You should keep in mind that typically you will have a longer wait for preventive care appointments through the DMO.

## Your Share of the Cost

Your contribution toward the cost of dental coverage is shown below. Costs vary according to the option selected. This cost is expected to remain the same during the Plan year. In the event there is a change in cost, you will be notified prior to the date the change becomes effective and your payroll withholding will be automatically adjusted. Your pay is reduced on a pre-tax basis for the cost of coverage you elect.

**Your Bi-weekly Contributions are as follows:**

| | Option 1 (PPO) | Option 2 (PPO) | Option 3 (DMO) |
|---|---|---|---|
| Associate Only | $23.36 | $16.34 | $6.04 |
| Associate + Spouse/Domestic Partner | $52.57 | $36.74 | $13.59 |
| Associate + Child(ren) | $46.73 | $32.66 | $12.08 |
| Associate + Family | $74.76 | $52.25 | $19.32 |

## Eligibility and Enrollment

See Eligibility and Enrollment in the General Information Section.

**Note:** If a dependent is confined for medical care or treatment in a hospital, extended care facility, or at home on the date coverage would become effective, then such coverage will be effective regardless of the confinement. All family members must elect the same option as the associate.

## What Services Are Covered

All dental options cover four types of dental services:

| Option 1 | Option 2 | Option 3 (DMO) |
|---|---|---|
| Preventive | Preventive | Preventive |
| Basic | Basic | Basic |
| Major | Major | Major |
| Orthodontic<br>(dependent children only) | Orthodontic<br>(dependent children only) | Orthodontic<br>(dependent children and adults) |

Your level of benefits and calendar year limits vary depending upon the option you select. Benefit payments are based upon either contracted rates or usual and prevailing charges, depending on the dental option you choose. If your dentist is out-of-network and the dental charges exceed the usual and prevailing charges, you are responsible for paying the difference between this Plan's payment based on the usual and prevailing charges and the dentist's actual charges. Remember, separate annual maximums apply to each covered person. Additionally, a separate lifetime orthodontic maximum is applied to each covered eligible dependent for Options 1 and 2. Option 3 has a lifetime orthodontic maximum of 24 months of active treatment plus 24 months of retention for In-Network orthodontic care and an $800 limit for Out-of-Network orthodontic care. Once you meet the orthodontic lifetime maximums under any option, additional orthodontic benefits may be available if you change to another option during annual enrollment.

# Dental Benefits-At-A-Glance Options 1 and 2

| Plan Type | | Plan Option 1<br>Indemnity Dental PPO (use network provider and obtain discount) | Plan Option 2<br>Dental PPO Plan (In Network) | Plan Option 2<br>Dental PPO Plan (Out of Network) |
|---|---|---|---|---|
| **Annual Deductible**<br>(waived for preventive) | **Associate Only**<br>**Associate + Spouse/DP**<br>**Associate + Child(ren)**<br>**Associate + Family** | $50<br>$50 per person<br>$50 per person/$150 per family<br>$50 per person/$150 per family | None | $50<br>$50 per person<br>$50 per person/$150 per family<br>$50 per person/$150 per family |
| **Annual Benefit Maximum** | | $2,000 per person | $3,000 per person(1) | $1,000 per person(1) |
| **Lifetime Orthodontia Maximum (child only)** | | $1,500 per person | $1,500 per person(1) | $1,000 per person(1) |
| **PREVENTIVE** | | | | |
| Exams (limit 2 per year) (2) | | ADP pays in full | ADP pays in full | ADP pays in full |
| Cleaning (limit 3 per year) (3) | | ADP pays in full | ADP pays in full | ADP pays in full |
| Full mouth debridement (limit 1 per lifetime) | | ADP pays in full | ADP pays in full | ADP pays in full |
| Fluoride (limit 1 per year) to age 18 | | ADP pays in full | ADP pays in full | ADP pays in full |
| Sealants on Permanent Molars (limit 1 every 3 years to age 16) | | ADP pays in full | ADP pays in full | ADP pays in full |
| Bitewing X-Rays (limit 1 per year) | | ADP pays in full | ADP pays in full | ADP pays in full |
| Vertical Bitewing X-Rays (limit 1 set every 3 years) | | ADP pays in full | ADP pays in full | ADP pays in full |
| Full Mouth X-Rays (limit 1 set every 3 years) (4) | | ADP pays in full | ADP pays in full | ADP pays in full |
| **BASIC** | | | | |
| **Endodontic** | | | | |
| Pulp Capping | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| Root Canal Anterior and Bicuspid | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| Molar Root Canal | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| **Restorations** | | | | |
| Fillings | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| Stainless Steel Crowns | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| Acrylic Temporary Crowns | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| **Periodontics Maintenance**(6) | | | | |
| Periapical X-Rays (used to diagnose a disease) | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| Scaling/root planing of 4 quadrants (limit once every 2 years) | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| Gingivectomy or gingivoplasty | | You pay 20% (5) | You pay 15% | You pay 50% (5) |
| **Anesthesia** is covered when medically necessary and in conjunction with covered services | | You pay 20% (5) | You pay 15% | You pay 50%(5) |
| **Space Maintainers** | | You pay 20% (5) | You pay 15% | You pay 50%(5) |
| **MAJOR** | | | | |
| **Oral Surgery**(7) | | | | |
| Extractions | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| **Restoration and Prosthodontics**(8) | | | | |
| Implants | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| Inlays and Onlays | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| Bridges | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| Crowns (freestanding) except stainless steel | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| Bridge and crown repairs (9) | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| Dentures | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| Denture Repairs(9) | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| False teeth | | You pay 20%(5) | You pay 40% | You pay 50%(5) |
| **Orthodontia** | | You pay 50% (child only) | You pay 50% (child only) | You pay 50% (child only) |

Indemnity Dental PPO means if you use a Participating dentist, covered charges will be discounted. Show ID card to obtain network discount. All non-network provider charges are subject to Usual & Prevailing fee (U&P).

(1) In-Network and Out-of-Network combined cannot exceed $3,000 in annual benefits and $1,500 in lifetime orthodontia benefits. If you use In-Network services first, they will apply against your Out-of-Network annual benefit maximum. Example: Out-of-Network of $1,000 then In-Network of $2,000 = $3,000 in total. In-Network of $2,000 and then you can't use Out-of-Network so total = $2,000.

(2) Only two exams per year whether it is preventive or due to a dental diagnostic visit. Associate out-of-pocket expense is based on dentist Usual and Prevailing fee (not a contract rate).

(3) For individuals age 14 and over, treatments will include scaling and polishing.

(4) Frequency limit waived if required for dental conditions.

(5) Once the deductible is met, coinsurance applies. There is no deductible applied to orthodontia.

(6) Periodontal Maintenance is limited to 2 visits per calendar year following active periodontal therapy.

(7) Oral surgery, except those described in the Basic Services portion above and those oral surgery procedures covered under the medical plan like Aetna Choice POS II/ UnitedHealthcare Choice Plus Plans. Some extractions are covered under medical and some under dental. Be sure to get a pre-determination of benefits before getting treatment to see how the extraction will be covered.

(8) Subject to replacement and missing tooth provisions.

(9) Replacement of crowns, dentures, or bridgework less than 7 years old is not covered.

# Dental Benefits At-A-Glance Dental Maintenance Organization (DMO) Option 3

| Plan Type/Network | In-Network[1] |
|---|---|
| **Annual Deductible** | No deductible, coinsurance may apply |
| **Annual Benefit Maximum** | Unlimited |
| **Lifetime Orthodontia Maximum** | Unlimited (child and adult) |
| **PREVENTIVE** | |
| Exams (limit 4 per year) | ADP pays in full |
| Cleaning (limit 2 per year) | ADP pays in full |
| Fluoride (limit 1 per year) to age 18) | ADP pays in full |
| Sealants on Permanent Molars (limit 1 every 3 years) | ADP pays in full |
| Bitewing X-Rays (limit 2 per year) | ADP pays in full |
| Vertical Bitewing X-Rays (1 set every 3 years) | ADP pays in full |
| Full Mouth X-Rays (limit 1 every rolling 3 years) | ADP pays in full |
| **BASIC** | |
| **Endodontic** | |
| Pulp Capping | ADP pays in full |
| Root Canal Anterior and Bicuspid | ADP pays in full |
| Molar Root Canal | You pay 40%[2] |
| **Restorations** | |
| Fillings (except gold) | ADP pays in full |
| Stainless Steel Crowns | ADP pays in full |
| Acrylic Temporary Crowns | You pay 40%[2] |
| **Periodontics** | |
| Scaling/root | ADP pays in full |
| Gingivectomy or gingivoplasty[3] | ADP pays in full |
| **MAJOR** | |
| **Oral Surgery** [4] | You pay 0% (e.g., erupted tooth or tissue impaction) or 40% (e.g., partial or full boney impactions) [5] |
| Extractions | |
| **Restoration and Prosthodontics** | |
| Implants[6] | You pay 40% [2] |
| Inlays | You pay 40% [2] |
| Onlays | You pay 40% [2] |
| Crowns (freestanding) | You pay 40% [2] |
| Bridge and crown repairs [7] | You pay 40% [2] |
| Dentures | You pay 40% [2] |
| Denture Repairs [7] | You pay 40% [2] |
| Bridges | You pay 40% [2] |
| False Teeth (Adding teeth to an existing denture) | You pay 40% [2] |
| **Anesthesia** | You pay 40%[2] |
| **Space Maintainers** | You pay 40%[2] |
| **Orthodontia (child and adult)** | You pay 50%[2] 24 months of active treatment plus 24 months of retention |

(1) You must select a personal dentist to use the DMO Plan. A few states require out-of-network benefits and they can vary. Go to www.aetna.com and log-in for a detailed schedule or call 1-800-829-3685.
(2) Associate out-of-pocket expense is based upon dentist's Usual & Prevailing fee (not a contract rate).
(3) Gingivectomy or gingivoplasty per tooth, per quadrant if 5-8 teeth.
(4) Certain oral surgery procedures are covered under medical plans. Refer to the "Covered Services" section of the Medical SPD for coverage under the Aetna Choice POSII / UnitedHealthcare Choice Plus Plans.
(5) Extractions can be covered at 60% or 100% coinsurance, so you pay 40% or 0%. Check with Aetna.
(6) Two per year limit for certain implants.
(7) Replacement of previously installed prosthetics and crowns less than 5 years old is not covered

**Note: Limitations may apply, please check with Aetna**

## Covered Services in the Dental PPO Plan Options 1 and 2

Additional services or details not listed in the Benefits-At-A-Glance.

### Preventive Services

These services are designed to help you take good care of your teeth. Eligible preventive services include:

- Entire x-ray series consisting of a least 14 films, including bitewings if necessary, is limited to once every three years (Frequency limit waived if required for dental condition)
- Panoramic survey, maxillary and mandibular, is considered an entire x-ray series

### Basic Services

These services include basic dental work such as fillings and extractions. Eligible basic services include:

- Frenulectomy
- Injections of antibiotic drugs by a dentist; treatment of periodontal and other diseases of the gums and tissues of the mouth
- Laboratory procedures
- Office visit after hours
- Palliative treatment
- Simple extractions and surgical removal of erupted tooth
- Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist
- Surgical exposure to aid eruption

The following oral surgical procedures are also considered basic services:

- Biopsy of Oral Tissue (both Soft and Hard)
- Excision of Periocoronal Gingiva
- Free Soft Tissue Grafts (Including Donor Site, Isolated Tooth Procedure) per Site
- Gingival Flap Procedure
- Incision and Drainage of Abscess, Intraoral or Extraoral
- Mucogingival Surgery-per Quadrant
- Oral Antral Fistula Closure (and/or Antral Root Recovery) with removal of impacted teeth
- Partial Ostectomy (Guttering or Saucerization)
- Pedicle Soft Tissue Grafts (Isolated Tooth Procedure) per Site
- Periodontal Pulpal Procedures
- Per Quadrant in conjunction with Extractions (Impactions only)
- Radical Resection of Mandible with Bone Graft
- Removal of Exostosis, Maxilla or Mandible
- Removal of Foreign Body, skin or Subcutaneous Areolar Tissue
- Removal of Odontogenic or Non-Odontogenic Cyst or Tumor (Periodontal or Radicular Cysts
- Removal of Reaction Producing Foreign Bodies, Musculoskeletal System
- Removal of Residual Root Tip (simple), in conjunction with removal of impacted teeth
- Removal of Torus Lingualis or Palatinus
- Root Recovery (Surgical Removal of Residual Root, in conjunction with removal of impacted teeth)
- Surgical Excision
- Treatment of Fractures
- Vestibuloplasty, per Arch-Uncomplicated (Simple Deepening or Ridge Extension and Complicated) (Deepening or Extension of Ridge involving Soft Tissue Grafts)

### Major Services

Services include more complex and expensive dental work. Eligible major services include:

- Impaction that requires Incision of Overlying Soft Tissue and the Removal of the Tooth
- Impaction that requires Incision of Overlying Soft Tissue, Elevation of a Flap, Removal of Bone and Removal of the tooth, or sectioning of tooth for removal and presents unusual difficulties and circumstances
- Implants
- Initial installation, including adjustments for partial or full removable dentures to replace one or more natural teeth

- Inlays, onlays, and crowns (except stainless steel), including precision attachments for dentures and initial installation of fixed bridgework
- Osseous Grafts (Including Flap Entry, Donor Site and Closure)-Single Site or Multiple Sites in Same Quadrant
- Osseous Surgery (including Flap Entry and Closure)
- Repair or recementing of crowns, inlays, bridgework, or dentures or relining of dentures
- Replacement of existing partial or full, removable or fixed bridgework by a new denture or new bridgework

**A pre-determination of benefits is strongly recommended, prior to having services rendered to determine the benefit available under the Plan**.

### Orthodontic Services

Services include teeth straightening or repositioning. Eligible orthodontic services (for dependent children who are under age 26) include:

- Service or supply furnished a dependent child in connection with an orthodontic procedure and before the end of the estimated duration shown in the Orthodontic Treatment Plan
- An active appliance for that orthodontic procedure is inserted while the dependent child is a covered person for the Orthodontic Services
- The charge is incurred during a 3-month period described in the Claiming a Benefits Dental section, entitled Orthodontic in Progress. That period must start while the dependent child is a covered person for the benefits of the Benefit Supplement
- The Orthodontic Procedure is needed to correct one of these conditions:
  - Cross-bite
  - Faulty alignment (either frontward or backwards) of the upper and lower arches with each other
  - Vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet)
- The service or supply is made part of an Orthodontic Treatment Plan that before the Orthodontic Procedure is performed, has been:
  - Returned by Aetna to the dentist showing estimated benefits
  - Sent to Aetna for review

## Limitations

### Replacement Rule

Crowns, inlays, onlays, veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the Plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:

- While you were covered by the Plan, you had a tooth or teeth extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge. However, this Plan covers replacement of teeth missing prior to the associate's date of hire as of the first of the month following two years of employment with ADP. Replacement services rendered on or after that date are eligible in accordance with the Plan provisions
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 7 years before its replacement and cannot be made serviceable
- You had a tooth or teeth extracted while you were covered by the Plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed. If the tooth or teeth were extracted prior to the associate's date of hire, this Plan will cover the replacement as of the first of the month following two years of employment

### Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the Plan

- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 7 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth If the tooth or teeth were extracted prior to the associate's date of hire, this Plan will cover the replacement as of the first of the month following two years of employment
- The replacement of teeth missing prior to the associate's date of hire occurs on or after the first of the month following two years of employment with ADP

**Alternate Treatment Rule**
If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided both of the following terms are met:
- The service selected must be deemed by the dental profession to be an appropriate method of treatment
- The service selected must meet broadly accepted national standards of dental practice

## Covered Services in the Dental Maintenance Organization (DMO) Plan
Additional services or details not listed in the Benefits-At-A-Glance

**Preventive Services and Basic Services** are designed to help you take good care of your teeth and complete basic dental work such as fillings and uncomplicated extractions. (ADP pays in full)

**Visits and Exams**
- Emergency palliative treatment
- Oral Hygiene instruction
- Prophylaxis, treatment to include scaling and polishing (limited to two treatments per year)
- Study models

**X-rays and Pathology**
- Biopsy and examination of oral tissue
- Extra-oral upper or lower jaw
- Intra-oral, occlusal view, maxillary or mandibular
- Periapical X-rays

**Endodontic**
- Apexification
- Apicoectomy
- Hemisection
- Pulpotomy
- Retrograde Filling
- Root Amputation
- Root canal therapy, including necessary X-rays and cultures but excluding complex molar cases approved as Specialty Services both single root and bi root
- Surgical exposure for rubber dam isolation

**Restorations and Repairs**
- Acrylic prefabricated crowns (excluding temporary crowns)
- Amalgam restoration for 1, 2, 3, surfaces
- Composite restoration (other than for molars) for 1, 2, 3, surfaces
- Recementing inlays, crowns, bridges, space maintainers
- Retention pins
- Tissue conditioning for dentures

**Periodontics**
- Emergency treatment (abscess, acute periodontitis, etc.)
- Free soft tissue graft
- Gingival flap procedure
- Occlusal adjustment (other than with an appliance or by restoration)
- Subgingival curettage (limited to 4 separate quadrants per year)

**Oral Surgery**
- Alveolectomy
- Closure of oral fistula
- Closure of salivary fistula
- Crown exposure to aid eruption
- Excision of hyperplastic tissue or pericoronal gingiva
- Extractions, uncomplicated
- Frenectomy
- Incision and drainage of abscess
- Removal of exostosis
- Removal of foreign body from bone
- Removal of foreign body from soft tissue
- Removal of residual root and odontogenic cyst
- Sequestrectomy
- Sialolithotomy; removal of salivary calculus
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Suture of soft tissue injury
- Transplantation of tooth or tooth bud

**Major Services (Restorations and Repairs)**
Services include more complex and expensive dental work. (You pay 40%)
- Adding teeth to an existing denture
- Crowns (including build-ups when necessary)
- Dentures and Partials-includes adjustments within six months after installation, Full or Partial (upper or lower)
- Gold Inlays & Onlays for 1 or more surfaces
- Implants
- Occlusal guard (for bruxism only)
- Pontics
- Posts
- Relining/rebasing dentures
- Stay plates
- Stress Breakers (per unit)

**Endodontic**
- Complex Molar Root Canal Therapy

**Oral Surgery**
- Surgical removal of impacted tooth

**Periodontics**
- Osseous surgery (including flap entry and closure) - per quadrant

**Space Maintainers (DMO)** includes all adjustments within six months after installation.
- Fixed, band type
- Removable acrylic with round wire clasp
- Removable appliance or Fixed or cemented appliance to correct habits

A charge is an eligible charge for orthodontic services, if all of these conditions are met:

- Service or supply furnished a person in connection with an Orthodontic Procedure and before the end of the estimated duration shown in the Orthodontic Treatment Plan
- An active appliance for that Orthodontic Procedure is inserted while the person is a covered person for the Orthodontic benefits
- The charge is incurred during a 3-month period. That period must start while the person is a covered person for the Orthodontic benefits, except this requirement will not apply to orthodontia in progress on your effective date
- The Orthodontic Procedure is needed to correct one of these conditions:
  - Cross-bite
  - Faulty alignment (either frontward or backwards) of the upper and lower arches with each other
  - Vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet)
- The service or supply is made part of an Orthodontic Treatment Plan that is reviewed by the insurance carrier before the Orthodontic Procedure is performed

**Tooth Missing but Not Replaced Rule**

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the Plan
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth If the tooth or teeth were extracted prior to the associate's date of hire, this Plan will cover the replacement as of the first of the month following two years of employment
- The replacement of teeth missing prior to the associate's date of hire occurs on or after the first of the month following two years of employment with ADP

**Alternate Treatment Rule**

If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- The service must be listed on the Dental Care Schedule
- The service selected must be deemed by the dental profession to be an appropriate method of treatment
- The service selected must meet broadly accepted national standards of dental practice

If treatment is being given by a **Participating Dental Provider** and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

- The copayment for the approved less costly service; plus
- The difference in cost between the approved less costly service and the more costly covered service

## Expenses that are Not Covered in the Dental Plan

There are certain dental expenses that are not covered under the Dental Plan. Ineligible expenses include:

- Any dental services and supplies which are covered in whole or in part under the ADP medical plan. This includes charges for those oral surgery procedures that are reimbursable under the ADP Medical Aetna Choice POS II / UnitedHealthcare Choice Plus Plans or HMOs offered as ADP medical plan options
- Services not reasonably necessary, or not customarily performed, for the dental care of a specific condition
- Treatment or services primarily for cosmetic purposes, including personalization or characterization of dentures and facings on crowns or pontics posterior to the second bicuspid
- Services not listed among the Covered Services for the Dental Plan (may differ between Plan Options 1 and 2 and the DMO)
- A charge for a service not furnished by a dentist. This does not apply if the service is performed by a licensed dental hygienist under the direction of a dentist
- Treatment or services due to dental disease or defect resulting from war or any act of war, declared or undeclared

- A charge for a service furnished by a Dentist to the extent that it exceeds the amount payable for it shown in the List of Dental Services that applies (pertains to DMO only)
- A charge for a service
  - Furnished by or for the United States Government or any other government, unless payment of the charge is required by law; or
  - To the extent that the service, or any benefit for the charge, is provided by any law or governmental plan under which the person is or could be covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program
- Replacement of lost or stolen appliances
- Drugs or medicine unless specifically listed as covered
- Orthodontic procedures for any covered person under the PPO Dental Plans, other than your covered dependent child(ren). Your dependent child(ren) is eligible for orthodontic treatment only if he/she is under age 26 on the date active orthodontic treatment begins
- Any of the following:
  - An appliance or modification of one, if an impression for it was made before the Person became covered
  - A crown, bridge, or gold restoration, if a tooth was prepared for it before the Person became covered
  - Duplicate prosthetic devices or any other duplicate appliances
  - Occlusal guard
  - Myofunctional therapy for correction of harmful habits
  - Periodontal splinting
  - Plaque control program
  - Replacement of dentures or bridgework that is less than five years old or which could otherwise be made serviceable
  - Replacement of teeth lost before the person's date of hire by the Company. However, this Plan covers replacement of teeth lost prior to the person's date of hire as of the first of the month following two years of employment. Replacement services rendered on or after that date are eligible
  - Root canal therapy, if the pulp chamber for it was opened before the Person became covered
  - Services for oral hygiene and dietary instruction
- Full mouth x-ray services that are performed less than every sixty months
- Any charges for an Orthodontic Procedures for which an active appliance has been installed within the two years starting with the date the person became a covered person for the orthodontic benefits. This applies only to a person who doesn't become such a covered person by the 31st day after the first day the person is eligible to become such a covered person
- Treatment for problems of the jaw joint, including temporomandibular joint syndrome, cranio-mandibular disorder or other conditions of the joint linking the jawbone and skull, and the complex muscles, nerves and other tissues related to that joint
- A charge for a replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for adding teeth to any of these, or for a replacement or modification of a crown or gold restoration, within 5 years for DMO and 7 years for Options 1 and 2 after that denture, bridge, bridgework, crown or gold restoration was installed
- A charge for a partial or full removable denture, removable bridge, or fixed bridgework if it includes replacement of one or more natural teeth missing before the person became a covered person under this coverage. This does not apply if the denture, bridge, or bridgework also includes replacement of a natural tooth that:
  - Is removed while the person is a covered person; and
  - Was not an abutment to a partial denture, removable bridge or fixed bridge installed during the prior 5 years for DMO and 7 years for Options 1 and 2
  - This does not apply with respect to replacement of teeth lost prior to the covered person's date of hire as of the first of the month following two years of employment. Replacement services rendered on or after that date are covered
- A charge for any of the following services:
  - An appliance or modification of one, if an impression for it was made before the person became a covered person
  - A crown, bridge, or gold restoration, if a tooth was prepared for it before the person became a covered person

    - A gold restoration or crown, unless it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material, or the tooth is an abutment to a covered partial denture or fixed bridge
    - Root canal therapy, if the pulp chamber for it was opened before either person became a covered person
- A charge in connection with a service furnished a person age 5 or more if that person becomes a covered person other than during the first 31 days the person is eligible for the coverage; or as prescribed for any period of annual enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
    - After the end of the twelve-month period starting on the date the person became a covered person; as a result of accidental injuries sustained while the person was a covered person; or
    - For a Basic Service in the List of Dental Services shown under the headings Visits and Exams, and X-rays
- Facings on crowns or pontics that are behind the second bicuspid will always be considered cosmetic. This does not apply if the service is needed as a result of accidental injuries sustained while a person is a covered person (applies to DMO only)
- A charge in connection with:
    - Appliances or restorations needed to alter vertical dimensions or restore occlusion
    - The purpose of splinting or correcting attrition or abrasion
- A charge in connection with an:
    - Disease covered with respect to such work by any workers compensation law, occupational disease law or similar law
    - Injury arising out of or in the course of any work for wage or profit (whether or not with the employer)
- A charge for a service or supply which is covered in whole or in part under the ADP Medical Plan. This includes charges for those oral surgery procedures that are reimbursable under the ADP Medical Aetna Choice POS II / UnitedHealthcare Choice Plus Plans
- A charge for a service to the extent that it is more than the usual charge made by the provider for the service when there is no insurance
- A charge for a service to the extent that it is above the prevailing charge in the area for dental care of a comparable nature. A charge is above the prevailing charge to the extent that it is above the range of charges generally made in the area for dental care of a comparable nature. The area and that range are as determined by Aetna

If you have any questions about what is covered under the Dental Plan, complete a written "Pre-treatment Estimate" or contact ADP's dental administrator.

## Claiming Benefits

**Pre-treatment Estimate**

You and your dentist can find out the amount of the benefit you will receive before dental work is performed. This is called a "Pre-treatment Estimate." If your work is expected to exceed $350, you should obtain a Pre-treatment Estimate by following these steps:

- Obtain a dental expense benefit claim form from Aetna's website, www.aetna.com
- Ask your dentist to complete the form, indicating any work already done, the work yet to be completed and your dentist's fees for each procedure
- Return the form to the Plan Administrator, who will process it for approval and notification of the benefit payable. This information will be returned to you and your dentist

Although you don't have to use this feature it is helpful because it enables you to avoid underestimating what you may owe a dentist.

In some cases, the Plan may pay benefits based on a less expensive dental treatment if the Plan Administrator determines that there is an alternative treatment for your condition that also meets acceptable dental standards. The choice of treatment is entirely up to you, but if the treatment you choose is more expensive than the recommended alternative treatment; you'll be responsible for the difference. For example, if you have a cavity and the tooth is crowned for cosmetic reasons instead of having a filling, your benefit is based on the scheduled amount for a filling. The predetermination of benefits procedure described above can help you determine in advance how much is paid.

### Orthodontic Benefit Payments

The lifetime maximum benefit per individual will be determined based on the option selected. Option 1 is $1,500. Option 2 is $1,500 In-Network and $1,000 Out-of-Network. (**Note**: The combined maximum is $1,500). Options 1 and 2 each cap orthodontia benefits at a lifetime maximum. If you change from one of these options to the other while undergoing orthodontia treatment, the lifetime maximum in the new option will apply. Option 3 (DMO) has a lifetime orthodontic maximum of 24 months of active treatment plus 24 months of retention for In-Network orthodontic care and an $800 limit for Out-of-Network orthodontic care. If you switch from Option 3 to Option 1 or Option 2, the lifetime limit under Option 1 or Option 2 will apply. Benefits that were released during that plan/benefit year under Option 3 will NOT be deducted from the new plan option's orthodontic maximum. If you switch from Option1 or Option 2 to the DMO, the lifetime maximum of the DMO applies. However, you are only permitted one course of treatment totaling 24 months under the DMO plan; therefore, benefits considered for the remaining orthodontic treatment will be considered as one course of treatment totaling 24 months under Options 1 and 2 and the DMO. Meaning, the treatment considered under Options 1 and 2 and the DMO cannot exceed 24 months.

### Orthodontic in Progress

You are eligible for the full ADP Plan lifetime orthodontia maximum for orthodontic treatment programs in progress on your effective date of coverage under the ADP Plan. Therefore, eligible orthodontia expenses incurred on and after the ADP coverage effective date would apply to this maximum. The total estimated covered charges for the treatment plan will be considered made and incurred in installments over the estimated duration of the treatment plan in the following amounts and at the following intervals:

- Installment payments will be in equal amounts except for the first, which will be twice the amount of the rest
- The payments will be made when the appliances are first inserted, at the end of the 3-month period starting with that date and at the end of each of the following 3-month periods

If actual covered charges for the treatment are less or more than the estimate, the last installment will be reduced or increased as appropriate.

### Charges that are not covered for Orthodontic Treatment:

Coverage for services and supplies are not provided for any of the following:

- Changes in treatment necessitated by an accident
- Lingually placed direct bonded appliances and arch wires (i.e., "invisible braces")
- Maxillofacial surgery
- Myofunctional therapy
- Replacement of broken appliances
- Re-treatment of orthodontic cases
- Treatment of cleft palate
- Treatment of macroglossia
- Treatment of micrognathia
- Treatment of primary dentition
- Treatment of transitional dentition

### Benefits after Termination of Coverage

Dental services given after the covered person's coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework, and root canals will be covered when ordered, if the item is installed or delivered no later than 30 days after coverage terminates.

"Ordered" means that prior to the date coverage ends:

As to a denture: Impressions have been taken from which the denture will be prepared.
As to a root canal: The pulp chamber was opened.
As to any other item listed above: The teeth, which will serve as retainers or support, or which are being restored have been fully prepared to receive the item and impressions have been taken from which the item will be prepared.

## Definitions of Words and Terms

**Contract Rate:** Rate the dentist negotiates with the network.

**Dental Treatment Plan:** The attending dentist's written report of recommended treatment for a period of dental treatment, including an itemized list of dental procedures and charges, diagnostic x-rays and a dental model if required by the Company.

**Dentist**: An individual who is legally licensed to practice dentistry by a governmental authority, which has jurisdiction over the licensure and practice of dentistry.

**DMO (Dental Maintenance Organization):** Provides prepaid dental care through participating DMO dentists in your geographical area. (It is similar to an HMO.) Your dentist will refer you for other specialist services. You must use a dentist affiliated with the DMO for services to be covered at the in-network level. **The plan covers out-of-network services and supplies, but your out-of-pocket expenses may be higher.**

**Implants:** Charges in connection with implants and any prosthetic appliances attached to such implants, but not in excess of the Plan's allowance for the covered standard procedure or appliance.

**Orthodontic Expense Benefits:** Options 1 and 2 provides benefits for some of the charges incurred for orthodontic procedures performed on a person's qualified dependent children who are age 26 or less on the date the orthodontic procedure starts. Under Option 3, child and adult orthodontia are covered, subject to plan limits.

**Orthodontic Treatment Plan:** A Dentist's Report, on a form approved by Aetna that states the class of malocclusion or malposition and recommends and describes needed treatment by Orthodontic Procedures and estimates the duration of the treatment and estimates the total charge for the treatment and includes cephalometric X-rays, study models and any other supporting evidence that Aetna may reasonably require.

**PPO:** Is a Dental Preferred Provider Organization where associates and members can receive the contracted rate on their dental services if they use a network provider. However, they can still use dentists outside of the network but usually pay more to do so.

**Usual and Prevailing (U&P) Fee: Any** charge which neither exceeds the fee usually charged by the individual rendering the service nor the general level of fees for similar services charged by others within the community where the service is rendered.

## Your ERISA Rights

### General Information

ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Dental Care benefit plan.

### Plan Continuation

ADP intends to continue the Plans indefinitely but reserves the right to amend or discontinue one or all of the Plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a Plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a Plan, you will receive notice.

### Plan Documents versus Guide

One of the primary purposes of the Summary Plan Description is to provide ADP associates with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these plans.

The full text of the Plans is contained in legal documents. Plan documents govern the administration of our benefit Plans contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, the actual legal document of the Plans will rule.

The named fiduciary for the Plan has the discretionary authority to determine eligibility under Plan terms, to interpret and apply the terms and provisions of the Plan, to resolve discrepancies and ambiguities, and to make final decisions on the appeal by a Plan participant of an initial claim denial  A decision made by the named fiduciary will be final and binding on all parties.

### Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may charge a reasonable fee for the copies
- 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. A copy of this Report is distributed annually and is also available on the web site

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights.  For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

## Benefit Determinations and Appeals

### Filing Dental Claims under the Plan

You may file claims for Plan benefits and appeal adverse claim decisions, either yourself or through an authorized representative.  If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company.  The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

### Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your dentist determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"A claim involving urgent care" is any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a dentist with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

### Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, dental condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

### Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

### Filing an Appeal of an Adverse Benefit Determination for a Dental Claim

As a member of an Aetna Dental Plan, you have the right to file an appeal about coverage for service(s) you have received from your dental care provider or Aetna if you are not satisfied with the outcome of the initial determination and the appeal is regarding a change in the decision for the following:

- Benefit determination
- Certification of dental care services
- Claim payment
- Eligibility
- Plan interpretation

You may file an appeal in writing to Aetna at the following address:

**Aetna Dental Claim**
P.O. Box 14094
Lexington, Kentucky 40512-4094

If your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Your appeal will be acknowledged within five working days of receipt. An Aetna representative may call you or your dental care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

The Claims Administrator will have full power to administer and interpret the Plan in all of its details, subject to applicable requirements of law. Benefits under the Plan shall be paid only if the Claims Administrator decides, in its discretion, that the applicant is entitled to them.

You may not file an action at law or in equity for benefits under the Plan until the administrative appeal rights described herein have been exercised and exhausted in full, and the Plan benefits requested in your appeal have been denied in whole or in part.

### External Review

The external review process applies to New Jersey residents enrolled in the DMO. You or any provider acting on behalf of you, with your consent, shall have the right to pursue an appeal to an independent utilization review organization (IURO). You will need to contact Aetna DMO member services for instructions on filing an appeal. The address for requests of determination for this level of appeals for New Jersey is:

**New Jersey Department of Banking and Insurance**
Consumer Protection Services
20 West State Street, 9th Floor
P.O. Box 325
Trenton, New Jersey 08625

Main Telephone #: 609-292-7272, Fax: 609-292-5865
**Hotline: 1-800-446-7467**

### Deadline for Filing Lawsuits

If the Claims Administrator or the Insurer denies your appeal, the Plan's decision to deny your claim will be final. When this occurs, you have exhausted your appeal rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a) (1) (B) of ERISA. **You have 90 days from the date of the notice denying your appeal in which to file a lawsuit. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim.**

### Administrative Details

The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

The following plans provide benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Dental Plan is a participating plan in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. In the event of a conflict between the Plan document, the SPD and the insurance contract, the terms and provisions of the insurance contract will control. |
| Claims Administrator & Claim Processing | The dental benefits under the PPO are self-insured and claims are processed by the claims administrator identified below. Benefits are paid with associate and employer contributions. Associate contributions are applied first to the payment of Plan benefits.<br>Claim administrator:<br>Aetna's Dental Claim address is: P.O. Box 14094, Lexington, KY 40512-4094. For Member Services call 800-829-3685 for the PPO Dental Plan.<br><br>The dental benefits under the DMO are insured under the Aetna group contracts GP 800201-DE, GP 800201-NJ, GP 800201-AZ, GP 800201-CA, GP 800201-NC. Aetna's DMO address is P.O. Box 14094, Lexington, KY 40512-4094. For Member Services call 800-843-3661 for the DMO Plan. The insurance premiums are paid with associate and employer contributions. |
| VEBA Trust | The associate and employer contributions are deposited in the Automatic Data Processing, Inc. and Subsidiaries Employee Welfare Benefit Trust, a voluntary employees' beneficiary association established under Internal Revenue Code Section 501(c)(9).<br>The Trustees for the Trust are individuals appointed by the Company.<br>The Trustees are responsible for making payments from the Trust, including premiums for insurance plans, which are paid directly to the insurance carriers. In addition, all self-insured Plan benefits and related administrative expenses are paid directly from the Trust. |
| Plan Year (for Fiscal and Other Records) | January 1 through December 31 |
| Plan Sponsor | Automatic Data Processing, Inc. |
| Source and Method of Plan Financing | See the section entitled "Eligibility" and "Your Share of the Cost" with each plan summary. |
| Plan Administrator and Address | **Automatic Data Processing, Inc.**<br>One ADP Boulevard M/S C237<br>Roseland, NJ 07068<br>Telephone: 973-974-5000<br>Identification Number: 22-1467904 |
| Agent for Service of Legal Process | ADP or where appropriate the insurance company or provider of service or the supervisory official of the insurance department of the state where you reside. |

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

### DOL Locations

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

# Vision Plan

ADP offers vision coverage through VSP® Vision Care, a program designed to promote visual wellness by providing quality eye care through eye exams and benefits toward glasses or contacts with an extensive, nationwide network of doctors who provide professional eye care services at a reduced price.

The VSP Standard and VSP Plus Plans allow you to use your benefit at any location, including specialty optical boutiques and retail chains such as Costco, Visionworks, Walmart, and Sam's Club. You get the best value from your VSP benefit when you visit a VSP network doctor (see chart below). If you decide not to see a VSP doctor, you'll receive a lesser benefit and typically pay more out-of-pocket. If you elect to use a non-VSP provider, you are reimbursed only up to the "allowable" amount determined by the plan. There is no ID card or claim form necessary to use your VSP benefit, however, you may obtain an online card when you log into VSP.com with your user ID and password.

For more information or to locate a VSP Signature Network Provider near you, call 800-877-7195 or visit VSP's web site at www.vsp.com to learn more about your VSP benefits.

## Vision (VSP) Benefits-At-A-Glance

| VSP Standard Benefit (1) | Coverage with VSP Signature Network Doctor & with Participating Retail Chains | Coverage with All Other Providers |
|---|---|---|
| **Eye Exam** | Fully covered after a $10 copay | Up to $50 after $10 copay |
| **Prescription Glasses** | $15 copay | $15 copay |
| **Frame** (2) | $170 allowance<br>($190 allowance for featured brand frames)<br>20% discount on amount over your allowance<br>$95 allowance at Costco®, Walmart, or Sam's Club | Up to $70 |
| **Lenses** (3) | Single vision, lined bifocal and lined trifocal lenses are fully covered<br>Polycarbonate lenses for dependent children are fully covered<br>Progressive Lenses Copays<br>Standard: $0<br>Premium: $80-$90<br>Custom: $120-$160 | Up to $50 Single Vision<br>Up to $75 Lined Bifocal<br>Up to $100 Lined Trifocal<br>Up to $75 Progressive Lenses |
| **Lens Options** | Average 35% - 40% off<br>Check with Costco, Walmart, and Sam's Club for VSP member pricing.<br>20% off at participating retail chains other than Costco, Walmart, and Sam's Club | None |
| **Contacts (instead of glasses)** (4) | $150 allowance for contacts and contact lens exam (fitting and evaluation) plus 15% off contact lens exam<br>Note: contact lens exam is not covered under participating retail chains | Up to $120 for contacts and contact lens exam |
| **Essential Medical Eye Care** | Retinal Screening $0 copay for members with diabetes<br>$20 copay for additional exams and services (6)<br>Note: N/A at Visionworks and not covered under participating retail chains. | None (5) |
| **Retinal Screening** | $39 copay<br>Note: N/A at Visionworks and not covered under participating retail chains | None |
| **Extra Savings and Discounts** | Available through VSP doctors only | Not available |

(1) VSP's frame allowance covers a large selection of popular frames. You must pay the balance for frames exceeding your plan allowance, less any applicable discount.

(2) Polycarbonate lenses for dependent children up to age 26 and disabled dependents are covered in full. Optional items, such as lens coatings or cosmetic treatments are not covered under your plan, but you will receive discounts averaging 35%-40% off VSP doctors' usual and customary fees.

(3) Contacts are covered when chosen instead of lenses and a frame. There is a 15% discount off the contact lens exam when received from a Network doctor or participating retail chains (except Costco, Walmart or Sam's Club). Members choosing contacts use their eligibility for both lenses and a frame. Visit Special Offers at www.vsp.com to learn about exclusive VSP member offers.
(4) Members may use their open access schedule, where applicable. Call VSP at 800-877-7195 for more details.
(5) Laser Vision Correction (PRK, LASIK and Custom LASIK Surgery) is available through contracted laser centers. Program availability may vary based on location and regulatory approval. Call 888-354-4434 to locate a participating doctor in your area.
(6) Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Coordination with your medical coverage may apply. Ask your VSP doctor for details.

## VSP Plus Coverage also known as VSP Easy Options*

If you purchase the VSP Plus option, you can receive one of the following at the time of your purchase:

- An additional $100 frame or contact lenses allowance
- Fully covered progressive lenses
- Fully covered light-reactive lenses
- Fully covered anti-glare coating

*You and your covered dependents can use the Easy Options benefit at a VSP Doctor location, Visionworks, or a regional retail chain location. While not available at Costco, Walmart and Sam's Club, members are able to use the Standard Plan at these locations.

## VSP Cost

| Bi-Weekly Associate Contributions | VSP Standard | VSP Plus |
|---|---|---|
| Associate Only | $5.04 | $5.93 |
| Associate + Spouse/Domestic Partner | $7.32 | $8.61 |
| Associate + Child(ren) | $8.02 | $9.43 |
| Associate + Family | $13.14 | $15.45 |

## Eligibility and Enrollment

See Eligibility and Enrollment in the General Information Section.

## How to Use Your Plan

Whether you choose to see a VSP network doctor, participating retail chain, or any other provider, using your vision coverage is simple and convenient.

- **Find an eye care provider who's right for you.** To find a VSP network doctor or participating retail chain, visit www.vsp.com or call 800-877-7195
- **Review your benefit information.** Visit www.vsp.com and log into your account with your user ID and password to review your plan coverage and how it differs with participating retail chains and other providers
- **At your appointment, tell them you have VSP Standard or VSP Plus (Signature Plan/VSP Easy Options).** You will pay any applicable copays (e.g., a $10 copayment for the eye exam and a $15 copayment for materials if getting frames or lenses). The VSP network doctor will coordinate your coverage through VSP. The doctor will itemize any non-covered services and you will pay the doctor directly for these additional fees

Please do not call to schedule an appointment until your coverage is effective. If you have questions, please contact Global HR Shared Services at 877-237-4711 or submit a case.

## How to File a Claim for a non-VSP Provider

Pay the provider in full and submit an itemized receipt and/or an insurance claim form to VSP. You may complete the claim form when you log in to vsp.com with your user ID and password and upload your receipts to submit online. Or you can print the form, attach your receipts and send via mail to:

**VSP**
**P.O. Box 495933**
**Cincinnati, OH 45249**

**Note:** Please include the covered member's name, mailing address, last four digits of their Social Security Number, the group name (ADP) and the patient's name, date of birth and relationship to member. Claims must be filed within twelve months of the date of service.

## Covered Services by a VSP Network Doctor or Participating Retail Chain

### Eye Exam

Covered in full, minus $10 copayment: one exam per calendar year

There are three levels of an eye exam which a doctor may choose to perform. These include comprehensive, intermediate, and limited. In most cases a comprehensive eye exam is provided and will include case history, health status of visual system evaluation, refractive status evaluation procedures, and binocular function tests.

### Prescription Glasses

One $15 copayment for lenses and/or frames per year

### Eyeglass Lenses

Covered in full; one set of lenses per calendar year

VSP covers any necessary eyeglass lenses, including single vision, lined bifocal, lined trifocal, or other more complex and expensive lenses necessary for your visual welfare. You may elect lenses or lens enhancements that are not necessary for your visual welfare but that are desired for cosmetic reasons. Examples of such lenses and lens enhancements are tinted or photochromic lenses, scratch coatings, progressive lenses, or blended bifocals. You will be required to pay any additional cost for all non-covered enhancements selected. These cosmetic enhancements are charged according to a cost-controlled price determined by VSP.

### Frames

Covered in full up to $170 ($190 for featured frame brands) plus 20% off any covered charge over that; one set of frames per calendar year

If you select a frame that exceeds the plan coverage, you will receive a 20% discount on the difference. For example, the copayment for frames is $15, if the frame selected is $180, then you will pay an out-of-pocket difference of $23. ($15 materials copayment plus $8 over plan allowance: $180 - $170 = $10; 20% of $10 = $8)

If you purchase your frame from Costco, Walmart, or Sam's Club the frame is covered up to $95 and you pay any amount over $95, i.e., the difference. If you purchase your frame from any other retail chain, then the frame is covered up to $170 and you pay any amount over the $170. If you purchase any of VSP's featured frame brands, the allowance is $190.

### Contacts

$150 allowance; instead of lenses and frames benefit; one set of contacts per calendar year.

You may choose contacts instead of glasses. The standard eye examination is covered in full, after your $10 copayment. VSP pays $150 toward the contact lens exam (evaluation and fitting) and materials. In addition, VSP offers a 15% discount off the evaluation and fitting services provided by your VSP network doctor or participating retail chains (except Costco, Walmart, or Sam's Club). Any extra costs are your responsibility.

You may receive these discounts from any VSP doctor or participating retail chains (except Costco, Walmart, or Sam's Club) within 12 months of your covered eye examination. If you elect contacts, you will not be eligible again for prescription glasses (lenses and frame) until the next calendar year.

### Laser Vision Care

To use laser vision correction services, call your VSP network doctor to check if he or she is participating in VSP's Laser Vision Care program. Schedule an appointment with your VSP network doctor for a complimentary screening and consultation on the benefits and risks of laser vision correction surgery. (Please do not call to schedule an appointment until your coverage is effective.) Your VSP network doctor can also make arrangements with one of many VSP approved laser surgeons and centers. Pre- and post-operative care will be coordinated between your VSP network doctor and your VSP laser surgeon.

VSP's Laser Vision Correction program offers a discount to members and groups. Covered VSP members receive an average of 15% off laser surgery from contracted centers. When you use a contracted provider, the maximum fee you will pay is $1,500 per eye for PRK, $1,800 per eye for LASIK and $2,300 per eye for Custom LASIK. Call VSP at 888-354-4434 to ask if your doctor is participating in this laser vision program.

After surgery, use your frame allowance up to $170/$190 (if eligible) for non-prescription sunglasses from any VSP doctor (excludes Visionworks).

### Essential Medical Eye Care

VSP's Essential Medical Eye Care provides coverage of additional eye care services that diagnose and monitor diabetic eye disease, AMD, glaucoma, and cataracts. Retinal screening for members with diabetes is covered with $0 copay. Essential Medical Eye Care also includes supplemental medical eye care coverage for all other members, as well. Examples of these medical eye care services include:

- Additional exams and services that diagnose and monitor diabetic eye disease, AMD, glaucoma, and cataracts
- Treatment for dry eye disease, pink eye, eye injury, and foreign body removal
- Tests for sudden changes in vision

### Retinal Screening Value Added Feature

Retinal Screening is offered to VSP members as a value-added feature to complement their WellVision Exam benefit. This value-added feature pertains to routine, retinal or fundus photography or imaging such as Optos. Retinal screening does not replace pupil dilation. Dilation is still the best way to see inside the eye and is the standard of care for patients with diabetes. Retinal scanning is an enhancement to a member's eye exam; therefore, they are covered once every calendar year. The member will pay up to the guaranteed maximum of $39 for each routine retinal screening.

### Low Vision

This benefit is available for those patients having vision loss sufficient enough to prevent reading, moving around in unfamiliar surroundings and completing desired tasks. Patients with low vision have visual impairments not fully treatable by medical, surgical or conventional eyewear or contact lenses. VSP's Low Vision Plan offers members low vision evaluations and low vision aids, up to a specified maximum, every two years.

Coverage is limited and subject to verification. $1,000 maximum benefit every two years (includes up to two supplemental exams and the remaining allowance is for materials). If benefit criteria is met, VSP will pay 75% of the allowable amount up to a maximum of $1,000 (less any amount paid for supplemental testing) per covered individual every two years. The patient is responsible for the remaining 25% of the allowed amount plus any amount over the maximum. If the patient meets the benefit criteria for low vision, the VSP network doctor will submit a Low Vision Verification Form to VSP. Not available at participating retail chains, Costco, Walmart, or Sam's Club.

**VSP Discounts**
As a value-added feature, VSP offers a 30% discount on additional complete pairs of non-covered prescription glasses and complete pairs of non-prescription sunglasses when ordered from the same VSP network doctor on the same day as your covered eye exam. Or get 20% off from any VSP network doctor within 12 months of your last covered eye exam. Plus, you'll receive a 15% discount from the VSP network doctor's professional fees when purchasing prescription contacts within 12 months of your covered eye exam.

## Expenses Not Covered

As a vision plan is designed to cover visual rather than cosmetic needs, the following will not be covered:

**Cosmetic enhancements**:
- Blended lenses
- Contact lenses (except as noted)
- Cosmetic lenses
- Frames exceeding plan coverage
- Lens coatings
- Lens laminating
- Optional cosmetic processes
- Oversize lenses
- Photochromic lenses
- Custom and premium Progressive multifocal lenses
- Tints (except pink #1 and #2)
- UV-protected lenses

**Professional services or materials:**
- Any eye examination, or corrective eyewear required by an employer as a condition of employment
- Corrective vision treatment of an experimental nature
- Lenses and frames covered under this program which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a ± .50 diopter in power)
- Two pairs of glasses in lieu of bifocals

An Example of Vision Benefit Payment when services are provided by a VSP network doctor:

| Services and Eyewear | Average Retail Charges | Cost Under VSP |
|---|---|---|
| Exam | $210 | $10 copayment |
| Bifocal Lenses | $174 | $15 copayment |
| Frames | $250 | Covered in full up to $170 (1)(2) |
| Transitions® Lenses | $141 | $70 (3) |
| Anti-reflective Coating | $159 | $61 (3) |
| Annual Contribution | - - - | $ 138.06(4) |
| Subtotal | $934 | $294.06 |
| Pre-Tax Savings on premium | - - - | $38.66 (5) |
| Adjusted Total Cost | $934 | $255.40 |

**(Difference in this example between retail cost and cost under VSP is $678.60)**

Comparison based on national averages for comprehensive eye exams and most commonly purchases brands.
(1) Up to $170 ($190 for featured frame brands). VSP's frame benefits fully cover over half of the frames currently available.
(2) Frame coverage or frame options that exceed the plan allowance will be the patient's responsibility (plan will pay 20% of the balance above the plan allowance).
(3) Cosmetic lens enhancements are not covered under the plan and will be the patient's responsibility, but you will receive discounts averaging 35%-40%. Prices above reflect standard lens enhancement selections; premium or custom lens enhancements may also be available at an additional cost.
(4) Annual Contribution is based on 12 months for associate only rate on VSP Standard Plan of $5.04 bi-weekly.
(5) Pre-Tax Savings assumes member is in the 28% tax bracket.

# Your ERISA Rights

### General Information
ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Vision plan.

### Plan Continuation
ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a Plan, you will receive notice.

### Plan Documents versus Guide
One of the primary purposes of the Summary Plan Description is to provide ADP associates with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these Plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans; contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, the actual legal document of the Plans will rule.

The named fiduciary for the Plan has the discretionary authority to determine eligibility under Plan terms, to interpret and apply the terms and provisions of the Plan, to resolve discrepancies and ambiguities, and to make final decisions on the appeal by a Plan participant of an initial claim denial. A decision made by the named fiduciary will be final and binding on all parties.

### Statement of ERISA Rights
As a participant in the plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may charge a reasonable fee for the copies
- 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. A copy of this report is distributed annually and is also available on the web site **https://associateportal.adp.com/**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

## Benefit Determinations and Appeals

### Prior Authorization

Certain Plan Benefits require VSP's prior authorization before such Plan Benefits are covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

A. **Initial Determination:** VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from your doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
B. **Appeals**: If VSP denies the doctor's request for prior authorization, you or your doctor may request an appeal of the denial. Please refer to the section on Claim Appeals below, for details on how to request an appeal. VSP shall provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. Second level appeals, and other remedies as described below, are also available. VSP shall resolve any second level appeal within thirty (30) calendar days.

### Claim Payments and Denials

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim. If a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

### Request for Appeals:

If a claim for benefits is denied by VSP in whole or in part, VSP will notify you in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, you may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the covered person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the patient's name and date of birth, the name of the provider of services and the claim number. You may state the reasons you believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You should submit all requests for appeals to:

**VSP**
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to you within thirty (30) calendar days after receipt of a request for appeal.

If you disagree with VSP's determination, you may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When you have completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA Section 502(a)(I)(B), you have the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, where the claims were not approved in whole or in part, and you disagree with the outcome. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after a claim for benefits has been filed in accordance with the requirements of the Policy, and no such action shall be brought within three (3) years from the expiration of the time within which claims can be submitted as required by the Policy.

## Administrative Details

The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

The following plans provide benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Vision Plan is a participating plan in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. In the event of a conflict between the Plan document, the SPD and the insurance contract, the terms and provisions of the insurance contract will control. |
| Plan Administration & Claim Processing | The vision benefits are insured by VSP under Contract Number 12057040. Premiums are paid with associate contributions.<br>**VSP**<br>3333 Quality Drive<br>Rancho Cordova, CA 95670 |
| VEBA Trust | The associate premiums are deposited in the Automatic Data Processing, Inc. and Subsidiaries Employee Welfare Benefit Trust, a voluntary employees' beneficiary association established under Internal Revenue Code Section 501(c)(9).<br>The Trustees for the Trust are individuals appointed by the Company.<br>The Trustees are responsible for making payments from the Trust, including premiums for insurance plans, which are paid directly to the insurance carriers. In addition, all self-insured Plan benefits and related administrative expenses are paid directly from the Trust. |
| Plan Year (for Fiscal and Other Records) | January 1 to December 31 |
| Plan Sponsor | Automatic Data Processing, Inc. |
| Source and Method of Plan Financing | See the sections entitled "Eligibility and Enrollment" and "VSP Cost". |
| Plan Administrator and Address | **Automatic Data Processing, Inc.**<br>One ADP Boulevard, M/S C237<br>Roseland, NJ 07068<br>Telephone: 973-974-5000<br>Identification Number: 22-1467904 |
| Agent for Service of Legal Process | ADP or where appropriate the insurance company or provider of service or the supervisory official of the insurance department of the state where you reside. |

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

## DOL Locations

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

# Flexible Spending Accounts (FSA)

## Your Options

You may choose to participate in the Health Care Flexible Spending Account and/or the Dependent Care Flexible Spending Account. If you elect the CDHP with HSA Medical Plan option, you will be eligible to participate in a Limited Purpose Health Care FSA instead of the Health Care FSA. When you enroll in an FSA, you authorize ADP to reduce your pay in the amount of your election. Your pay is reduced in equal installments before-taxes through the year, and you receive reimbursement for eligible expenses tax free (with pre-tax dollars).

Sounds great, but in return for the tax advantage, the IRS has set some strict rules about FSAs. The major rule that can affect you is that, generally, you lose any money left in your account at the end of the Plan year (plus the applicable grace period for Dependent Care FSA only), if you do not use it. These unused funds are forfeited. The "use it or lose it" rule means you must think carefully about what eligible expenses you will have in 2026 and select the right amount to contribute. It can be worth the effort because of the tax savings.

In addition, please see the Qualified Reservist distribution described below which is a limited exception to the IRS "use it or lose it" rule for the Health Care FSA.

If you elect to reduce your FLEX benefits under a Health Care, Limited Purpose Health Care, or Dependent Care FSA based on a qualified life change, the following rules apply:

- You may not reduce your total benefits election for that FSA for the Flex Plan year to an amount less than the amount reimbursed from that FSA as of the date of the change in election
- Your benefits election for that FSA for the remaining portion of the Flex Plan year will be determined by adding the balance in that FSA (including a positive or negative account balance) as of the date of the change in election to the total pre-tax contributions you are scheduled to make to that FSA for the remainder of the Flex Plan year
- If a life change occurs at the end of the plan year that permits changes to your FSA, there must be enough net pay available and enough payrolls in that year that the life event occurred, for ADP to honor the change. For example, a birth that occurs on December 26 would allow an associate 31 days to add the baby to their medical coverage and this life event would normally permit an increase to HCFSA. However, there are no pay periods in the remaining plan year for us to honor the increase in FSA.

**Note**: If you are a Highly Compensated Employee (HCE) as defined by the IRS, in 2025 you will be able to contribute up to $3,000 of your pay to the Dependent Care FSA. You will be considered an HCE if your earnings from ADP were more than $160,000 in 2025. All others will be able to contribute up to $7,500 of their pay to the Dependent Care FSA in 2026. New hires this year will be considered a Non-HCE for the year.

The **maximum** you can contribute to the FSA is based on how you and your spouse/domestic partner file your tax returns. Check with your tax advisor or www.irs.gov to review current maximums based upon your tax filing status.

## Eligibility and Enrollment

See Eligibility and Enrollment in the General Information Section.

## Enrollment

Elections must be made within 31 calendar days of eligibility (e.g., date of hire), or during the Annual Enrollment period for an effective date of January 1. Elections can be changed with certain "qualified life changes." See the "Qualified Life Change" section. Contact Global HR Shared Services if you experience a "qualified life change." You may submit a case or call 877-237-4711 for assistance. Contributions will be made to your account for the Plan year through payroll deductions.

You must re-enroll in the FSAs each Plan year; otherwise, you will default to No coverage.

If you are enrolled in the Health Care FSA or Limited Purpose Health Care FSA and are terminated and rehired in the same Plan year after being terminated for more than 31 calendar days, you can elect to:

- Reinstate your prior FSA election, or
- Elect to have no FSA coverage for the remainder of the Plan year

## Important Reminders!

In return for the tax break, the IRS applies the following rules to FSAs:

- You cannot change the amount you contributed to an FSA until the next Plan year unless you experience a qualified life change and make the change on the web within 31 days of the event. For FSA life changes that permit a contribution increase, the increased contribution amount may only be used to reimburse charges incurred on or after the date of the life change. If you elect to reduce your benefits under an FSA based on a qualified life change, the following rules apply:
  - Your total benefits election for that FSA for the Plan year may not be reduced to an amount less than the amount reimbursed from that FSA as of the date of the change in election; and
  - Your benefits election for that FSA for the remaining portion of the Plan year will be determined by adding the balance in that FSA (including a positive or negative account balance) as of the date of the change in election to the total pre-tax contributions you are scheduled to make to that FSA for the remainder of the Plan year (See the "Qualified Life Change" section.)
- Transfers of money from one account to the other are not allowed
- Eligible expenses for the Health Care and Limited Purpose Health Care FSAs must be incurred during the Plan year
- Eligible expenses for the Dependent Care FSA must be incurred during the Plan year or during the applicable grace period following the end of the Plan year from your account(s) by the appropriate deadline.

Remember, any money left in an FSA at the end of the Plan year (plus the two and one-half month grace period for the Dependent Care FSA) must be forfeited. The money cannot be carried forward to the next Plan year. Generally, claims for FSA expenses must be received by the FSA Administrator no later than the March 31st following the end of the Plan year to be eligible for reimbursement.

You decide which account(s), if any, you want to use. Then determine how much you want to contribute to each account. Contributions will be deducted from each paycheck before federal, state (except New Jersey), and Social Security taxes are deducted. This reduces your taxable income, so you pay less in taxes. Your salary-based benefits (Life, Long Term Disability, 401(k), etc..) will still be calculated according to your total salary.

When you set money aside for FSAs, you are reducing your taxable pay by the amount of your contributions. This reduces your federal income and Social Security taxes. Since your Social Security taxes are reduced, your Social Security benefits may also be affected. In most cases, this reduction will be less than 1% of your Social Security benefit. For more information, contact your Social Security Administration office.

## How the Plans Work

### Deadline for Submitting HCFSA and LPFSA Claims

The deadline for filing HCFSA and LPFSA claims is typically the March 31st following the end of the Plan Year. The deadline to submit claims incurred from January 1, 2026, through December 31, 2026, to apply to your 2026 HCFSA or LPFSA is **March 31, 2027**.

## The Health Care Flexible Spending Account

### Amount You Can Contribute

You choose whether to contribute to the Health Care FSA. If you decide to participate, the **minimum** you can contribute is $100 per year and the **maximum** you can contribute is $3,300 per year. Each pay period, your pay is reduced on a prorated basis before taxes are withheld. You can use the money in your account to pay yourself back for eligible health care expenses for you and your family that are not reimbursed by any health care plan. This includes health care expenses for you and your dependents for whom you claim an exemption on your federal income tax return (your spouse/domestic partner, dependent children, and any other persons who meet the IRS definition of dependent).

**The FSA administrator, HealthEquity, must receive claims no later than March 31 after the end of the Plan Year to be eligible for reimbursement.**

### Eligible Health Care Expenses

In general, any expenses that qualify as legitimate medical deductions on your federal income tax return are eligible for reimbursement from your Health Care FSA. Examples of eligible health care expenses include deductibles, coinsurance and copayments under the Medical, Dental and Vision Plans.

Expenses not covered under your health care plans that are eligible for Health Care FSA reimbursement include:

- Eye exams, glasses and contacts
- Contact lens solution and Lasik surgery
- Hearing exams and aids
- Chiropractor expenses not covered under the medical plan
- Orthodontia expenses
- Treatment of substance abuse
- Physical therapy and speech therapy not covered under the medical plan
- Smoking cessation programs and prescription drugs used for nicotine withdrawal
- Routine physicals not covered under the medical plan
- Insulin (obtained with or without a prescription)
- Over-the-counter medicines and drugs obtained with or without a prescription
- Feminine hygiene products

**Note:** Orthodontia expenses are typically incurred over several years. To determine your estimated expenses for each year, contact your dental claims administrator.

Over-the-counter medicines and drugs are eligible for reimbursement under your Health Care FSA without a prescription. A letter of medical needs (LMN) is required for vitamins and dual-purpose OTC items. (*Glucosamine, chondroitin and pre-natal vitamins are eligible without LMN.*)

- Over-the-counter medicines or drugs must be legally procured and must be purchased for "medical care" as defined by the Internal Revenue Code. The term "medical care" refers to amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure of function of the body. Items that are merely beneficial to your general health (such as vitamins and nutritional supplements) are not for "medical care" and are generally not reimbursable (unless prescribed by a physician to treat a specific medical condition). Toiletries and cosmetics are never reimbursable
- You must substantiate your expenses for over-the-counter medicines or drugs. This requires you to submit a receipt identifying the date of purchase, the name of the over-the-counter medicine or drug, and the amount of the purchase. In some cases, the Health Care FSA claims administrator may need to ask for additional substantiation, showing the reasons the drug was purchased (e.g., in situations where the medicine or drug can be taken for both general health and to treat a specific medical condition). The Health Care FSA claims administrator (subject to the final discretionary authority of the Plan Administrator) will determine, considering the relevant facts and circumstances, whether a particular over-the-counter medicine or drug is for "medical care"

Examples of expenses that **cannot be reimbursed** through your Health Care FSA include:

- Cosmetic surgery expenses
- Health plan premiums for you or your spouse
- Weight loss programs for general well-being
- Cost of toiletries or cosmetics

For a complete list of covered expenses, refer to **IRS Publication 502 for HCFSA and 503 for DCFSA,** which is available from the FSA web site address at www.healthequity.com/qme.

**Note:** Some Health Care FSA expenses that are deductible on your tax return, e.g., health insurance premiums, are specifically excluded as reimbursable through flexible spending accounts under tax law. Interpretation of eligible expenses is the responsibility of our administrator, HealthEquity.

Because your Health Care FSA contributions go into your account per payroll period, you may incur an eligible expense that is greater than your Health Care FSA balance. You can file a claim for reimbursement up to the total amount of your election minus any payments you have already received from the Health Care FSA. Your payroll deductions will continue to the end of the year to reimburse the Plan in full.

### When Expenses Must be Incurred

Your health care expenses must be incurred during the same Plan year in which you made contributions to the Health Care FSA. For example, eligible expenses incurred from January 1, 2026 through December 31, 2026 may be reimbursed from your 2026 Health Care FSA contributions. You generally cannot be reimbursed for expenses incurred before you began participating in the account or after your participation stops. An expense is incurred not when payment is made, but rather when the service is rendered.

### Qualified Reservist Distribution

If you are a qualified reservist or national guardsman and you are ordered or called to active duty for a period of at least 180 days (or an indefinite period), you may request a distribution of all your Health Care FSA balance.

The following conditions apply to a Qualified Reservist Distribution:

- You must request the Qualified Reservist Distribution in writing (on a form which you can obtain by contacting Global HR Shared Services at 877-237-4711) during the period beginning with the date of your order or call to active duty and ending on the last day of the Plan year during which the order or call occurred
- You must submit an order or call to active duty to ADP prior to the disbursement date
- You may receive only one Qualified Reservist Distribution per Plan year
- After you have made a distribution request, you may not file further reimbursement claims for services in the Plan year which includes the date of the distribution request
- The amount of your Qualified Reservist Distribution shall be equal to all contributions made to your Health Care FSA (including, discretionary matching contributions, if any, made by ADP) up until the distribution date, less any reimbursements previously made from your Health Care FSA
- Your Qualified Reservist Distribution will occur no later than 60 days after ADP receives your written request and will only occur while you are serving in active duty
- The Qualified Reservist Distribution coordinates with your election of continuation coverage as follows:
  - If you elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) while serving in active duty and continue to receive compensation from ADP, your Health Care FSA contributions will continue to be made to the Health Care FSA on a pre-tax basis up to the last day of the Plan year, unless otherwise revoked
  - If you elect continuation coverage under USERRA while serving in active duty and do not receive compensation from ADP, your Health Care FSA contributions will continue to be made to the Health Care FSA on a post-tax basis up to the last day of the Plan year, unless otherwise revoked
  - If you do not elect continuation coverage while serving in active duty, you may request a Qualified Reservist Distribution consistent with the conditions described above

## The Limited Purpose Health Care Flexible Spending Account

### Amount You Can Contribute

You choose whether or not to contribute to the Limited Purpose Health Care FSA. If you decide to participate, the **minimum** you can contribute is $100 per year and the **maximum** you can contribute is $3,300 per year. Each pay period, your pay is reduced on a prorated basis before taxes are withheld. You can use the money in your account to pay yourself back for eligible dental and vision expenses for you and your family that are not reimbursed by any health care plan. This includes dental and vision expenses for you and your dependents for whom you claim an exemption on your federal income tax return (your spouse/domestic partner, dependent children, and any other persons who meet the IRS definition of dependent). Medical and prescription drug expenses incurred after you meet your CDHP deductible are also eligible for reimbursement through the Limited Purpose Health Care FSA . **Claims must be received by the FSA administrator, HealthEquity, no later than March 31 after the end of the Plan Year to be eligible for reimbursement.**

### Eligible Health Care Expenses

In general, any dental and vision expenses that qualify as legitimate medical deductions on your federal income tax return are eligible for reimbursement from your Limited Purpose Health Care FSA. Examples of eligible expenses include:

- Deductibles, coinsurance and copayments under the Dental and Vision Plans
- Eye exams, glasses and contacts
- Contact lens solution and Lasik surgery
- Orthodontia expenses
- Prescriptions and eligible over-the-counter items for dental and vision care
- Medical and prescription drug expenses incurred after you meet your CDHP deductible

**Note:** Orthodontia expenses are typically incurred over several years. To determine your estimated expenses for each year, contact your dental claims administrator. After you meet your CDHP deductible, eligible health care expenses are the same as those listed for a Health Care FSA (see prior section).

For a complete list of covered expense, refer to **IRS Publication 969 for Limited Purpose HCFSA,** which is available from the FSA web site address at www.healthequity.com/qme.

**Note:** Some Limited Purpose Health Care FSA expenses that are deductible on your tax return are specifically excluded as reimbursable through flexible spending accounts under tax law. Interpretation of eligible expenses is the responsibility of our administrator, HealthEquity.

Because your Limited Purpose Health Care FSA contributions go into your account per payroll period, you may incur an eligible expense that is greater than your Limited Purpose Health Care FSA balance. You can file a claim for reimbursement up to the total amount of your election minus any payments you have already received from the Limited Purpose Health Care FSA. Your payroll reductions will continue to the end of the year to reimburse the Plan in full.

### When Expenses Must be Incurred

Your health care expenses must be incurred during the same Plan year in which you made contributions to the Limited Purpose Health Care FSA. For example, eligible expenses incurred from January 1, 2026, through December 31, 2026, may be reimbursed from your 2026 Limited Purpose Health Care FSA contributions. You generally cannot be reimbursed for expenses incurred before you began participating in the account or after your participation stops. An expense is incurred not when payment is made, but rather when the service is rendered.

### Qualified Reservist Distribution

If you are a qualified reservist or national guardsman and you are ordered or called to active duty for a period of at least 180 days (or an indefinite period), you may request a distribution of all of your Limited Purpose Health Care FSA balance.

The following conditions apply to a Qualified Reservist Distribution:

- You must request the Qualified Reservist Distribution in writing (on a form which you can obtain by contacting Global HR Shared Services at 877-237-4711) during the period beginning with the date of your order or call to active duty and ending on the last day of the Plan year during which the order or call occurred
- You must submit an order or call to active duty to ADP prior to the disbursement date
- You may receive only one Qualified Reservist Distribution per Plan year
- After you have made a distribution request, you may not file further reimbursement claims for services in the Plan year which includes the date of the distribution request
- The amount of your Qualified Reservist Distribution shall be equal to all contributions made to your Limited Purpose Health Care FSA (including, discretionary matching contributions, if any, made by ADP) up until the distribution date less any reimbursements previously made from your Limited Purpose Health Care FSA
- Your Qualified Reservist Distribution will occur no later than 60 days after ADP receives your written request and will only occur while you are serving in active duty

- The Qualified Reservist Distribution coordinates with your election of continuation coverage as follows:
  - If you elect continuation coverage under USERRA while serving in active duty and continue to receive compensation from ADP, your Limited Purpose Health Care FSA contributions will continue to be made to the Limited Purpose Health Care FSA on a pre-tax basis up to the last day of the Plan year, unless otherwise revoked
  - If you elect continuation coverage under USERRA while serving in active duty and do not receive compensation from ADP, your Limited Purpose Health Care FSA contributions will continue to be made to the Limited Purpose Health Care FSA on a post-tax basis up to the last day of the Plan year, unless otherwise revoked

If you do not elect continuation coverage while serving in active duty, you may request a Qualified Reservist Distribution consistent with the conditions described above.

## The Dependent Care Flexible Spending Account

### How the Dependent Care FSA Works

Your Dependent Care FSA can be used to pay the cost of eligible expenses incurred in providing care for your eligible dependents so that you and your spouse can work, seek work, or attend school full-time. The Dependent Care FSA saves you money by taking advantage of the tax law that allows you to pay for these expenses using pre-tax dollars.

The amount you contribute is deducted from each paycheck before federal and Social Security taxes are withheld. **You can use the money in your account to pay yourself back for eligible dependent care expenses you pay so you (and your spouse if you are married) can work.** If you're married, this means that you must work and your spouse must be employed outside the home, disabled or a full-time student for at least five months during the year.

### Eligible Dependents

Eligible dependents for this account are individuals for whom you can claim an exemption on your federal income tax return and who are either:

- Under age 13 or
- Mentally or physically unable to care for him/herself regardless of age (this may be a spouse or older relative)
  To qualify as an eligible dependent, the IRS imposes the following requirements:
- **For dependents under age 13:**
  - You must be able to claim an exemption on your federal income tax return for the child, or you must be the parent who has custody for a longer time during the year than the other parent, even if you cannot claim a dependent exemption
  - A relative can provide the care, unless the relative is your spouse, child or stepchild under age 19, or a relative that you can claim as a dependent on your federal income tax return
  - If the care is given by a day care center (a center that cares for more than six individuals), that center must comply with all applicable state and local regulations
- **For dependents 13 or older:**
  - The individual must be your dependent for federal income tax purposes and must be physically and mentally incapable of caring for himself/herself/themself
  - The dependent must live with you for more than half the year
  - The care may be given outside the home provided the dependent regularly spends at least eight hours each day in your home
  - The dependent day care center must care for more than six individuals and must comply with all applicable state and local regulations

If you are divorced or legally separated, you do not necessarily have to claim your child as your dependent on your federal income tax return. However, the child is an eligible dependent only of the custodial parent (the parent having custody for the greater portion of the calendar year).

Your spouse or other dependent of any age who is incapacitated and must need assistance with personal hygiene, nutrition, or safety or who would endanger others without care, and whom you claim as an exemption on your federal income tax return is eligible under the plan. This may include your parents or a sibling if the person is incapacitated and you claim them as a dependent on your federal income tax return.

You may change, elect, or cancel your Dependent Care FSA contributions as a result of a qualifying life change, if you request the change on the web within 31 calendar days of the event.

### Amount You Can Contribute

You choose whether or not to contribute to the Dependent Care FSA. If you decide to participate, the **minimum** you can contribute is $500 per year. If you are a Highly Compensated Employee (HCE) as defined by the IRS, you will not be able to contribute more than $3,000 of your pay to the Dependent Care FSA in 2026. You will be considered an HCE if your earnings from ADP were more than $160,000 in 2025. All others will be able to contribute up to $7,500 of their pay to the Dependent Care FSA in 2026. New hires this year will be considered Non-HCE for the year. Note that the **maximum** you can contribute to the Dependent Care FSA is based on how you and your spouse file your tax returns. Check with your tax advisor or www.irs.gov to review current maximums based upon your tax filing status.

### Dependent Care FSA vs. Federal Income Tax Credit

You have three options to help you pay eligible dependent care expenses:

- Use the Dependent Care FSA to pay your expenses with pre-tax dollars. You save money by paying for your eligible dependent care expenses with tax-free dollars. Unlike the federal tax credit, the FSA contribution is not subject to Social Security and Medicare tax. However, any expenses for which you receive FSA reimbursement will not be eligible for the federal dependent care income tax credit. For 2026, the maximum contribution to a Dependent Care FSA is $7,500 (this amount is limited to $3,000 for HCEs, as discussed above).
- Take a federal tax credit on your dependent care expenses when you file your annual income tax return. For 2026, the amount of expenses eligible for the federal tax credit is limited to $3,000 for one dependent and $6,000 for two or more. The actual tax credit is a percentage of your eligible dependent care expense (20%-50%), which is based on your adjusted gross income. This results in a maximum available credit of $1,500 for one child and $3,000 for two or more children.
- Use a combination of the Dependent Care Spending FSA and federal tax credit. Your expenses that are eligible for federal tax credit are reduced, dollar for dollar, by the expenses for which you are reimbursed by the Dependent Care FSA

**Example**: Ron contributes $5,000 a year to the Dependent Care Spending FSA to help pay dependent care expenses for his two children. If Ron has more than $5,000 in dependent care expenses, he can apply some of the remaining amount toward the federal tax credit.

| | |
|---|---|
| Maximum federal tax credit expenses for two or more dependents | $6,000 |
| Ron's contribution to the Dependent Care Spending FSA | -$5,000 |
| Ron's adjusted federal tax credit expenses | $1,000 |
| Adjusted federal tax credit maximum for two or more dependents (20% -50% depending on Ron's adjusted income) | $200 - $350 |

Eligible expenses covered through your Dependent Care FSA include payments for:

- Childcare or baby-sitting in your home or someone else's if the child-care provider is not (1) another child of yours who is under age 19, or (2) anyone else for whom you can claim a tax exemption on your federal income tax return
- Care at a licensed day-care center
- A live-in, full-time housekeeper who also provides dependent care
- Preschool expenses (such as nursery school or similar program below the level of kindergarten)
- Elder care

- Before-school or after-school care for a child who is in kindergarten or a higher grade
- Day camps
- Day care expenses during a short, temporary absence (such as a vacation or minor illness, if the care giving arrangement requires you to pay for care during the absence)
- If one spouse works at night, day care expenses during hours when one spouse is sleeping

For a complete list of covered expenses, refer to IRS Publication 502 for HCFSA and 503 for DCFSA, which are available from the FSA web site: www.healthequity.com/qme.

**Examples of Expenses that are NOT Covered**
You may not request reimbursement from your Dependent Care FSA for:
- The cost of food or clothing
- The cost of tuition for children in kindergarten or higher
- The cost of transportation between your house and the place where dependent care services are provided
- The cost of nursing home facilities
- The cost of overnight camps
- Expenses for which a dependent care tax credit is taken
- Caregivers for a disabled dependent or spouse where the caregiver lives with you

**When Expenses Must be Incurred**
Generally, your dependent care expenses must be incurred during the same Plan year in which you made contributions to the Dependent Care FSA or during the 2½ month grace period following the end of that Plan year. Claims must be submitted by March 31 following the end of that Plan year:

- Eligible expenses for the 2025 Dependent Care FSA must be incurred from January 1, 2025, through March 15, 2026, and you will have until March 31, 2026, to submit them.

- Eligible expenses for the 2026 Dependent Care FSA must be incurred from January 1, 2026, through March 15, 2027, and you will have until March 31, 2027, to submit them.

**Amounts remaining in your Dependent Care FSA following the claims filing deadline for a Plan year will be forfeited.** You generally cannot be reimbursed for expenses incurred before you began participating in the account or after your participation stops. An expense is incurred not when payment is made, but rather when the service is rendered.

## Claiming Benefits

**Automatic Claims Submission (Pay Me Back) Feature of Health Care and Limited Purpose Health Care FSA**
If you are enrolled in the Health Care FSA and you have elected Aetna or UHC Medical Option 1, Aetna Dental Option 1, or Aetna Dental Option 2, your claims information will automatically be sent by the carriers to our FSA administrator for processing on a bi-weekly basis based on the date the claim was processed. This will include Express Scripts prescription drug expenses as well. The automatic claim submission feature means you will not have to file claims with the FSA administrator for reimbursement of eligible expenses submitted directly by those plans. For the Limited Purpose Health Care FSA, Aetna Dental Option 1 and 2 claims will automatically be sent by the carrier. If you meet your CDHP deductible, your medical and prescription drug claims will automatically be sent to our FSA Administrator for processing. Associates who are not enrolled in these plans must submit an FSA claim form for reimbursement.
**Note**: You may opt out of the Pay Me Back feature by following these steps:
1. Log into my.healthequity.com
2. From dashboard click into the HealthCare FSA plan
3. Select Program Options from left hand side tool bar
4. Under *Your Options* select the Pay Me Back *Feature*
    a. Click *OFF* to disable

By opting out, you will then be required to file a claim form for FSA reimbursement. You will not be able to opt out of the Pay Me Back feature until your FSA has been established.

### Filing a Claim

If you have claims that are not eligible for automatic claim submission (e.g., HMO or vision claims) or you opted out of the automatic claim submission you may file a claim with the FSA administrator for reimbursement. Be sure to sign up for direct deposit through my.healthequity.com to ensure the fastest turnaround time on your reimbursement.

Reimbursement Request Forms are on the FSA website at my.healthequity.com. Complete the form and attach supporting documentation, such as receipts and copies of Explanation of Benefits from the Medical, Dental and Vision Plans. For Dependent Care, you will also need to provide the following information:

- Provider name and complete address
- Provider tax identification number (for an individual, this is the person's Social Security Number)

Once you incur an eligible expense, you can file a claim anytime by faxing the claim to 1-866-643-2219 or by mailing the claim to the address on the claim form.

You also have the option of submitting your claims online by accessing the FSA website and selecting Forms or File a Claims quick link. Complete the online form and click save, attached your receipts by selecting "Attached" under the receipt section. Select the image file you want to attach and choose "Open," Select "Download" to save your receipts. Then select "Submit" to submit the form for processing.

You may have your reimbursement deposited directly to your bank account. You will receive a notice of your new balance each time you receive a reimbursement. You can be reimbursed for health care expenses up to the total amount you have elected to contribute for the Plan year. However, you can only be reimbursed for dependent care expenses up to the total amount in your account on the date your claim is processed. You have to "float" one month's dependent care expense since you must pay for the expenses while the pre-tax contributions are being deducted from your check.

For health care expenses, you have until March 31 after the end of the Plan year to file claims for expenses incurred during the Plan year. **Claims must be received by the FSA administrator no later than March 31 after the end of the Plan year to be eligible for reimbursement.** Remember, any money left after the claims filing deadline will be forfeited. The money cannot be carried forward to the next Plan year.

For dependent care expenses, you have until March 31 after the end of the Plan year to file claims for expenses incurred during the Plan year and the two and one half-month grace period following the end of the Plan year. **Claims must be received by the FSA administrator no later than March 31 after the end of the Plan year to be eligible for reimbursement.** Remember, any money left in either account after the March 31 claims filing deadline must be forfeited. The money cannot be carried forward to the next Plan year.

### How to Appeal a Health Care FSA or Limited Purpose Health Care FSA Claim Denial

Please see "Your ERISA Rights" regarding the review of claims.

### How to Appeal a Dependent Care FSA Claim Denial

If you want to appeal a decision made by the administrator of the Dependent Care FSA, address your appeal to Global Total Rewards Department within 60 days after you receive the denial. Your claim will be reviewed, and you will receive a written notice of the decision. The decision will be final and binding, and there will be no further appeal rights. **Note**: The Dependent Care FSA is not an ERISA plan.

## When Coverage Ends

### How long will my participation in the FSAs remain in effect?

Your participation in the FSAs generally continues until the end of the Plan year but may end earlier if you take a leave of absence, retire or terminate employment. Each year, you will have an opportunity to re-enroll and change your contribution amount if necessary. Changes in contribution amounts for these accounts are possible during the Plan year ONLY if the participant experiences a qualified change in family status (such as marriage, divorce, or birth of a child, etc.), as outlined by the IRS. Otherwise, these contributions will be deducted for the remainder of the year.

Participation in the FSAs is determined by your eligibility. Participation ceases when you are no longer employed by ADP. (See section entitled "Continuation of Coverage".)

### What happens if I take a Leave of Absence (LOA)?

If you have a Health Care FSA or a Limited Purpose Health Care FSA, your participation will continue while you are on an LOA, but you cannot make contributions while you are on a LOA.

If you go on an LOA and return in the same Plan year, missed payments for your Health Care FSA or Limited Purpose Health Care FSA must be made through re-adjusted payroll deductions. Upon your return from an LOA, the Resource Center will advise you and the Payroll Department of the FSA adjusted amount. If you go on a, LOA and return in a different Plan year, no adjustment can be made for your missed Health Care FSA or Limited Purpose Health Care FSA payments. You should call Global HR Shared Services to determine if you have experienced a "qualified life change" that will permit you to establish a new Health Care FSA or Limited Purpose Health Care FSA.

If you have a Dependent Care FSA, you should cancel it once you start your Leave of Absence. If you return in the same Plan year, you can either call Global HR Shared Services (877-237-4711 for assistance) or submit a Flex form to reinstate your Dependent Care FSA and adjust the Dependent Care per pay period amount, if necessary, to get to the desired annual amount. If you return in a different Plan year, you should call Global HR Shared Services to determine if you have experienced a "qualified life change" that will permit you to establish a new Dependent Care FSA.

### What happens if I retire or terminate employment with my company mid-year?

Your participation in the FSAs generally ends if you retire or terminate employment during the Plan year. In accordance with IRS regulations, you are permitted to submit claims for reimbursement for expenses incurred prior to your retirement or termination date. Any amounts more than the expenses incurred prior to your retirement or termination, that remains in your Dependent Care FSA, will be forfeited. If you have no expenses that were incurred before leaving your employer, then any funds remaining in your Dependent Care FSA will be forfeited. Dependent Care expenses incurred after you leave your employer are not eligible for reimbursement. Health Care expenses incurred after you leave your employer are eligible for reimbursement only if you elect COBRA continuation coverage for your Health Care FSA or Limited Purpose Health Care FSA. If your employment with ADP is terminated for any reason other than gross misconduct, you have the right to continue your Health Care FSA or Limited Purpose Health Care FSA under COBRA by making monthly contributions with after-tax money. Contact Global HR Shared Services for more information.

If you elect COBRA for your Health Care FSA or Limited Purpose Health Care FSA and make all required COBRA contributions for the Plan year, you will be entitled to submit claims for reimbursement for expenses incurred during the Plan year. If you choose not to elect COBRA for your Health Care FSA or Limited Purpose Health Care FSA, and you have no expenses that were incurred before leaving your employer (or you have amounts in excess of the expenses incurred prior to your retirement or termination that remain in your Health Care FSA or Limited Purpose Health Care FSA), then any funds remaining in your Health Care FSA or Limited Purpose Health Care FSA will be forfeited.

### For More Information

Our FSA administrator is HealthEquity 1-866-346-5800. Their web site my.healthequity.com has information to assist you in making your election and filing claims, and it also includes an FAQ section. If you have any other questions, please contact Global HR Shared Services. You may submit a case or call 877-237-4711 for assistance.

## Your ERISA Rights

### General Information

ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in any of the benefit plans described: Health Care, Dental Care, Prescription, Vision, Health Care FSA, Limited Purpose Health Care FSA, Long Term Disability and Life Insurance. (The proper name of each plan is contained in each section.)

### Plan Continuation

ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a Plan, you will receive notice.

### Plan Documents versus Guide

One of the primary purposes of the Summary Plan Description is to provide ADP associates with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans and contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, the actual legal document of the plans will rule.

The named fiduciary for the Plan has the discretionary authority to determine eligibility under Plan terms, to interpret and apply the terms and provisions of the Plan, to resolve discrepancies and ambiguities, and to make final decisions on the appeal by a Plan participant of an initial claim denial. A decision made by the named fiduciary will be final and binding on all parties.

### Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may charge a reasonable fee for the copies
- 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. A copy of this report is distributed annually and is also available on the web site
- Continue health care coverage for yourself or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. To review your COBRA continuation coverage rights, please refer to the section of this Summary Plan Description entitled "Continuation of Coverage"

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

### If a Claim is Denied

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

In the event a claim for benefits has been denied in whole or in part, you can request a review. This request for review must be in writing and must be sent to the FSA administrator, HealthEquity, within 180 days after you receive notice of denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments that you think applicable.

The Plan Administrator will review and decide on the appeal within 30 days after you file your request. If you are notified that there will be a delay, however, you will receive an explanation of the reasons for needing more time. Once a decision is reached, you will be notified in writing of the outcome.

If you disagree with the appeal determination, you may file a second level of appeal. This appeal should be made in writing within 60 days of receipt of the first level appeal decision. The Plan Administrator will notify you of the decision no later than 30 days after the appeal is received. This decision shall be final and binding.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's appeal procedures.

**Deadline for Filing Lawsuits**
If the Plan Administrator denies your appeal, the Plan's decision to deny your claim will be final. When this occurs, you have exhausted your appeal rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a)(1)(B) of ERISA. **You have 90 days from the date of the notice denying your appeal in which to file a lawsuit. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim.**

**Administrative Details**
The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

| Plan Number | Plan 503 | |
|---|---|---|
| Plan Name and Coverage | The Health Care Spending Account Plan and Limited Purpose Health Care Spending Account Plan are participating plans in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. | |
| Plan Administration | Claims Administrator:<br>HealthEquity<br>P.O. Box 14053<br>Lexington, KY 40512<br>my.healthequity.com<br>Phone: 1-866-346-5800<br>Fax: 1-877-353-9236 | Appeals Fiduciary<br>HealthEquity Appeals Team<br>P.O. Box 14034<br>Lexington, KY 40512<br>Fax: 1-877-220-3248 |
| Plan Year (for Fiscal and Other Records) | January 1 to December 31 | |
| Plan Sponsor | Automatic Data Processing, Inc. | |
| Source and Method of Plan Financing | See the section entitled "Amount You Can Contribute" in this Plan summary. | |
| Agent for Service of Legal Process | ADP or where appropriate the insurance company or provider of service or the supervisory official of the insurance department of the state where you reside. | |

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

### DOL Locations

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

# Basic Life and Accidental Death & Dismemberment Insurance

Your Basic Life Insurance coverage is insured through The **Metropolitan Life Insurance Company**

Your Accidental Death & Dismemberment coverage is insured through **National Union Fire Insurance Company of Pittsburgh, PA (an AIG Company)**.

### Cost and Coverage

You automatically receive Basic Life and Accidental Death and Dismemberment (AD&D) coverage on the first day of active full-time employment, at no cost to you. ADP pays the full cost of this coverage.

You automatically have Basic Life Insurance coverage equal to one and one-half times your annual base salary*, up to a maximum benefit of $2,000,000. Your coverage amount will be rounded to the nearest $1,000, if not already a multiple of $1,000.

In addition, you automatically have AD&D Insurance coverage equal to another one and one-half times your annual base salary*, up to a maximum benefit of $2,000,000. Your coverage amount will be rounded to the nearest $1,000, if not already a multiple of $1,000.

***Annual base salary does not include any special pay such as bonuses, overtime or other compensation. Sales associate's benefits are based upon a formula called "Benefit Earnings."**

**Note**: Federal law requires you to pay income taxes on the value of any Company paid Life Insurance, which is over $50,000. This is called Imputed Income. This amount will be noted as Group Term Life on your paycheck and as Group Term Life on your year-end W-2 form.

### Additional Services

Under Basic Life insurance with MetLife, you have access to MetLife Advantages[SM] Services including tools and resources to help navigate many challenges associates and their families may face.

- **Grief Counseling:** You, your dependents, and your beneficiaries have access to grief counseling sessions and funeral related concierge services to help cope with a loss — at no extra cost. You can have up to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to death, bankruptcy, divorce, terminal illness, or losing a pet.[1] In addition, you have access to funeral assistance for locating funeral homes and cemetery options, obtaining funeral cost estimates and comparisons, and more. You can access these services by calling 1-888-319-7819 or log on to one.telushealth.com (Username: metlifeassist; Password: support).
- **Funeral Discounts and Planning Services:** As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life — at no additional cost to you. Dignity Memorial provides you and your loved one's access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States. When using a Dignity Memorial Network, you have access to convenient planning services - either online at www.finalwishesplanning.com, by phone (1-866-853-0954),
- **Digital Estate Planning:** You have access to Digital Estate Planning services to create key estate planning documents online in as little as 15 minutes by answering a few simple questions. Documents include Last Will and Testament, Advance Healthcare Directive (Living Will), and Durable Financial Power of Attorney. Visit www.willscenter.com to get started.

## How the Plan Works

### Eligibility and Enrollment

See Eligibility and Enrollment in the General Information Section.

### How to Calculate Coverage Amount

Your death benefit is the amount of insurance in effect on your date of death reduced by the amount of any terminal illness benefits paid under the Basic Life Insurance option to accelerate payment of death benefits. Your annual base earnings include any pre-tax contributions to other benefit programs, but exclude overtime, bonuses and commissions. As your salary increases, your benefit levels increase automatically. If you are not actively at work on the date an automatic increase is scheduled to take effect, the increase will go into effect when you return to active work.

Special rules apply for sales associates. Basic earnings for sales associates are called Benefit Earnings. Benefit Earnings are determined in accordance with the sales benefit earnings formula as calculated by ADP.

Following is how "Benefit Earnings" is calculated:

- Sales benefit earnings will be determined by calculating benefit eligible earnings* (prior year W-2 earnings less non-benefit eligible earnings) multiplied by 80%
- Associates that have been in a sales position for less than one calendar year will have their benefit eligible earnings annualized and the greater of their base salary or 80% of their benefit eligible earnings will be used to determine their sales benefit earnings
- Associates that have been in a sales position for greater than one calendar year will have their sales benefit earnings calculated by taking the greater of their base salary or 80% of their benefit eligible earnings
- An increase in Basic Life insurance due to an increase in basic earnings is calculated annually and retroactively applied January 1 of the current year.

*Excludes non-benefit eligible earnings such as any car allowance, recruitment bonus, taxable relocation payment, stock options, carpool allowance, company car, sales lead adjustment, meals, and sales vacations.

Your Basic Life Insurance amount is subject to reduction once you attain the limiting age while actively employed as a full-time employee. At age 70, your amount of coverage is reduced to 65% of the amount for which you would then be insured if there were no reduction for age. At age 75, your coverage is reduced to 50%. Reduction occurs on the first January 1 that occurs while you are a limiting age. If you are already at a limiting age when becoming insured, the reduction occurs immediately.

### Naming a Beneficiary

You will be asked to name a beneficiary to receive benefits in case of your death. Please note you must make a separate beneficiary designation for the Basic Life and AD&D Insurance.

Your beneficiary may be any person or persons, or your estate. This includes a religious organization, a favorite charity, or other nonprofit group. If you are divorced or legally separated, you may wish to consider revising your beneficiary designations.

You may change your beneficiary at any time by submitting your beneficiary designation on the ADP Benefits Enrollment System available through the Associate Portal. For questions, submit a case to Global HR Shared Services or call 877-237-4711.

If there is more than one beneficiary but the beneficiary designation does not specify their shares, they will share equally. If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries, unless the beneficiary designation states otherwise. Any amount of insurance for which there is no beneficiary at your death will be payable to the first of the following: Your (a) estate; (b) surviving spouse ; (c) surviving child(ren) in equal shares ; (d) surviving parent(s) s in equal shares; (e) surviving sibling(s) in equal shares.

### Failure to Enroll
New full-time associates will automatically be assigned Basic Life Insurance and AD&D Insurance, each equal to one and a half times their annual base earnings, up to a maximum of $2 million, subject to the actively at work requirement of the Plan.

### Claiming Benefits
Basic Life Insurance is payable upon death from any cause while covered. AD&D Insurance benefits are paid if you die or lose a limb within 365 days of an accident, for any cause except those listed in the Limitations Section under AD&D. The combined maximum benefit for Basic Life and AD&D Insurance is $4 million.

### Option to Accelerate Payment of Death Benefits
If you become terminally ill, which means that due to injury or sickness, your life expectancy is twelve months or less, while insured or while your death benefit protection is being extended, you or your legal representative may elect the accelerated benefit option under Basic Life insurance. This amount is paid to the associate to assist with expenses. Accelerated benefits are equal to 80%, to a maximum of $500,000 of the amount of Basic Insurance in force on your life on the date MetLife receives proof you are terminally ill. When you elect this option, the total amount of your Life Insurance that would be payable at your death will be reduced by the accelerated benefits. Accelerated benefits may be considered taxable income. See your tax advisor prior to making this election.

### How to File a Claim
To file a claim for benefits, your beneficiary should contact Global HR Shared Services at 877-237-4711 for Basic Life and contact AIG at 800-551-0824 for an AD&D claim to begin the claim process and obtain claim forms. Your beneficiary must complete a Life Insurance Claim Form before benefits can be paid. Upon receipt of the completed Basic Life forms, the claim will be processed by MetLife.

### When Your Coverage Terminates
Coverage ends if the Plan terminates, at retirement, termination of employment, or if you no longer meet the eligibility requirements.

For purposes of this coverage, your employment will not be considered to end while you:
- Are absent from work at ADP on account of your disability, and
- Have been so absent for less than 12 months

Exception to termination of your coverage: If you become totally disabled you may be eligible to continue your Basic Life coverage. See the section on "Continuation of Insurance during Total Disability" for more details.

### Conversion Privilege
If you terminate employment or cease to be insured, you may be able to replace your Basic Life Insurance coverage with an individual policy, but you cannot convert your Accidental Death and Dismemberment Insurance coverage to an individual policy. To convert to an individual Basic Life policy without a medical examination, you must apply directly to the insurance company within 31 days after you stop working or cease to be insured. The amount of insurance you are entitled to convert is subject to the terms of the MetLife Basic Life Insurance contract. Shortly after your termination from ADP, MetLife will send you a "MetLife Notice of Group Life Conversion Privilege" form. Contact MetLife at 800-300-4296, if you have any questions.

If you die within 31 days after your insurance ends, Basic Life Insurance benefits may still be payable to the designated beneficiary.

### Continuation of Insurance during Total Disability
If you are less than age 90 and become totally disabled (as defined under LTD) while you are a covered person, your Basic Life Insurance coverage will be extended while you are totally disabled. The extension ends one year after your total disability started, unless, within that year, you give MetLife written proof that you are still totally disabled, and your total disability has continued for at least nine months. MetLife will further extend your death benefit protection for successive one-year periods subject to your providing written proof once each year that your total disability continues.

On and after the date you attain age 70, your coverage is reduced to 65% and at age 75 your coverage is reduced to 50% of the amount of insurance as long as you are continued under the Continuation of Insurance due to total disability.

Your extension protection ends if and when:
1. Your total disability ends
2. You fail to furnish any required proof that your total disability continues
3. You fail to submit to a medical exam by Doctors named by MetLife when and as often as MetLife requires. After two full years of this protection, MetLife will not require an exam more than once a year

## Basic Accidental Death & Dismemberment (AD&D) Insurance

### Losses Covered under AD&D

AD&D Insurance benefits will be paid for loss of life, limbs or sight within 365 days of an accident.

| AD&D Benefit for the Loss of: | Benefit Amount |
|---|---|
| Life | 100% |
| Both hands or feet or entire sight of both eyes | 100% |
| One hand and one foot | 100% |
| One hand or one foot and the sight of one eye | 100% |
| Speech and hearing in both ears | 100% |
| One hand or one foot, entire sight of one eye, speech or hearing in both ears | 50% |
| Hearing in one ear | 25% |
| Thumb and index finger of the same hand | 25% |

In no event will the benefit payable under the AD&D schedule due to the same accident exceed yours or your eligible Spouse or Dependent Child(ren)'s applicable benefit amount. If more than one loss is sustained as a result of the same accident, only one benefit amount, the largest, will be paid.

Loss with reference to hand and foot means complete severance through or above the wrist or ankle joint; with reference to eye, means total and irrecoverable loss of the entire sight in that eye; with reference to hearing means total and irrecoverable loss of the entire ability to hear in that ear; with reference to speech means total and irrecoverable loss of the entire ability to speak; with regard to thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

### Seat Belt and Air Bag Benefit

If an Accidental Death loss is payable under the Plan, the benefit amount payable to the insured person whose loss is the basis of the claim will be increased by an amount equal to the lesser of $50,000 or 10% of your benefit amount if, at the time of the accident the insured person was driving or riding in an automobile and wearing a properly fastened seat belt or, if the insured person is a child, a properly installed and fastened child restraint device as defined by state law. In addition, an additional benefit (the lesser of $50,000 or 10% of your benefit amount) is payable if the insured person is positioned in a seat protected by a properly functioning Supplemental Restraint System that inflates on impact. Supplemental Restraint System means an air bag, which inflates for added protection to the head and chest areas.

- Automobile is defined as a self-propelled private passenger motor vehicle with four or more wheels designed and licensed for use on highways of any state or country. It includes, but is not limited to a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional or business purposes, a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit

### Paralysis Benefits

In addition to paying benefits for Accidental Death and Dismemberment, benefits are provided in the event of paralysis that occurs within 365 days of a covered accident as follows:

| For Loss of: | % of Benefit Amount |
|---|---|
| Quadriplegia (total paralysis of all four limbs) | 100% |
| Paraplegia (total paralysis of both lower limbs) | 100% |
| Hemiplegia (total paralysis of upper and lower limbs of the same side of the body) | 100% |
| Uniplegia (total paralysis of 1 limb) | 25% |

If the insured person suffers more than one type of paralysis as a result of the same accident, only one amount, the largest, will be paid.

### Coma Benefits

If you or a covered family member suffers a covered injury resulting in a coma, a monthly benefit will be paid if the coma:

- Occurs within 365 days of the accident and continues for 30 consecutive days; and
- Is diagnosed by a competent medical authority

The Coma Benefit is equal to 2% of your benefit amount and is payable monthly. Payment begins with the 31st consecutive day that you or a covered family member remains in a coma and ceases on the earliest of the following dates, provided such a coma continues, (1) when you cease to be comatose due to that injury; (2) upon the death of the person in a coma; (3) when 100% of the applicable benefit amount is reached (after 11 months the remaining benefit to equal 100% will be paid) for you or a covered family member whose injury is the basis for the claim.

Coma means a profound state of unconsciousness from which you cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.

### Felonious Assault Benefit (Not applicable to insured dependents)

If you suffer a loss of life, or accidental dismemberment, or paralysis, or a coma due to a covered injury sustained because of a felonious assault, the benefit amount payable under the plan will be increased by 25% of your selected benefit amount. The incident causing the Felonious Assault must either be directed towards Automatic Data Processing, its property or assets, or occur while you are acting on behalf of Automatic Data Processing as a representative. Only one benefit is payable for all losses resulting from the same Felonious Assault.

Felonious Assault means any willful or unlawful use of force upon you:

- With the intent to cause bodily injury to you; and
- That results in bodily harm to you; and
- That is a felony or a misdemeanor in the jurisdiction in which it occurs

### Travel Assistance Services (AIG Benefits Travel Assist)

Provides travel assistance for all employees and eligible dependents while traveling on either business or pleasure trips 100 or more miles away from home. Travel assistance is available 24 hours a day, 7 days per week and provides:

- Concierge Services which include:
  - Event ticketing
  - Ground transportation coordination
  - Golf tee times reservations
  - Restaurant referrals and reservations
- Emergency Message Service
- Emergency Telephone Interpretation Assistance
- Emergency Translation Service

- Emergency Travel Agency Services
- Legal Referral Assistance
- Medication Shipment/Lost Document Assistance
- Pre-Trip Assistance
- Security Evacuation Assistance

**Emergency Evacuation Benefit & Repatriation of Remains Benefit**
In addition to the above, the insurance company will pay for covered emergency evacuation expenses if the insured person suffers an injury or emergency sickness that warrants his/her/their emergency evacuation/repatriation while he/she is 100 or more miles from his or her primary residence, up to a maximum of $5,000,000 for all Emergency Evacuations due to all injuries from the same accident or all Emergency Sicknesses from the same or related causes.

The physician ordering the Emergency Evacuation must certify that the severity of the insured person's injury or emergency sickness warrants his or her emergency evacuation. All transportation arrangements made for the emergency evacuation must be by the most direct and economical conveyance and route possible. All arrangements must be handled by the assistance vendor and certified by the local attending physicians treating the insured for the injury/sickness.

**Family Travel Benefit**
Following an emergency evacuation eligible for a benefit, the insurance company will pay for expenses reasonably incurred:
- To return to their current primary residence, with an attendant, if necessary, any of the insured person's children who were accompanying the insured person when the injury or emergency sickness occurred; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per child; and
- To bring one person chosen by the insured person to and from the hospital or other medical facility where the insured person is confined if the insured person is alone and if the place of confinement is outside a 100-mile radius from the insured person's place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket.

To contact AIG Benefits Travel, Assist call 877-244-6871 (in US or Canada) or call collect 011-715-346-0859 (when calling from outside the US or Canada).

**AD&D Insurance Maximum**
AD&D coverage includes death benefits, accidental dismemberment benefits, paralysis benefits, or coma benefits. However, if you have more than one loss in any one accident, the total benefit paid will not exceed 1 1/2 x Basic Annual Earnings rounded to the next higher $1,000 to a maximum benefit of $1 million.
Basic Annual Earnings includes any pre-tax contributions to other benefit programs, but excludes overtime, bonuses and commissions.

Special rules apply for sales associates. Basic Earnings for sales associates are called Benefit Earnings. Benefit Earnings are determined in accordance with the sales benefit earnings formula as calculated by ADP and described earlier in this section.

The AD&D Coverage in this policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New Jersey State Insurance Department.

**IMPORTANT NOTICE---THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS**

### Limitations

Benefits under the AD&D policy will not be paid for a Loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily Injury:

- Declared or undeclared war, or any act of declared or undeclared war.
- Suicide or attempted suicide, intentionally self-inflicted injury or any attempt at intentionally self-inflected injury or auto-eroticism.
- Travel or flight or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the insured person is: a) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or b) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft.
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.

The foregoing summary/report/outline does not take the place of or alter any of the conditions, exclusions, and other terms of the insurance policy herein summarized. It is merely a short descriptive guide to the policies in force for convenient reference. If there are any discrepancies, the Policy shall govern.

## Your ERISA Rights

### General Information

ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Life Insurance benefit plans.

### Plan Continuation

ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a Plan, you will receive notice.

### Plan Documents versus Guide

One of the primary purposes of the Summary Plan Description is to provide ADP associates with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans; contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, the actual legal document of the plans will rule.

### Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all Plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may charge a reasonable fee for the copies

- 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. A copy of this report is distributed annually and is also available on the web site https://associateportal.adp.com/

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

## Basic Life Insurance

### Extraterritorial

### Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the coverage(s) described in the Metropolitan Life Insurance Company (MetLife) Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your Metropolitan Life Insurance Company (MetLife) Group Insurance Certificate.

### Determination of Benefits for Death Benefits

After MetLife receives a claim for benefits, MetLife will review the claim and notify the claimant of its decision to approve or deny the claim. Such notification will be provided to the claimant within a reasonable period, not to exceed 90 days from the date we received the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies the claim in whole or in part, the notification of the claim decision will include:

- The specific reason(s) for the denial
- References to the specific plan provisions on which the benefit determination was based
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary
- A description of the MetLife plan review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after appeal

### Appeals of Adverse Determination

In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after the claimant received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision and shall include:

- The specific reason(s) for the adverse determination
- References to the specific plan provisions on which the determination was based
- A statement describing any appeals procedures offered by the Plan, and your right to bring a civil suit under ERISA
- Upon written request, MetLife will provide the claimant free of charge with copies of documents, records and other information relevant to the claim.

**Deadline for Filing Lawsuits**

If the Insurer denies your appeal, the Plan's decision to deny your claim will be final. When this occurs, you have exhausted your appeal rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a) (1) (B) of ERISA. **You have 90 days from the date of the notice denying your appeal in which to file a lawsuit. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim.**

## Basic AD&D

**Denied Claims and the Appeals Process**

Participants, their beneficiaries (if applicable) or any individual duly authorized by them have the right under ERISA to file a written claim for benefits with the Insurer. If a claim is denied in whole or in part, the claimant will receive a written notice from the Insurer of the Insurer's decision, including the specific reason for the decision, within 90 days after the Insurer receives the claim. The written notice will include:

- The specific reason(s) for the denial
- Reference to the specific provisions, statutes or regulations on which the denial was based
- A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- Information about the steps to be taken if you, your dependent, or an authorized representative, wishes to submit the claim for review

If the Insurer needs more than 90 days to make a decision, a representative will notify you in writing within the initial 90-day period and explain why more time is required. An additional 90 days (for a total of 180 days) may be taken if the Insurer sends this notice. The extension notice will show the date by which the Insurer's decision will be sent.

If you submit your claim according to the procedures described in this section and you do not hear from the Insurer within the time limits given here, your claim is considered denied.

If a claim for benefits is denied in whole or in part, or if you or your dependents believe that benefits under the Plan to which you are entitled have not been provided, an appeal process is available to you. You, your dependents, or your authorized representative may appeal in writing within 60 days after the denial is received or the 90 (or 180) day period has expired.

**Appeal Procedures**

A claimant can appeal a denied claim if:

- No reply at all is received from the Insurer after 90 days
- The Insurer has extended the response time by an additional 90 days and no reply is received within that time
- Written denial of the claim is received within the appropriate time frame and the claimant wants to appeal it

If you wish to file an appeal, you must do so in writing within 60 days of receiving notification of the Insurer's decision. You are entitled to request a copy and review the Plan document when you prepare your appeal. If you believe an error has occurred, you can support your request by giving the reason you think there is an error. Also, whenever possible, send copies of any documents or records that support your appeal. Whether or not you can provide such additional information, your claim will be reconsidered after your request is received. Send a written request for review of any denied claim directly to the Insurer.

The Insurer will conduct a review and make a final decision within 60 days after receiving the request for review.

If special circumstances cause the Insurer to need more that 60 days to make a determination, a representative will notify you in writing within the initial 60-day period and explain why more time is required. An additional 60 days (for a total of 120 days) may be taken if the Insurer sends this notice. The decision will be in writing and will specify the pertinent Plan provisions on which the decision is based.
If you submit your request for a written review according to the procedures described in this section and you do not hear from the Insurer within the time frame given here, your appeal is considered denied.

Although this decision is final and is not subject to further review, you or your beneficiaries may have additional rights under ERISA. However, applicable law and the Plan's provisions require you to pursue your claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits.

The Insurer will have full power to administer and interpret the Plan in all of its details, subject to applicable requirements of law. Benefits under the Plan shall be paid only if the Insurer decides, in its discretion, that the applicant is entitled to them.

You may not file an action at law or in equity for benefits under the Plan until the administrative appeal rights described herein have been exercised and exhausted in full, and the Plan benefits requested in your appeal have been denied in whole or in part.

### Deadline for Filing Lawsuits

If the Insurer denies your appeal, the Plan's decision to deny your claim will be final. When this occurs, you have exhausted your appeal rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a) (1) (B) of ERISA. **You have 90 days from the date of the notice denying your appeal in which to file a lawsuit. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim.**

### Administrative Details

The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

The following plans provide benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Basic Life and Accidental Death and Dismemberment Insurance Plans are participating plans in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. In the event of a conflict between the Plan documents, the SPD and the insurance contracts, the terms and provisions of the insurance contracts will control. |
| Plan Administration & Claim Processing | The basic life insurance benefits are insured under Metropolitan Life Insurance Company (MetLife) group contract 105899-2-G. MetLife's address is 200 Park Avenue, New York, New York 10166. MetLife's toll free number for questions regarding claims is 10-800-638-6420.<br><br>The accidental death and dismemberment benefits are insured under National Union Fire Insurance Company of Pittsburgh, PA (an AIG Company) Group Policy BSC 9125477. National Union's address is 32 Old Slip, New York, NY 10005. Claim processing for AD&D benefits is handled by National Union. Call 1-800-551-0824 for claims. The insurance premiums are fully paid by employer contributions. |

| Plan Number | Plan 503 |
|---|---|
| VEBA Trust | Employer contributions are deposited in the Automatic Data Processing, Inc. and Subsidiaries Employee Welfare Benefit Trust, a voluntary employees' beneficiary association established under Internal Revenue Code Section 501(c)(9).<br>The Trustees for the Trust are individuals appointed by the Company. The Trustees are responsible for making payments from the Trust, including premiums for insurance plans, which are paid directly to the insurance carriers. In addition, all self-insured Plan benefits and related administrative expenses are paid directly from the Trust. |
| Plan Year<br>(for Fiscal and Other Records) | January 1 to December 31 |
| Source and Method of Plan Financing | Corporate assets of ADP |
| Plan Administrator<br>and Address | Automatic Data Processing, Inc.<br>One ADP Boulevard, M/S C237<br>Roseland, NJ 07068<br>Telephone: 973-974-5000 Identification Number: 22-1467904 |
| Agent for Service of Legal Process | ADP or where appropriate the insurance company or provider of service or the supervisory official of the insurance department of the state where you reside. |

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

### DOL Locations

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

## Important ERISA Information for Basic Life Insurance and AD&D Insurance

The named fiduciary for each Plan has the discretionary authority to determine eligibility under Plan terms, to interpret and apply the terms and provisions of the Plan, to resolve discrepancies and ambiguities, and to make final decisions on the appeal by a Plan participant of an initial claim denial. A decision made by the named fiduciary will be final and binding on all parties.

### Basic Life Insurance

Certain states including Arkansas, California, Georgia, Idaho, Illinois, Indiana, Texas, Utah, Vermont, Washington and Wisconsin have specific disclosure requirements concerning the Basic Life Insurance plan. Refer to your Certificate of Insurance for these specific disclosures.

### Accidental Death & Dismemberment Insurance

Refer to your Certificate of Insurance for details.

# Long Term Disability

Long Term Disability ("LTD") insurance provides income that would otherwise be lost when you are unable to work due to an extended period of disability.

## What Is It?

This elective insurance replaces 60 percent of your monthly income (up to a maximum monthly benefit of $15,000) to normal retirement age for most conditions (or later, depending on when the disability begins) if you are unable to work after an initial disability of 26 weeks (182 days). The 60 percent replacement income will be offset by any income you receive from other sources such as Social Security (disability) or Workers' Compensation (but will not be below a minimum amount of $100 while you remain disabled).

Earnings used to determine LTD benefits are your base salary (including any pre-tax contributions to other benefit programs), excluding overtime, bonuses, commissions or any other fringe benefit or extra compensation. Special rules apply for Sales associates. See the Benefit Earnings definition at the end of this section for more information.

If you were treated for a condition during any of the three months prior to your LTD insurance effective date, your LTD insurance coverage has been in effect for less than 12 consecutive months, a disability for that pre-existing condition would not be covered.

### Severe Condition Benefit

A severe condition means you are unable to perform (without substantial assistance from another individual) at least 2 Activities of Daily Living (ADLs) due to a loss of functional capacity; or you require substantial supervision by another individual to protect oneself from threats to health and safety due to severe cognitive impairment. A severe condition can have a devastating impact on your income and ability to cover regular bills and expenses, plus staggering medical expenses. Associates with a severe condition, enrolled in LTD and disabled under the terms of the plan, may be entitled to receive an additional 10 percent of pre-disability monthly earnings. This benefit is not reduced by any other income sources and could result in replacing up to 100 percent of pre-disability earnings when added to the standard LTD benefit.

### Cost

The cost for LTD is deducted from your paycheck on an after-tax basis. The monthly cost for LTD is $0.168 per $100 of covered monthly salary. (ADP pays the full cost of LTD for full-time non-exempt associates that have been continuously covered by the Plan since 01/01/94.) No contributions are required while you are receiving payments under this Plan.

## How the Plan Works

### Eligibility and Enrollment

See Eligibility and Enrollment in the General Information Section.

The Long Term Disability Plan is insured through Metropolitan Life Insurance Company (MetLife).

You may opt out of coverage at any time, however, if you later want to elect LTD coverage, you will have to provide proof of good health to MetLife and approval by the insurance company is not guaranteed.

### *Exception if Not Actively at Work*

If you are absent from work on the date coverage would otherwise become effective, then coverage shall not become effective until you return to active employment.

If you are in active employment or if you are on a covered leave of absence or layoff, any increased or additional coverage will take effect immediately upon the effective date of the change. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment. An increase in your long term disability coverage may be subject to a pre-existing condition limitation as described in the plan.

Any decrease in coverage will take effect immediately upon the effective date of the change. Neither an increase nor a decrease in coverage will affect a payable claim that occurs prior to the increase or decrease. Payable claim means a claim for which MetLife is liable under the terms of the Group Contract.

### When Your Coverage Terminates

Your coverage will terminate on the earliest of the following dates:

- The date the policy terminates
- The last day of the period for which you make any required contribution
- If you fail to make any further required contribution
- The date your employment terminates unless provided under the temporary absence from work provisions
- The date you are no longer an eligible associate
- The date you cease to meet the policy definition of a covered insured
- The date you request termination of coverage
- The date you are no longer in active employment due to a disability that is not covered under the plan

### Claiming Benefits

If you are disabled and expect the disability to continue for more than 182 calendar days, you must apply for the Long-Term Disability insurance benefit. Your application should be requested from the ADP Leaves Administrator no later than 120 days from the date of the onset of your disability.

#### *When is Proof of Disability Required?*

MetLife will contact you approximately 20 weeks (140 days) after the date your disability begins. If you don't receive an LTD claim form within 150 days of the first day of disability, please contact ADP Leaves at 1-866-381-2857. Alternatively, you can request a claim form from MetLife by calling 1-800-300-4296 and identifying yourself as an ADP associate under Group number 105899. All expenses incurred to provide documentation to support your claim are your responsibility and will not be reimbursed by the Plan.

MetLife may request that you provide proof of continuing disability, satisfactory to MetLife, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be provided to MetLife no later than 90 days after the end of the elimination period.

In some cases, you will be required to give MetLife authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. MetLife will deny your claim or stop sending you payments if the appropriate information is not submitted. You must notify MetLife immediately when you return to work in any capacity.

#### *When Will I Begin to Receive Disability Payments?*

You will begin to receive payments when MetLife approves your claim, providing the elimination period has been met. You will receive a payment each month for any period for which you remain disabled under the plan provisions.

#### *How Much Will MetLife Pay If You Are Disabled and Not Working?*

The monthly payment is 60 percent of your monthly earnings to a maximum monthly benefit of $15,000. This is your gross disability payment. Then subtract from your gross disability payment any deductible sources of income. Deductible sources of income means income from deductible sources you are entitled to receive while you are disabled. The severe condition benefit is not reduced by any other income sources.

## What Are My Monthly Earnings?

### Other than Sales Associates

Basic earnings mean your gross monthly income from ADP in effect just prior to your date of disability. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than ADP.

### Sales Associates
Basic earnings for sales associates are determined in accordance with the sales benefit earnings formula as calculated by ADP. Benefit Earnings mean the amount of total income that is used in determining the disability benefits. Refer to the Definitions section for a description of the Benefit Earnings formula.

***How do I Appeal a Claim Denial?***
See "Your ERISA Rights" for details on requesting a review of claims and the appeal process.

***Is the Benefit Taxable?***
Associates who pay 100% of the cost do so with contributions made on an after-tax basis. If they should become eligible for LTD benefits, the benefit received is not subject to federal taxes but some states consider LTD benefits taxable income. Benefits are taxable for those associates whose coverage is paid for by the Company.

***How Long Must You Be Disabled Before Your Benefits Begin?***
You must be continuously disabled through your elimination period. MetLife will treat your disability as continuous if your disability stops for 60 days or less during the elimination period, and you become disabled again for the same or related condition. In that instance, the days that you are not disabled will not count toward your elimination period. If your disability stops for more than 60 days and you become disabled again, you will have to complete a new elimination period.

Your elimination period is 26 weeks (182 days). Elimination period means a period of continuous disability, which must be satisfied before you are eligible to receive benefits from MetLife.

### Definition of Disability
You are disabled when MetLife determines that due to sickness or direct result of accidental injury:
- You are receiving appropriate care and treatment and complying with the requirements of treatment; and
- You are unable to earn more than 80% of your basic earnings at your own occupation and unable to perform each of the material duties of your own occupation; and
- After 24 months, you are disabled when MetLife determines that due to the same sickness or injury, you are unable to earn more than 60% of your basic earnings at any gainful occupation and unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience

### Rehabilitation Incentives
MetLife provides certain rehabilitation incentives for employees participating in an approved rehabilitation program. Participating in a rehabilitation program may mean returning to work full time or part time or participating in vocational training or physical therapy. If you participate in a rehabilitation program, MetLife will increase your monthly benefit by an amount equal to 10% of the monthly benefit. Other incentives may apply for those participating in a rehabilitation program such as a family care reimbursement and moving expense reimbursement. Your MetLife claim representative can provide more details about these incentives.

Benefits may be payable for a period of Partial Disability that starts while an eligible associate is actively at work or that follows a period of continuous disability (whether or not such continuous disability extends beyond the Elimination Period). While you may become partially disabled during the elimination period, benefits are not payable for partial disability until after the completion of the elimination period. Please contact the HR and Payroll Resource Center to discuss your specific needs.

***What will be used to determine monthly earnings if you become disabled during a covered Leave of Absence?***
If you become disabled while you are on a covered leave of absence, we will use your monthly earnings from ADP in effect just prior to the date your absence begins.

**How much will MetLife pay if you work while you are disabled?**
If you work while you are disabled and receiving monthly benefits from MetLife, your monthly benefit will be adjusted as follows:

- Your monthly benefit will be increased by any applicable Rehabilitation Program Incentive; and
- Reduced by other sources of income if applicable.

Your monthly benefit as outlined above will not be reduced by the amount you earn from working, except to the extent that such adjusted monthly benefit plus the amount you earn from working and the income you receive from other applicable sources exceeds 100% of your basic earnings.

After the first 12 months following your return to work, we will reduce your monthly benefit by 50% of the amount you earn from working while disabled.

**For example:**
Associate earned $3,200 part-time. The associate's regular monthly salary is $10,000 and the LTD scheduled benefit is $6,000. Add $6,000 + $3,200 = $9,200. Because the part-time income plus the LTD scheduled benefit is equal to or less than the associate's regular monthly salary of $10, 000, the associate will receive his/her/their regular scheduled LTD benefit for that month.

After 12 months of working while disabled, MetLife will reduce your monthly LTD benefit by 50% of any part-time work earnings.

During the first 24 months of disability payments, if your monthly disability earnings exceed 80% of your indexed monthly earnings, you may no longer meet the definition of disability and MetLife may stop sending you payments and end your claim.

Beyond 24 months of disability payments, if your monthly disability earnings exceed 60% of your indexed monthly earnings, you may no longer meet the definition of disability and MetLife may stop sending you payments and end your claim.. MetLife may require you to send proof of your monthly disability earnings on a monthly basis. We will adjust your payment based on your monthly disability earnings.

As part of your proof of disability earnings, MetLife can require that you send them appropriate financial records, including copies of your IRS federal income tax return, W-2s and 1099s, which they believe are necessary to substantiate your income.

**Disability earnings** mean the earnings, which you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations:

- During the first 24 months of disability payments, the greatest extent of work you are able to do in your own occupation that is reasonably available
- Beyond 24 months of disability payments, the greatest extent of work you are able to do in any occupation that is reasonably available, for which you are reasonably fitted by education, training or experience

Salary continuance paid to supplement your disability earnings will not be considered payment for work performed.

***What happens if your disability earnings fluctuate?***
If your disability earnings are expected to fluctuate widely from month to month, MetLife may average your disability earnings over the most recent 3 months to determine if your claim should continue subject to all other terms and conditions in the plan.

If MetLife averages your disability earnings, they will terminate your claim if:

- During the first 24 months of disability payments, the average of your disability earnings from the last 3 months exceeds 80% of indexed monthly earnings; or
- Beyond 24 months of disability payments, the average of your disability earnings from the last 3 months exceeds 60% of indexed monthly earnings

MetLife will not pay for any month during which disability earnings exceed the above amounts.

**Duration of LTD Benefits**

Generally, Long Term Disability benefit payments continue until you recover, or as long as you remain disabled (as defined by the Plan), until you reach your normal retirement age*. However, the duration of your disability benefits will depend on your age when LTD benefits begin as outlined in the following chart.

| Age when LTD Benefits Begin | Duration of Long Term Disability Benefits<br>Maximum Benefit Period |
|---|---|
| Less than 62 | Normal retirement age* but not less than 60 months |
| 62 but less than 65 | 60 months |
| 65 but less than 69 | To age 70 |
| 69 and over | 12 months |

***Your normal retirement age is your retirement age under the Social Security Act where retirement age depends on your year of birth.

## Limitations

***What disabilities have a limited pay period?***

Certain disabilities due to mental and nervous disorders or diseases or self-reported conditions which, as determined by MetLife, have a limited pay period during your lifetime.

Disability benefits for one or more of the conditions described below are limited toa combined 24 months during your lifetime.

MetLife will continue to send you payments for disabilities due in whole or part to mental illness beyond the 24-month period if you meet one or both of these conditions:

1. If you are **confined** to a **hospital or institution** at the end of the 24-month period, MetLife will continue to send you payments during your **confinement.**
   - If you continue to be disabled after you are discharged from confinement in a hospital or mental health facility, we will continue your monthly benefits for a period of 90 consecutive days following the date of your discharge from such hospital or mental health facility as long as you remain disabled during that period
   - If you are re-confined for the same disability for at least 14 days during such 90 day period, we will continue your monthly benefits during the period of re-confinement, and for a period of 90 consecutive days following the date of your discharge from re-confinement as long as you remain disabled during such period
2. In addition to item 1, if, after the 24-month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, MetLife will send payments during the length of the confinement.

MetLife will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

MetLife will not apply the mental illness limitation that results from Neurocognitive Disorders or Schizophrenia.

**Neurocognitive Disorders** means a condition that meets the diagnostic criteria for neurocognitive disorders set forth in the most recent edition of the Diagnostic And Statistical Manual of Mental Disorders (DSM) as of the date of your disability, and the cognitive deficits that relate to the disability are not attributable to another mental or nervous disorder or disease. Neurocognitive disorders include but are not limited to conditions such as Alzheimer's disease and other forms of dementia, and Traumatic Brain Injury.

**Schizophrenia** means a chronic psychiatric disorder diagnosed in accordance with the diagnostic criteria for Schizophrenia set forth in the most recent edition of the DSM as of the date of your disability.

**Self-reported symptoms** mean the symptoms and other manifestations of your condition which you tell your doctor, which are not verifiable using tests, procedures and clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.

**Mental illness** means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the DSM as of the date of your disability.

### Termination of Benefits

LTD Benefits will end the earlier of:

- The end of the maximum benefit period
- The date benefits end as specified under Limitations above
- The date you are no longer disabled under the terms of the Plan
- The date you fail to submit proof of continuing disability satisfactory to MetLife
- The date you fail to have a medical exam if requested by MetLife
- The date your disability earnings exceed the amount allowable under the Plan
- The date you die
- The date you decline to participate in a rehabilitation program that MetLife considers appropriate for your situation and that is approved by your doctor

### Other Sources of Income

Your LTD benefits are subject to offset by certain other types of income defined as **Deductible Sources of Income**. Deductible sources of income means income from deductible sources listed in the Plan which you receive or are entitled to receive while you are disabled.

### What happens if you receive a Lump Sum Payment?

If you receive a lump sum payment from any deductible source of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, MetLife will use a reasonable one.

### Deductible Sources of Income

MetLife will deduct from your gross disability payment the following deductible sources of income:

1. any disability or retirement benefits which you, your spouse or child(ren) receive or are eligible to receive because of your disability or retirement under:
   - Federal Social Security Act;Railroad Retirement Act;
   - any state, public or federal employee retirement or disability plan, including State Teachers Retirement System (STRS); Public Employee Retirement System (PERS) or Federal Retirement System (FERS). You must apply for such benefits through the highest appeal level that is applicable to such benefits and available under the plan; or
   - any pension or disability plan of any other nation or political subdivision thereof.
2. any income received for disability or retirement under the Employer's Retirement Plan, to the extent that it can be attributed to the Employer's contributions.

3. any income received for disability under:
   - a group insurance policy to which the Employer has made a contribution, such as:
     - benefits for loss of time from work due to disability;
     - installment payments for permanent total disability;
   - a no-fault auto law for loss of income, excluding supplemental disability benefits;
   - a government compulsory benefit plan or program which provides payment for loss of time from Your job due to your disability, whether such payment is made directly by the plan or program, or through a third party;
   - a self-funded plan, or other arrangement if the Employer contributes toward it or makes payroll deductions for it;
   - workers' compensation or a similar law which provides periodic benefits;
   - occupational disease laws;
   - laws providing for maritime maintenance and cure;
   - unemployment insurance law or program.
4. any income that you receive from working while disabled to the extent that such income reduces the amount of your monthly benefit as described in REHABILITATION INCENTIVES. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.
5. recovery amounts that you receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings.

If there is a reasonable basis for you to apply for benefits under the Federal Social Security Act, a government compulsory plan or program or a federal, state or other public employee retirement or disability plan or program, including a STRS, PERS or FERS Retirement System, you are expected to apply for such benefits. MetLife may reduce your LTD benefit by an estimated amount of these other sources of income. Your MetLife claim representative will provide more information about this process.

MetLife will only subtract deductible sources of income which are payable as a result of the same disability.

MetLife will not reduce your payment by your Social Security retirement benefits if your disability begins after age 65 and you were already receiving Social Security retirement payments.

### Non-Deductible Sources of Income

MetLife will not reduce your disability benefit to less than the minimum benefit of $100, or by the following sources:

- Amounts rolled over to a tax qualified plan unless subsequently received by you while you are receiving benefit payments;
- Benefits received from an accelerated death benefit payment;
- Cost of living adjustments that are paid under any of the above sources of Other Income;
- Early retirement benefits that have not been voluntarily taken by you;
- Group credit insurance;
- Individual disability income insurance policies;
- Mortgage disability insurance benefits;
- Reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration; or
- Veteran's benefits.

### Overpayments

MetLife has the right to recover any overpayments due to:

- Any error MetLife makes in processing a claim
- Fraud
- Your receipt of deductible sources of income

You will be required to reimburse MetLife in full. MetLife will determine the method by which the repayment is to be made.

### Rehabilitation

One of the primary goals of the Plan is to help you return to work. If you become disabled, you are encouraged to take part in any rehabilitation program recommended by MetLife. Programs and counseling will be provided, and the Company will make reasonable accommodations to help you return to work. If you decline to participate in a rehabilitation program that MetLife considers appropriate for your situation and that has been approved by your doctor, your claim payments may end.

If You participate in a rehabilitation program, MetLife will increase your monthly benefit by an amount equal to 10% of the monthly benefit. MetLife will do so before your monthly benefit is reduced by any other income. MetLife may also reimburse you for up to $400 for monthly expenses you incur for each family member to provide care. You may also be eligible for reimbursements for expenses you incur in order to move to a new residence recommended as part of such rehabilitation program. Refer to your Group Contract and MetLife claim representative for additional details.

### What disabilities are not covered under your Plan?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- Active participation in a riot
- Commission of or attempt to commit or taking part in a felony
- Intentionally self-inflicted injuries

Your plan does not cover a disability which:

- Begins within 12 months of the date your coverage under the plan becomes effective; and
- Is due to a pre-existing condition

Your plan does not cover a disability due to war, declared or undeclared, or any act of war.

MetLife will not make a payment for any period of disability during which you are confined in any penal or correctional institute.

### What is a pre-existing condition?

You have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, took prescribed drugs or medicines, or followed treatment recommendation in the three months prior to your effective date of coverage or the date an increase in benefits would otherwise be available.

The pre-existing condition will apply if you have been covered under the Plan for less than 12 consecutive months after the date your insurance, or elected increase in the amount of such insurance, takes effect.

### How does a pre-existing condition affect an increase in your benefits?

If there is an increase in your benefits due to an amendment of the plan or your enrollment in another plan option, a benefit limit will apply if your disability is due to a pre-existing condition.

You will be limited to the benefits you had on the day before the increase if your disability begins during the 12-month period starting with the date the increase in benefits would have been effective. The increase will not take effect until your disability ends.

### How does the pre-existing condition work if you were covered under ADP's prior Plan?

Special rules apply to pre-existing conditions if this long term disability plan replaces ADP's prior plan and:

- You were covered by that plan on the day before this plan became effective and
- You became covered under this plan within thirty-one days of its effective date

The special rules are:

- MetLife will credit any time you were insured under the prior plan
- If your disability is due to a pre-existing condition but would not have been due to a pre-existing condition under the prior plan, MetLife will pay a benefit equal to the lesser of the benefit amount under the MetLife group plan or the disability income benefit that would have been payable under the prior plan.
- If your disability would have been due to a pre-existing condition under the prior plan, it would be treated as having been caused by a pre-existing condition under the MetLife group plan.

### What happens if you return to work and your disability occurs again?

If you have a **recurrent disability**, as determined by MetLife, your disability will be considered part of your prior claim and you will not have to complete another elimination period if:

- You were continuously insured under this plan for the period between your prior claim and your current disability and
- Your recurrent disability occurs within 182 days of the end of your prior claim

Your recurrent disability will be subject to the same terms of the plan as your prior claim. Any disability, which occurs after 182days from the date your prior claim ended, will be treated as a new claim. The new claim will be subject to all of the plan provisions. If you become covered under any other group long term disability plan, you will not be eligible for payments under the MetLife plan.

**Recurrent disability** means a disability, which is:

- Caused by a worsening in your condition; and
- Due to the same cause(s) as your prior disability for which MetLife made a Long Term Disability payment

### Survivor Benefit

If you die and MetLife receives proof of your death, a lump sum benefit equal to the lesser of 3 times your gross monthly disability payment or the gross monthly benefit you were entitled to receive for the month you die if you die during the first month that disability benefits are payable. This amount will be payable to your eligible beneficiary if, on the date of your death:

- Your disability had continued for 26 weeks (182 or more days) and
- You were receiving or were entitled to receive payments under the plan

If you have no eligible beneficiary, payment will be made according to the following order: a) to your estate; b) your spouse; c) your child(ren); d) your parent(s); or e)your sibling(s).

The survivor benefit will first be applied to any overpayment that may exist on your claim.
**Beneficiary** is based on each state's definition of spouse and child. Spouse means your lawful spouse. The term "children" or "child" includes natural and adopted children. Payment to a minor or incompetent will be made to such person's guardian.

## Definitions

These definitions are customized for the FLEX 2000 disability benefits as described in the ADP SPD and may not be applicable in other contexts.

### Active Associate

An associate who works for ADP or one of its participating affiliates on a regular basis in the usual course of the Company's business or alternate worksite or location to which the job requires you to travel. The associate must work at least 20 standard hours per week.

### Basic Earnings (excluding Sales Associates)

Regular pay, not counting commissions, bonuses, overtime pay, or any other fringe benefit or extra compensation.

If you become disabled, your rate of basic earnings will be the rate in effect on your last day as an active associate before becoming disabled.

### Basic Earnings for Sales Associates

Basic earnings for sales associates are called Benefit Earnings. Benefit Earnings are determined in accordance with the sales benefit earnings formula as calculated by ADP.

**Benefit Earnings**
The amount of income that benefits will be based upon for the next calendar year. Sales benefit earnings will be determined by calculating benefit eligible earnings* (prior year W-2 earnings less non-benefit eligible earnings) multiplied by 80%.
Associates that have been in a sales position for less than one calendar year will have their benefit eligible earnings annualized. The greater of their base salary or 80% of their benefit eligible earnings will be used to determine their sales benefit earnings.

Associates that have been in a sales position for greater than one calendar year will have their sales benefit earnings calculated by taking the greater of their base salary or 80% of their benefit eligible earnings.

*Excludes any car allowance, recruitment bonus, taxable relocation payment, stock options, carpool allowance, company car, sales lead adjustment, meals, sales vacations, and all other similar items included in earnings.

**Indexed Monthly Earnings**
Your monthly earnings as adjusted on each July 1 provided you were disabled for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% or the current annual percentage increase in the Consumer Price Index for the prior calendar year. Your indexed monthly earnings may increase or remain the same but will never decrease.

The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. MetLife reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W. Indexing is only used to determine your percentage of lost earnings while you are disabled and working.

**Disability**
You are considered disabled when MetLife determines that, due to sickness or as a direct result of accidental injury:
- You are receiving appropriate care and treatment and complying with the requirements of such treatment; and
- You are, during the elimination period and the next 24 months, unable to earn more than 80% of your basic earnings at your own occupation and unable to perform the material duties of your own
- After 24 months, you are disabled when MetLife determines that due to the same sickness or injury, you are unable to earn more than 60% of your basic earnings at any gainful occupation and unable perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience

**Gainful Occupation**
An occupation, including self-employment, which is or can be expected to provide you with an income equal to at least 60% of your indexed monthly earnings.

**Injury** means a bodily injury that is the direct result of an accident and not related to any other cause. The disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

**Material Duties**
Material duties means duties that:
- Are normally required for the performance of your own occupation
- Cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, MetLife will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week

**Normal Retirement Age**
Your retirement age as defined by the federal Social Security Administration on the date your disability starts.

### Physician
A person licensed to practice medicine in the jurisdiction where such services are performed or any other person whose services, according to applicable law, must be treated as physician's services for purposes of the group plan. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction. Physician does not include you, your spouse or any member of your immediate family including your and/or your spouses, parents, children (natural, step or adopted), siblings, grandparents, or grandchildren.

### Pre-existing Condition
A condition for which you received medical treatment, consultation, care or services including diagnostic measures, took prescribed drugs or medicines or followed a treatment recommendation for your condition during the given period of time as stated in the Plan.

### Appropriate Care and Treatment
Appropriate care and treatment means medical care and treatment that is:
- Given by a physician whose medical training and clinical specialty are appropriate for treating your disability
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies
- Consistent with a physician's diagnosis of your disability
- And intended to maximize your medical and functional

### Own Occupation
The specific occupation you are routinely performing when your disability occurs. MetLife will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

### Employer's Retirement Plan
A defined contribution plan or defined benefit plan. These are plans that provide retirement benefits to employees and are funded entirely by employee contributions.

### Sickness
Sickness means illness, disease or pregnancy, including complications of pregnancy.

## Extraterritorial.
### Important Information for Residents of Certain States
Certain states including Arkansas, California, Connecticut, Georgia, Idaho, Illinois, Indiana, Maine, Massachusetts, Mississippi, New Hampshire, North Dakota, Texas, Utah, Vermont, Washington and Wisconsin have specific disclosure requirements concerning the Long Term Disability Insurance plan. Refer to your Certificate of Insurance for these specific disclosures.

## Fiduciary
The Metropolitan Life Insurance Company (MetLife), as Plan Administrator, has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Plan Administrator shall not be overturned unless arbitrary and capricious.

## Your ERISA Rights
### General Information
ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Long Term Disability plan.

## Plan Continuation

ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a Plan, you will receive notice.

## Plan Documents versus Guide

One of the primary purposes of the Summary Plan Description is to provide ADP associates with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans and contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, the actual legal document of the plans will rule. ***All benefits and coverages described in this booklet are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this booklet and the insurance policies, the insurance policies will always govern.***

This Group Contract underwritten by Metropolitan Life Insurance Company (MetLife) provides insured benefits under ADP's ERISA plan(s). For all purposes of this Group Contract, the Employer/Policy holder acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder be deemed the agent of Metropolitan Life Insurance Company (MetLife), absent a written authorization of such status executed between the Employer/Policyholder and Metropolitan Life Insurance Company (MetLife). Nothing in these documents shall, of themselves, be deemed to be such written execution.

Metropolitan Life Insurance Company (MetLife) as plan administrator has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Plan Administrator shall not be overturned unless arbitrary and capricious.

## Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office or at the office of ADP, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may charge a reasonable fee for the copies
- 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. A copy of this report is distributed annually and is also available on the web site https://associateportal.adp.com/

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including ADP or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

### Determination of Benefits

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring and extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information of filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision shall include:

(a) The specific reason or reasons for the adverse determination
(b) Reference to the specific Plan provisions on which the benefit determination is based;
(c) If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.

### Appeals of Adverse Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

(a) As part of your appeal, you may submit any written comments, documents, records or other information relating to your claim. After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgement. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of its final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies your claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific plan provisions on which the denial is based. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

### Deadline for Filing Lawsuits

If the Insurer denies your appeal, the Plan's decision to deny your claim will be final. When this occurs, you have exhausted your appeal rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a) (1) (B) of ERISA. **You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law. If you do not file a lawsuit within this 60-day period, you will have no further right to contest the denial of your claim.**

### Administrative Details

The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

The following plans provide benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Long Term Disability Plan is a participating plan in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. In the event of a conflict between the Plan document, the SPD and the insurance contract, the terms and provisions of the insurance contract will control. |
| Plan Administration, Funding & Claim Processing | Long Term Disability benefits are insured under Metropolitan Life Insurance Company (MetLife) Group Contract 105899-2-G. MetLife's address is:<br>MetLife Disability<br>PO Box 14590<br>Lexington, KY 40512-4592<br>The insurance premiums are paid with associate and employer contributions. |
| VEBA Trust | The associate and employer contributions are deposited in the Automatic Data Processing, Inc. and Subsidiaries Employee Welfare Benefit Trust, a voluntary employees' beneficiary association established under Internal Revenue Code Section 501(c)(9).<br>The Trustees for the Trust are individuals appointed by the Company. The Trustees are responsible for making payments from the Trust, including premiums for insurance plans, which are paid directly to the insurance carriers. In addition, all self-insured Plan benefits and related administrative expenses are paid directly from the Trust. |

| Plan Number | Plan 503 |
|---|---|
| Plan Year<br>(for Fiscal and Other Records) | January 1 through December 31 |
| Plan Sponsor | Automatic Data Processing, Inc. |
| Source and Method of Plan Financing | See the section entitled "Eligibility" and "Your Share of the Cost" with each plan summary. |
| Plan Administrator and Address | **Automatic Data Processing, Inc.**<br>One ADP Boulevard M/S C237<br>Roseland, NJ 07068<br>Telephone: 973-974-5000 Identification Number: 22-1467904 |
| Agent for Service of Legal Process | ADP or where appropriate the insurance company or provider of service or the supervisory official of the insurance department of the state where you reside. |

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

**DOL Locations**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

# Business Travel Accident Insurance

Business Travel Accident ("BTA") Insurance is an accidental death and dismemberment/paralysis policy that is provided to ADP associates who suffer a covered injury while traveling on a covered Business Trip. This benefit is provided by ADP at no cost to you and is effective on your first day of active employment. Business Travel Accident Insurance will pay up to four times your base annual earnings ($2.5 million is the maximum benefit) for accidental death and will pay certain benefit amounts according to an injury schedule. This policy also provides Business Travel assistance and medical evacuation emergency services.

## How BTA Insurance Works

### Eligibility and Enrollment

See Eligibility and Enrollment in the General Information Section.

### Payment of Benefits

Business Travel Insurance will be paid if, while traveling on a business trip, you suffer a covered injury that results in one of the following losses within 365 days from the date of the accident:

| For Loss of | Benefit Amount |
|---|---|
| Life | 4 X Basic Annual Earnings (BAE) |
| Both hands or feet or entire sight of both eyes | 4 X Basic Annual Earnings (BAE) |
| One hand and one foot | 4 X Basic Annual Earnings (BAE) |
| Either one hand or one foot and the sight of one eye | 4 X Basic Annual Earnings (BAE) |
| Speech and hearing | 4 X Basic Annual Earnings (BAE) |
| Speech or hearing | 2 X Basic Annual Earnings (BAE) |
| Either one hand or one foot | 2 X Basic Annual Earnings (BAE) |
| Sight of one eye | 2 X Basic Annual Earnings (BAE) |
| Hearing in one ear | 1 X Basic Annual Earnings (BAE) |
| Thumb and index finger of the same hand | 1 X Basic Annual Earnings (BAE) |

In addition, Business Travel Insurance will pay a Paralysis Benefit if a covered injury to the spinal cord results in one of the following types of paralysis while on a business trip:

| Paralysis | Benefit Amount |
|---|---|
| Quadriplegia (total paralysis of all four limbs) | 4 X Basic Annual Earnings (BAE) |
| Paraplegia (total paralysis of both lower limbs) | 4 X Basic Annual Earnings (BAE) |
| Hemiplegia (total paralysis of the upper and Lower limbs of the same side of the body) | 4 X Basic Annual Earnings (BAE) |
| Uniplegia (total paralysis of 1 limb) | 1 X Basic Annual Earnings (BAE) |

The 4 X Basic Annual Earnings (BAE) is subject to a maximum benefit payable under the Plan of $2,500,000. In no event will the benefit payable under the Accidental Death and Dismemberment Benefit due to the same accident exceed your applicable maximum benefit amount If more than one Loss or Paralysis is sustained as a result of the same accident, only one benefit amount, the largest, will be paid.

In no event will the benefit payable under the Paralysis Benefit plus the Accidental Death and Dismemberment Benefit due to the same accident exceed your applicable maximum benefit amount. Loss with reference to hand and foot means complete severance through or above the wrist or ankle joint; with reference to eye means total and irrecoverable loss of entire sight in that eye; with reference to speech means total and irrecoverable loss of the entire ability to speak; with reference to hearing means total and irrecoverable loss of the entire ability to hear in that ear; with regard to thumb and index finger means actual and complete severance through or above the metacarpophalangeal joints of both digits.

### Naming a Beneficiary
You will be asked to name a beneficiary to receive benefits in case of your death. Please note you must make a separate beneficiary designation for the Basic Life and Accidental Death & Dismemberment Insurance.
Your beneficiary may be any person or persons, or your estate. This includes a religious organization, a favorite charity, or other nonprofit group. If you are divorced or legally separated, you may wish to consider revising your beneficiary designations.

You may change your beneficiary at any time by submitting your beneficiary designation on the ADP Benefits Enrollment System available through the Associate Portal. For questions, submit a case to Global HR Shared Services or call 877-237-4711.

If there is more than one beneficiary but the beneficiary designation does not specify their shares, they will share equally. If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries, unless the beneficiary designation states otherwise. Any amount of insurance for which there is no beneficiary at your death will be payable to the first of the following: Your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

## Definitions (applicable to BTA coverage only)
### Aggregate Limit
If more than one covered individual suffers a covered Injury as the result of the same accident, the total limit of liability under the Plan for all Losses cannot exceed $15 million. If the total amount payable exceeds $15 million, the benefit amount for each covered individual is made based on the proportionate share that this maximum amount bears to the total amount that would have been payable without this limitation.

### Basic Annual Earnings (BAE)
BAE means the annual equivalent of your periodic wage or salary on the date of the accident, including bonus payments and restricted stock options. For Sales Associates working at least 20 standard hours per week on a regular basis, this will also include your commissions based on the average for the 12 months prior to the date of the accident.

### Coverage
You are covered for business travel accident insurance while on a business trip. Business trip means travel, including personal deviations, which are authorized by or at the direction of ADP for the purpose of furthering the business of ADP. The business trip begins when you leave home or your regular place of employment, whichever last occurs, and continues until you return to your home or regular place of employment, whichever first occurs. Business Trip does not include a trip to a location that extends for more than 365 days. Such a trip will be deemed to change your residence or place of regular employment to that new location. Vacations, leaves of absence or travel to and from work are not covered.

The Plan also covers your immediate family for certain benefits if ADP requests that your family accompany you on a business trip or if you are asked to relocate with your family to another city or country. If you are accompanied by your spouse or eligible dependent child(ren) on relocation or business trip and the cost of the trip is paid for by ADP, then the maximum benefit for your spouse/domestic partner will be $100,000 and each child will be covered for $25,000.

### Injury
Injury means bodily injury (1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while your coverage under the Policy is in force; (2) which occurs under the circumstances described in the Policy applicable to you; and (3) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes you a covered loss under a Benefit applicable to you.

### Seat Belt and Air Bag Benefit

If an Accidental Death loss is payable under the Plan, the benefit amount payable to the insured person whose loss is the basis of the claim will be increased by an amount equal to the lesser of $25,000 or 10% of the insured person's benefit amount if, at the time of the accident the insured person was driving or riding in an automobile and wearing a properly fastened original, factory-installed seat belt.

In addition, an additional benefit is payable if a seat belt was worn and the insured person is positioned in a seat protected by a properly functioning original, factory-installed Supplemental Restraint System that inflates on impact. The additional amount payable is the lesser of $25,000 or 10% of the insured person's benefit amount.

Automobile is defined as a self-propelled private passenger motor vehicle with four or more wheels while is designed and licensed for use on highways of any state or country. It includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit. Supplemental Restraint System means an air bag, which inflated for added protection to the head and chest areas.

### Limitations

Business Travel Accident Benefits will not be paid for losses incurred as a result of:

- Suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or auto-eroticism
- Declared or undeclared war or an act of either occurring in the United States or the insured's country of permanent residence. The carrier reserves the right to exclude additional countries subject to ADP notification
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a passenger, pilot, operator or crew member, unless specifically provided by the policy.
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these
- Infections of any king regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accident cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes
- Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority

## Disclaimer

The foregoing summary/report/outline does not take the place of or alter any of the conditions, exclusions, and other terms of the insurance policy herein summarized. It is merely a short descriptive guide to the policies in force for convenient reference.

### Emergency Evacuation Benefit & Repatriation of Remains Benefit with Travel Assistance Services (AIG Travel Guard)

In addition to the above, the insurance company will pay for covered emergency evacuation expenses if the insured person suffers an injury or emergency sickness that warrants his/her/their emergency evacuation/repatriation while he/she is 100 or more miles from home. All arrangements must be handled by the assistance vendor and certified by the local attending physicians treating the insured for the injury/sickness. The maximum benefit for all emergency evacuations due to all injuries from the same accident or all emergency sicknesses from the same or related causes is $5 million.

- **AIG Assistance with Travel Insurance Coordination**
  Filling out paperwork in a foreign country can be confusing. AIG Travel Guard Services can help you complete insurance and medical claim forms. In addition, this service can help you verify your insurance coverage and guarantee payment to a medical provider based on the confirmation of your insurance benefits or your credit card.

- **Legal Assistance**
  If you need legal assistance, AIG Travel Guard can arrange help from local attorneys, embassies, and consulates. Bail, cash advances, or guarantee of payment for your legal services can be arranged through your financial resources. Also, AIG Travel Guard can keep a communication link between you, your family, and your employer.
- **Lost Baggage/Passport**
  Losing important baggage or documents is extremely inconvenient. AIG Travel Guard Services can provide immediate telephone advice to a traveler whose baggage has been lost or delayed by a carrier. This service also notifies the appropriate authorities of a traveler's lost passport and provides directions for replacement.
- **Pre-Departure Services**
  Pre-departure services can give you valuable information so there are no surprises after you leave home. You can get information on immunization requirements, appropriate medical exams and treatments, passport and visa requirements, weather, and travel hazards.
- **Travel Agency**
  This 24-hour service can replace your lost or stolen airline ticket by arranging payment through your credit card. Pre-paid tickets can be delivered by mail courier or collected at an airline counter. In addition, hotel reservations can be arranged.
- **Travel Medical Emergency Services**
  If a medical problem occurs, you may feel more comfortable knowing that someone is there to assist you.

This service can help you obtain local medical care, monitor the quality and cost of the hospital treatment, guarantee payment to the provider of medical services using your financial resources, and arrange the payment of non-insured medical expenses.

Moreover, AIG Travel Guard can maintain contact between local and personal physicians; arrange shipment of prescription drugs, medical equipment, and prescription lenses; provide your medical records; and maintain daily contact between patient, family, employer, and physicians.

## Your ERISA Rights

### General Information

ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Business Travel Accident Benefit Plan described.

### Plan Continuation

ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a Plan, you will receive notice.

### Plan Documents versus Guide

One of the primary purposes of the Summary Plan Description is to provide ADP associates with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans; contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, the actual legal document of the Plans will rule.

The named fiduciary for the Plan has the discretionary authority to determine eligibility under Plan terms, to interpret and apply the terms and provisions of the Plan, to resolve discrepancies and ambiguities, and to make final decisions on the appeal by a Plan participant of an initial claim denial. A decision made by the named fiduciary will be final and binding on all parties.

## Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may charge a reasonable fee for the copies
- 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. A copy of this report is distributed annually and is also available on the web site https://associateportal.adp.com/

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

## Denied Claims and the Appeals Process

Participants, their beneficiaries (if applicable) or any individual duly authorized by them have the right under ERISA to file a written claim for benefits with the Insurer.

If a claim is denied in whole or in part, the claimant will receive a written notice from the Insurer of the Insurer's decision, including the specific reason for the decision, within 90 days after the Insurer receives the claim. The written notice will include:

- The specific reason(s) for the denial
- Reference to the specific provisions, statutes or regulations on which the denial was based
- A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- Information about the steps to be taken if you, your dependent, or an authorized representative, wishes to submit the claim for review

If the Insurer needs more than 90 days to make a decision, a representative will notify you in writing within the initial 90-day period and explain why more time is required. An additional 90 days (for a total of 180 days) may be taken if the Insurer sends this notice. The extension notice will show the date by which the Insurer's decision will be sent.

If you submit your claim according to the procedures described in this section and you do not hear from the Insurer within the time limits given here, your claim is considered denied.

If a claim for benefits is denied in whole or in part, or if you or your dependents believe that benefits under the Plan to which you are entitled have not been provided, an appeal process is available to you. You, your dependents, or your authorized representative may appeal in writing within 60 days after the denial is received or the 90 (or 180) day period has expired.

## Appeal Procedures

A claimant can appeal a denied claim if no reply at all is received from the Insurer after 90 days:

- The Insurer has extended the response time by an additional 90 days and no reply is received within that time, or
- Written denial of the claim is received within the appropriate time frame and the claimant wants to appeal it

If you wish to file an appeal, you must do so in writing within 60 days of receiving notification of the Insurer's decision. You are entitled to request a copy and review the Plan document when you prepare your appeal. If you believe an error has occurred, you can support your request by giving the reason you think there is an error. Also, whenever possible, send copies of any documents or records that support your appeal. Whether or not you can provide such additional information, your claim will be reconsidered after your request is received. Send a written request for review of any denied claim directly to the Insurer.

The Insurer will conduct a review and make a final decision within 60 days after receiving the request for review.

If special circumstances cause the Insurer to need more than 60 days to make a determination, a representative will notify you in writing within the initial 60- day period and explain why more time is required. An additional 60 days (for a total of 120 days) may be taken if the Insurer sends this notice. The decision will be in writing and will specify the pertinent Plan provisions on which the decision is based.

If you submit your request for a written review according to the procedures described in this section and you do not hear from the Insurer within the time frame given here, your appeal is considered denied. Although this decision is final and is not subject to further review, you or your beneficiaries may have additional rights under ERISA. However, applicable law and the Plan's provisions require you to pursue your claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits.

The Claims Administrator will have full power to administer and interpret the Plan in all of its details, subject to applicable requirements of law. Benefits under the Plan shall be paid only if the Claims Administrator decides, in its discretion, that the applicant is entitled to them.

You may not file an action at law or in equity for benefits under the Plan until the administrative appeal rights described herein have been exercised and exhausted in full, and the Plan benefits requested in your appeal have been denied in whole or in part.

### Deadline for Filing Lawsuits

If the Claims Administrator or the Insurer denies your appeal, the Plan's decision to deny your claim will be final. When this occurs, you have exhausted your appeal rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a) (1) (B) of ERISA. **You have 90 days from the date of the notice denying your appeal in which to file a lawsuit. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim.**

### Administrative Details

The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

The following plan provides benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Business Travel Accident Plan is a participating plan in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. In the event of a conflict between the Plan document, the SPD and the insurance contract, the terms and provisions of the insurance contract will control. |
| Plan Administration & Claim Processing | ADP administers benefits in conjunction with National Union Fire Insurance Company of Pittsburgh, PA (an AIG Company)<br><br>P.O. Box 25987<br>Shawnee Mission, KS 66225<br>Telephone: 800-551-0824<br><br>Benefits are insured under National Union Fire Insurance Company of Pittsburgh, PA GTP9129187 |

| Plan Number | Plan 503 |
|---|---|
| | Requests for claim forms can be made to:<br>ADP Global Total Rewards Department<br>1 ADP Blvd.<br>Roseland, NJ 07068<br>or by calling Global HR Shared Services at 1-877-237-4711 |
| Plan Year<br>(for Fiscal and Other Records) | January 1 to December 31 |
| Plan Sponsor | Automatic Data Processing, Inc. |
| Source and Method of<br>Plan Financing | Corporate assets of ADP |
| Plan Administrator and Address | Automatic Data Processing, Inc.<br>One ADP Boulevard, M/S C237<br>Roseland, NJ 07068<br>Telephone: 973-974-5000<br>Identification Number: 22-1467904 |
| Agent for Service of Legal Process | ADP or where appropriate the insurance company or provider of service or the supervisory official of the insurance department of the state where you reside. |

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

**DOL Locations**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

# Personal Accident Insurance

Personal Accident Insurance ("PAI") provides benefits if you die or suffer a covered dismemberment as the result of a covered accident. Personal Accident Insurance can be elected at variable benefit amounts. Your payroll deduction amount will be deducted on a pre-tax basis based on the chart below. You may also choose Family coverage for your spouse/domestic partner and your eligible dependents.

**When is Coverage Effective?**
The coverage effective date depends on the timing of when you enroll. If you enroll within 31 days of your hire date, coverage is effective from your hire date. If you later enroll during Annual Enrollment, coverage will be effective for the January 1st following that Annual Enrollment period. For all other enrollments, coverage will be effective for the 1st day of the month following enrollment.

**Your Cost**

| Option | Amount of Coverage | Bi-Weekly Cost Associate Only | Bi-Weekly Cost Family |
|---|---|---|---|
| 1 | $25,000 | $0.09 | $0.13 |
| 2 | $50,000 | $0.18 | $0.26 |
| 3 | $100,000 | $0.36 | $0.52 |
| 4 | $200,000 | $0.72 | $1.04 |
| 5 | $300,000 | $1.09 | $1.56 |
| 6 | $400,000 | $1.45 | $2.08 |
| 7 | $500,000 | $1.82 | $2.60 |
| 8 | $1,000,000* | $3.64 | $5.21 |
| 9 | No Coverage | $0.00 | $0.00 |

## How the Plan Works

**Eligibility and Enrollment**
See Eligibility and Enrollment in the General Information Section.
You are required to enroll within 31 calendar days from your date of hire. PAI can be changed only during annual enrollment or due to a qualified life change.

## Coverage Options

**Associate Only Coverage**
This option allows you to purchase personal accident insurance in flat dollar amounts. That is, you may buy coverage in one of the following increments: $25,000, $50,000, $100,000, $200,000, $300,000, $400,000, $500,000 or $1,000,000.
*The $1,000,000 benefit option is subject to a maximum of ten (10) times your annual base pay or Benefit Earnings for Sales Associates. You may only elect the $1,000,000 benefit option if your base annual salary or your Benefit Earnings is greater than or equal to $100,000.

Your annual base pay includes any pre-tax contributions to other programs, but excludes overtime, bonuses and commissions.
Special rules apply for sales associates. Basic earnings for sales associates are called Benefit Earnings. Benefit Earnings for sales associates are determined in accordance with the sales benefit earnings formula as calculated by ADP.

Following is how Benefit Earnings is calculated:

- Sales benefit earnings will be determined by calculating benefit eligible earnings* (prior year W-2 earnings less non-benefit eligible earnings) multiplied by 80%

- Associates that have been in a sales position for less than one calendar year will have their benefit eligible earnings annualized and the greater of their base salary or 80% of their benefit eligible earnings will be used to determine their sales benefit earnings
- Associates that have been in a sales position for greater than one calendar year will have their sales benefit earnings calculated by taking the greater of their base salary or 80% of their benefit eligible earnings

*Excludes any car allowance, recruitment bonus, taxable relocation payment, stock options, carpool allowance, company car, sales lead adjustment, meals, sales vacations, and all other similar items included in earnings.

### Family Coverage

If you elect Personal Accident Insurance, you may also cover your eligible dependents as defined in the Eligibility and Enrollment section of this Summary Plan Description. If an associate and spouse/domestic partner are both eligible to enroll for coverage, only one but not both, may purchase the Family Coverage. If a person is covered as an associate and a dependent, the combined Principal Sum on that person cannot exceed $1,000,000.

### Benefit Amounts

Your benefit amount for Personal Accident Insurance is based on the amount of elected coverage. If you elect family coverage your dependents are covered for the following percentage of the benefit amount you elected:

| Coverage | Percent of Benefit |
|---|---|
| Spouse/DP only | 60% |
| Children only | The lesser of $200,000 or 20% for each child |
| Spouse/DP & Children | 50% spouse/domestic partner and the lesser of $200,000 or 15% for each child |

**Example:** Suppose you elected $50,000 of Personal Accident Insurance for yourself and you want to cover your spouse/domestic partner and children. Your spouse/domestic partner would be covered for $25,000 and your children would be covered for $7,500 each. If you have no dependent children, your spouse would be covered for $30,000. If you have dependent children and no spouse/domestic partner, each child would be covered for $10,000.

### Payment of Benefits for Covered Losses

Benefits will be paid if you or a covered dependent die as the result of a covered injury. The plan will also pay a benefit if you suffer certain dismembering injuries such as loss of limb, loss of hearing, sight or speech. Loss must occur within 365 days after the date of a covered injury to be eligible to receive benefits. If more than one loss occurs as the result of the same accident, the total payment for all losses cannot exceed 100% of the applicable benefit amount.

The maximum amount of Accidental Death and Dismemberment benefit paid for all losses resulting from injuries you receive in one accident will be one lump sum of the benefit amount that you elected multiplied by the percentage shown below for that loss:

| Accidental Loss | Percent of Benefit Paid |
|---|---|
| Life | 100% |
| Both hands or both feet | 100% |
| Entire sight of both eyes | 100% |
| One hand and one foot | 100% |
| One hand and the sight of one eye | 100% |
| One foot and the sight of one eye | 100% |
| Speech and hearing in both ears | 100% |
| One hand or one foot | 50% |
| Entire sight of one eye | 50% |
| Speech or hearing in both ears | 50% |
| Hearing in one ear | 25% |
| Thumb and index finger of same hand | 25% |

Loss with reference to hand and foot means complete severance through or above the wrist or ankle joint; with reference to eye, means total and irrecoverable loss of the entire sight in that eye; with reference to hearing means total and irrecoverable loss of the entire ability to hear in that ear; with reference to speech means total and irrecoverable loss of the entire ability to speak; with regard to thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. If more than one loss is sustained as a result of the same accident, only one benefit amount, the largest, will be paid.

Injury means bodily injury which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's coverage under the policy is in force, and which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

### Additional Dependent Child Accidental Dismemberment & Paralysis Benefit

If a covered dependent child suffers a covered accidental dismemberment or paralysis loss due to a covered injury, they are eligible for an additional 100% payment of the benefit amount issued under the policy for the accidental dismemberment or paralysis, subject to a maximum benefit of $200,000. This is payable for only one of the above listed payable benefits suffered in the covered accident. If more than one loss occurs as a result of the same accident, the benefit will be based on the largest amount payable for all injuries suffered, up to the maximum benefit amount listed.

### Naming a Beneficiary

The beneficiary for your covered family members is you, the associate. You will be asked to name a beneficiary to receive benefits in case of your death. Please note you must make a separate beneficiary designation for the Basic Life and Accidental Death & Dismemberment Insurance. Your beneficiary may be any person or persons, or your estate. This includes a religious organization, a favorite charity, or other nonprofit group. If you are divorced or legally separated, you may wish to consider revising your beneficiary designations.

You may change your beneficiary at any time by submitting your beneficiary designation on the ADP Benefits Enrollment System available through the Associate Portal. For questions, submit a case to Global HR Shared Services or call 877-237-4711.

If there is more than one beneficiary but the beneficiary designation does not specify their shares, they will share equally. If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries unless the beneficiary designation states otherwise. Any amount of insurance for which there is no beneficiary at your death will be payable to the first of the following: Your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

## Additional Features

### Exposure and Disappearance

If you are unavoidably exposed to the elements and suffer a covered loss as the result of a covered injury, the full benefit applicable will be paid. If you are not found within one year of the disappearance, sinking or wrecking of a conveyance in which you were riding at the time of an accident, death will be presumed from injury caused by the accident and the full benefit applicable will be paid.

### Paralysis Benefit

In addition, the Plan will pay a Paralysis Benefit if a covered injury to the spinal cord results in one of the following types of paralysis within 365 days after the date of the accident:

| Paralysis | Percent of Benefit Amount |
|---|---|
| Quadriplegia (total paralysis of all four limbs) | 100% |
| Paraplegia (total paralysis of both lower limbs) | 100% |
| Hemiplegia (total paralysis of the upper and lower limbs of the same side of the body) | 100% |
| Uniplegia (total paralysis of one limb) | 25% |

In no event will the Paralysis Benefit plus any Accidental Death or Dismemberment benefit exceed your selected benefit amount. Paralysis must be determined by competent medical authority to be permanent, complete, and irreversible. If more than one type of Paralysis is sustained as a result of the same accident, only one benefit amount, the largest, will be paid.

### Common Disaster Benefit

If you elect Family coverage and you and your spouse/domestic partner die due to covered injuries caused by the same accident (or separate accidents which occur within 24 hours of each other), the plan will increase the benefit amount for your spouse/domestic partner to equal that of yours, provided you both suffer loss of life within 90 days of the accident.

### Seat Belt and Air Bag Benefit

If an Accidental Death loss is payable under the plan, your benefit amount will be increased by an amount equal to the lesser of $50,000 or 10% of your selected benefit amount, if at the time of the accident, the insured person was:

- Driving or riding as a passenger in an automobile and was wearing a properly fastened seat belt
- In addition, an additional benefit is payable if a seat belt was worn and you are positioned in a seat protected by a properly functioning Supplemental Restraint System that inflates on impact. The additional amount payable is the lesser of $50,000 or 10% of your selected benefit amounts.

As part of the written proof of loss, the insurance company will require both items below be part of an official report of the accident or be certified, in writing, by the investigating officer(s):

1. Verification of the actual use of the seat belt, at the time of the accident
2. Verification that the Supplemental Restraint System inflated properly upon impact

- ***Automobile*** means a self-propelled private passenger motor vehicle with four or more wheels which is designed and licensed for use on highways of any state or country. It includes, but is not limited to, a sedan, station wagon or jeep-type vehicle and, if not used primarily for occupational, professional or business purposes, a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit
- ***Supplemental Restraint System*** means an air bag which inflates for added protection to the head and chest areas

### Carjacking Benefit

Your benefit amount will be increased by an amount equal to $25,000 if you suffer an accidental death, dismemberment, coma or paralysis and for which benefits are payable as a result of a Carjacking of an Automobile while you are operating or riding as a passenger. Verification of the Carjacking must be part of an official report of the Carjacking or be certified in writing by the investigating officer. Only one benefit is payable for all losses as a result of the same Carjacking.

Carjacking means taking unlawful possession of an Automobile by means of force or threats against the person then rightfully occupying such Automobile. Automobile definition is as above.

### Felonious Assault Benefit

If you or a covered family member suffers loss of life, or accidental dismemberment, or paralysis, or a coma due to a covered injury sustained as a result of a Felonious Assault the benefit amount payable under the Plan will be increased by 25% of your selected benefit amount. The incident causing the Felonious Assault must either be directed towards Automatic Data Processing, its property or assets, or occur while you, or your covered family member, are acting on behalf of Automatic Data Processing as a representative. Only one benefit is payable for all losses resulting from the same Felonious Assault.

### Home Alteration & Vehicle Modification Benefit

If you or a covered family member suffer an accidental dismemberment or Paralysis which is payable and did not, prior to the date of the accident, require the use of a wheelchair to be ambulatory and as a direct result of such covered loss are now required to use a wheelchair to be ambulatory, up to $50,000 will be paid for the following:

- Alterations to your residence that are necessary to make the residence accessible and habitable for a wheelchair-confined person; or modifications to a motor vehicle owned or leased by you or modifications to a motor vehicle newly purchased for you that are necessary to make the vehicle accessible to and/or drivable by you and
- Do not include charges that would not have been made if no insurance existed and
- Do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred

These alterations must be made on your behalf; recommended by a nationally recognized organization providing support and assistance to wheelchair users; carried out by individuals experienced in these alterations and modifications and in compliance with any applicable laws or requirements for approval by the appropriate government authorities. Expenses incurred for or resulting from any condition for which you are entitled to benefits under any Workers' Compensation Act or similar law are not covered.

### Psychological Therapy Benefit

If you or a covered family member suffer a covered injury from an accident that results in accidental dismemberment and a benefit is payable under the policy, an additional benefit equal to the lesser of $50,000 or 10% of your selected benefit amount is payable for Covered Psychological Therapy Expenses, the expenses must be incurred within one year after the date of the accident causing the injury and does not include any expenses for or resulting from an injury for which you are entitled to receive benefits paid or payable by Workers' Compensation or other similar law.

Covered Psychological Therapy Expenses means an expense that: (1) is charged for a medically necessary psychological therapy session for you provided under the care or supervision of a physician; (2) does not exceed the usual level of charges for similar therapy sessions in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed. The therapy session means any individual, joint or family mental health counseling session that is essential to assist you in coping with the accidental dismemberment and meets generally accepted standards of medical practice and is ordered by a physician.

### Coma Benefit

If you or a covered family member suffers a covered injury resulting in a coma, a monthly benefit will be paid if the coma occurs within 365 days of the accident, continues for 30 consecutive days and is determined by a Physician.

The Coma Benefit is equal to 2% of your benefit amount and is payable monthly. Payment begins with the 31st consecutive day that you or a covered family member remains in a coma and ceases on the earliest of the following dates, provided such a coma continues, (1) when you cease to be comatose due to that injury; (2) upon the death of the person in a coma; (3) when 100% of the applicable benefit amount is reached (after 11 months the remaining benefit to equal 100% will be paid) for you or a covered family member whose injury is the basis for the claim.

Coma means a profound state of unconsciousness from which you cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.

### Day Care Benefit under the Family Plan

In the event of your covered death, an additional benefit is payable for all eligible dependent children under age 13 who are enrolled in a Day Care Center on the date of your death or enroll in a Day Care Center within 365 days after the day of your death. The additional benefit is 5% of your selected benefit amount to a maximum of $15,000 per child per year (not to exceed the actual cost charged by the Day Care Center for that year), for up to four years or the date the child reaches age 13, whichever is earlier. Day Care Center means a facility that is duly licensed, certified or accredited by the jurisdiction in which it is located to provide childcare and is operating in compliance with applicable laws and regulations of the jurisdiction.

### Dependent Child Tuition under the Family Plan

In the event of your covered accidental death, an additional benefit is payable for all insured dependent children that are at the 12th grade level and plan to enroll in college within 365 days of your death or are already in college and enrolled as a full-time student. The additional benefit is 5% of your selected benefit amount to a maximum of $20,000 per child per year of continuous enrollment, (not to exceed the cost of the actual tuition for enrollment that year), for up to four consecutive years. This benefit will pay for the actual tuition (exclusive of room and board) charged by the institution to the maximum limits outlined above.

### Spouse/Domestic Partner Tuition Benefit under the Family Plan

Provides an additional benefit to or on behalf of any spouse/domestic partner who was insured on the date of the accident causing your death and who needs to obtain an independent source of support or enrich his/her/their ability to earn a living and who is enrolled on the date of your death or subsequently enrolls within 30 months after the date of your death in an institution of higher learning or professional or trade training program. The additional benefit is 5% of your selected benefit amount to a maximum of $20,000 per person per year of continuous enrollment, (not to exceed the cost of the actual tuition for enrollment that year), for up to four consecutive years. This benefit will pay for the actual tuition (exclusive of room and board) charged by the institution to the maximum limits outlined above.

### Travel Assistance Services (AIG Benefits Travel Assist)

Provides travel assistance for all employees and eligible dependents while traveling on either business or pleasure trips 100 or more miles away from home. Travel assistance is available 24 hours a day, 7 days per week and provides:

- Concierge Services which include:
  - Event ticketing
  - Ground transportation coordination
  - Golf tee times reservations
  - Restaurant referrals & reservations
- Emergency Message Service
- Emergency Telephone Interpretation Assistance
- Emergency Translation Service
- Emergency Travel Agency Services
- Legal Referral Assistance
- Medication Shipment/Lost Document Assistance
- Pre-Trip Assistance

### Emergency Evacuation Benefit & Repatriation of Remains Benefit

In addition to the above, the insurance company will pay for covered emergency evacuation expenses if the insured person suffers an injury or emergency sickness that warrants his/her/their emergency evacuation/repatriation while he/she is 100 or more miles from home. All arrangements must be handled by the assistance vendor and certified by the local attending physicians treating the insured for the injury/sickness.

### Family Travel Benefit

Following an emergency evacuation eligible for a benefit, the insurance company will pay for expenses reasonably incurred:

- To return to their current primary residence, with an attendant, if necessary, any of the insured person's children who were accompanying the insured person when the injury or emergency sickness occurred; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per child; and
- To bring one person chosen by the insured person to and from the hospital or other medical facility where the insured person is confined if the insured person is alone and if the place of confinement is outside a 100-mile radius from the insured person's place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket.

To contact AIG Benefits Travel Assist, call 877-244-6871 (in US or Canada) or call collect 715-346-0859 (when calling from outside the US or Canada).

## Claiming Benefits

To file a claim for benefits, you or your beneficiary should notify a Global HR Shared Services representative to begin the claim process and to obtain claim forms. You or your beneficiary must complete a claim form before benefits can be paid.

### How to Claim Personal Accident Benefits

Written notice of claim must be given to AIG within 20 days after any loss covered by this Plan. If notice cannot be given at that time, it must be given as soon as reasonably possible. The notice will be sufficient if it identifies the Covered Person and ADP as the Plan Holder. It must be sent to AIG., A&H Claims Department, P.O. Box 25987, Shawnee Mission, KS 66225.

After AIG receives the written notice of claim, they will furnish claim forms within 15 days. Written proof of loss must be given to AIG within 90 days after the date of loss. Benefits payable under this Plan will be paid immediately after the written proof of loss is provided.

### Losses the Plan Does Not Cover

The plan does not cover losses caused by, or that result from:

- Being under the influence of any narcotic unless administered or consumed on the advice of a Physician
- Declared or undeclared war, or any act of declared or undeclared war
- Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the insured person is not covered due to his or her active-duty status will be refunded. Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are performing (learning to perform or instructing others to perform), as a pilot or crew member, of if you are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes
- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury or auto-eroticism

### How to Appeal a Claim Denial

See the section "Your ERISA Rights" for details.

### When Your Coverage Terminates

Your insurance ends on the earliest of the following dates:

- Your employment ends
- You are no longer an eligible employee
- You withdraw from the Plan
- Your coverage is terminated due to nonpayment of required contributions, or
- The Plan terminates

An insured dependent's coverage under the Policy ends on the earliest of:

- the date the Insured's coverage under the Policy ends;
- the premium due date, if premiums for the insured dependent are not paid when due;
- the date the insured requests, in writing, that coverage for the insured dependent be terminated; or
- the date the insured dependent ceases to be a member of any eligible class of persons.

### Continuation of Medical Coverage Funding Benefit Provision:

This benefit is payable if you suffer a covered accidental death and your eligible family members are covered on the date of the accident, you had dependent group medical and/or dental coverage in effect under a group medical and/or dental plan provided through ADP, and within 60 days after your death, your eligible covered family members elect to continue the coverage. In that situation, the following benefit will also be payable.

The Plan will pay a benefit for continuation of medical coverage for your covered family members. This benefit will be paid in three equal annual payments. Each payment will equal the least of:

a) 3% of your benefit amount under Personal Accident Insurance or
b) $3,000 or
c) the actual cost of the premium charged and paid for the continued medical and/or dental coverage for those insured dependents for that year.

However, the applicable portion of the yearly benefit for each period of coverage is payable upon receipt of due proof of enrollment for that period of coverage but not more frequently than monthly.

This benefit is not payable for any period of coverage under the ADP group medical and/or dental plan before the date of your death. This benefit is not payable for any period of time after the earliest of:

- The date ADP ceases to make available the group medical and/or dental plan under which the insured dependents continue coverage
- If that insured dependent becomes covered under any other group medical and/or dental plan without a pre-existing condition limitation, the date coverage begins
- If the insured dependent becomes covered under any other group medical and/or dental plan with a pre-existing condition limitation, the date that limitation no longer applies
- The date that insured dependent becomes eligible for Medicare
- The date the insured spouse remarries (in which case this benefit ends for all insured dependents)
- The date the insured dependent otherwise ceases to be a member of an eligible class of persons
- The date the continued coverage under ADP's group Medical and/or Dental Plan terminated with respect to that insured dependent

### Conversion of Personal Accident Insurance

If coverage terminates for any reason other than nonpayment of premium, you and your covered family members may purchase a personal accident conversion policy. However, an insured dependent may convert only if he or she is the age of majority or over on the date coverage ends.

The conversion coverage will be issued without evidence of insurability subject to the following conditions:

- Written application and the first premium must be sent to the Insurance Company within 31 days after termination of coverage under this Plan
- The amount of insurance will not exceed that amount in force under this Plan before termination subject, however, to a minimum of $100,000 and a maximum of $500,000
- The conversion coverage will be at the premium rate on the form then being made available to the Plan for conversion
- Once you have terminated, you can convert your coverage into an individual policy by completing the Personal Accident Conversion application within 31 days of your termination. Call the AIG conversion center at 800-421-3005
- The effective date will be the later of the date the application and required premium payment are received by the Insurance Company or the date that the insurance under this Plan ceases

Conversion is not available if ADP provides access to similar coverage within 31 days after termination of coverage under this Plan. Please note that the Personal Accident Conversion policy provides for accidental death and dismemberment benefits only.

This is a brief description of the coverage(s) available under policy series C11656(REV 3-99) DBG-NJ. The Policy contains reductions, limitations, exclusions, and termination provisions. Full details of the coverage are contained in the Policy. If there are any conflicts between this document and the Policy, the Policy shall govern. Insurance underwritten by National Union Fire Insurance Company of Pittsburgh, Pa., a Pennsylvania insurance company, with its principal place of business at 175 Water Street, 15th Floor, New York, NY 10038. It is currently authorized to transact business in all states and the District of Columbia. NAIC No. 19445.

## Your ERISA Rights

### General Information

ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Personal Accident Insurance benefit plan.

### Plan Continuation

ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a Plan, you will receive notice.

### Plan Documents versus Guide

One of the primary purposes of the Summary Plan Description is to provide ADP associates with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these Plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans and contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, the actual legal document of the Plans will rule.

The named fiduciary for the Plan has the discretionary authority to determine eligibility under Plan terms, to interpret and apply the terms and provisions of the Plan, to resolve discrepancies and ambiguities, and to make final decisions on the appeal by a Plan participant of an initial claim denial. A decision made by the named fiduciary will be final and binding on all parties.

### Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may charge a reasonable fee for the copies
- 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. A copy of this report is distributed annually and is also available on the web site **https://associateportal.adp.com/**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

## Denied Claims and the Appeals Process

Participants, their beneficiaries (if applicable) or any individual duly authorized by them have the right under ERISA to file a written claim for benefits with the Insurer.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. If a claim is denied in whole or in part, the claimant will receive a written notice from the Insurer of the Insurer's decision, including the specific reason for the decision, within 90 days after the Insurer receives the claim. The written notice will include:

- The specific reason(s) for the denial
- Reference to the specific provisions, statutes or regulations on which the denial was based
- A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- Information about the steps to be taken if you, your dependent, or an authorized representative, wishes to submit the claim for review

If the Insurer needs more than 90 days to make a decision, a representative will notify you in writing within the initial 90-day period and explain why more time is required. An additional 90 days (for a total of 180 days) may be taken if the Insurer sends this notice. The extension notice will show the date by which the Insurer's decision will be sent.

If you submit your claim according to the procedures described in this section and you do not hear from the Insurer within the time limits given here, your claim is considered denied.

If a claim for benefits is denied in whole or in part, or if you or your dependents believe that benefits under the Plan to which you are entitled have not been provided, an appeal process is available to you. You, your dependents, or your authorized representative may appeal in writing within 60 days after the denial is received or the 90 (or 180) day period has expired.

## Appeal Procedures

A claimant can appeal a denied claim if:

- No reply at all is received from the Insurer after 90 days
- The Insurer has extended the response time by an additional 90 days and no reply is received within that time
- Written denial of the claim is received within the appropriate time frame and the claimant wants to appeal it

If you wish to file an appeal, you must do so in writing within 60 days of receiving notification of the Insurer's decision. You are entitled to request a copy and review the Plan document when you prepare your appeal. If you believe an error has occurred, you can support your request by giving the reason you think there is an error. Also, whenever possible, send copies of any documents or records that support your appeal. Whether or not you can provide such additional information, your claim will be reconsidered after your request is received. Send a written request for review of any denied claim directly to the Insurer.

The Insurer will conduct a review and make a final decision within 60 days after receiving the request for review. If special circumstances cause the Insurer to need more than 60 days to make a determination, a representative will notify you in writing within the initial 60-day period and explain why more time is required. An additional 60 days (for a total of 120 days) may be taken if the Insurer sends this notice.

The decision will be in writing and will specify the pertinent Plan provisions on which the decision is based.

If you submit your request for a written review according to the procedures described in this section and you do not hear from the Insurer within the time frame given here, your appeal is considered denied.

Although this decision is final and is not subject to further review, you or your beneficiaries may have additional rights under ERISA. However, applicable law and the Plan's provisions require you to pursue your claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits.

The Insurer will have full power to administer and interpret the Plan in all of its details, subject to applicable requirements of law. Benefits under the Plan shall be paid only if the Insurer decides, in its discretion, that the applicant is entitled to them.

You may not file an action at law or in equity for benefits under the Plan until the administrative appeal rights described herein have been exercised and exhausted in full, and the Plan benefits requested in your appeal have been denied in whole or in part.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's appeal procedures.

**Deadline for Filing Lawsuits**
If the Insurer denies your appeal, the Plan's decision to deny your claim will be final. When this occurs, you have exhausted your appeal rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a)(1)(B) of ERISA. **You have 90 days from the date of the notice denying your appeal in which to file a lawsuit. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim.**

**Administrative Details**
The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

The following plan provides benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Personal Accident Insurance is a participating plan in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. In the event of a conflict between the Plan document, the SPD and the insurance contract, the terms and provisions of the insurance contract will control. |
| Plan Administration &<br>Claim Processing | ADP administers benefits in conjunction with National Union Fire Insurance Company of Pittsburgh, PA (NUFIC) No. 19445 (a member company of AIG) Group Policy PAI 9125478.<br>National Union Fire Insurance Company of<br>Pittsburgh, PA<br>Telephone #: 800-551-0824<br><br>Requests for claim forms can be made to:<br>ADP Global Total Rewards Department<br>One ADP Blvd., M/S C237<br>Roseland, NJ 07068<br>or by calling Global HR Shared Services at1-877-237-4711 |
| Plan Year<br>(for Fiscal and Other Records) | January 1 to December 31 |
| Plan Sponsor | Automatic Data Processing, Inc. |
| Source and Method of<br>Plan Financing | The plan is funded through associate-paid premiums. There are no employer contributions to the plan. |

| Plan Number | Plan 503 |
|---|---|
| Plan Administrator and Address | Automatic Data Processing, Inc.<br>One ADP Boulevard, M/S C237<br>Roseland, New Jersey 07068<br>Telephone: 973-974-5000<br>Identification #: 22-1467904 |
| Agent for Service of Legal Process | Where appropriate, the insurance company or provider of service or the supervisory official of the insurance department of the state where you reside. |

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

**DOL Locations**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

# Employee Assistance Program

The LifeCare Work-Life Employee Assistance Program (EAP) is designed to help participants by providing **confidential counseling** services in such areas as:

- Emotional Health
  - Anxiety and depression
  - Domestic violence
  - Grief
  - Marital or relationship difficulties
  - Stress management
  - Substance use disorder
- Financial and Legal Concerns
  - Insurance
  - Legal and personal finance
  - Retirement planning
  - Discounts, articles and tools on LifeCare.com
- Parenting, Child Care and Education
  - Adoption and prenatal care
  - Child care and education services
  - Child development and special needs
  - Discounts on child care tuition
  - Homework Connection
- Senior Caregiving Services
  - Care options and living arrangements
  - Home meal delivery programs
  - Hospice
  - Medicare, Medicaid and Social Security
  - Transportation services
- Wellness and Daily Living
  - Automotive services
  - Diet and fitness
  - Moving, utilities and other home services
  - Personal event planning
  - Pet care
  - Safety
  - Travel

## Eligibility and Enrollment

All full and part-time U.S. associates employed by ADP (and their dependents and household members) regardless of whether the associate is enrolled in the ADP Medical Plan or any other ADP benefit plans are eligible for benefits under the EAP. Senior care services that fall under the work/life benefit can also be used for loved ones living outside of the household including those that live in another area.

## Definitions

**Participant** - The term "Participant" means U.S. associates and their dependents and household members. Dependents are defined as an associate's spouse or qualified domestic partner, dependent children, including dependent step or foster children, and dependent children away at school up until the end of the month in which they turn 26 years old.

**Medical Plan** - The term "Medical Plan" means the ADP specific medical plan based on associate's elections, as amended from time to time.

## 24-Hour Hotline

All participants have access to the EAP and will receive a summary of EAP services, which includes information on accessing an EAP counselor. To reach the EAP, 24 hours a day, seven days a week, please call toll-free 1-866-608-8368 (1-800-873-1322 TTY).

To access the LifeCare website, you can go to the Associate Portal. First time users will need to register. You can also go to http://member.lifecare.com. Registration code: ADPLIFECARE.

## Eligible Services

The EAP counselor will provide the following services under the Plan:

- Assistance will be provided to participants requesting EAP help through initial interviews with an EAP counselor who will assess the issues and recommend a plan of action to the individual.
- The EAP provides up to eight (8) free face to face or telephonic counseling sessions per issue per Plan year to participants.
- Supported by a network of more than 5,000 highly skilled, licensed therapists and psychiatric providers across all 50 states and backed by over 25 published research studies, Talkspace provides quicker access to high-quality mental health care. The service offers a personalized mental health benefit tailored to participants' specific needs.
- Where, after one or more counseling sessions, the EAP counselor determines the participant will need more extensive counseling, the EAP will advise a participant, who is enrolled in the ADP Medical Plan to follow through with a mental health or substance abuse provider under the terms of the ADP Medical Plan coverage option in which the participant is enrolled. If the participant is not enrolled in the ADP Medical Plan, the EAP will advise the participant to inquire into appropriate services under any other medical coverage the participant may have. In the event, a participant elects to continue counseling through an EAP referral; the household member will be responsible for the full cost of the referral counselor after the first eight (8) sessions.

### On-Demand Tutoring

On-Demand Tutoring offers on-demand access to professional tutors at no cost to you. Tutors can assist in all core subject areas grades K-12 and college level. Associates receive up to 5 hours of free tutoring per month per household.

## Your ERISA Rights

### General Information

ADP believes in open communication with its associates in fair and equitable treatment concerning employment and compensation. In addition, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections if you participate in the Employee Assistance Plan.

### Plan Continuation

ADP intends to continue the plans indefinitely but reserves the right to amend or discontinue one or all of the plans with respect to all associates or specific classes of associates, at any time and for any reason. Any amendment or termination of a plan will be made by the Board of Directors of the Company, or by a person or persons designated by the Board of Directors. If you are affected by an amendment or termination of a Plan, you will receive notice.

### Plan Documents versus Guide

One of the primary purposes of the Summary Plan Description is to provide ADP associates with a clear concise description of their benefits. ADP wants its associates to know the benefits and programs that are available to them, to understand the coverage, and to have information concerning these plans.

The full text of the plans is contained in legal documents. Plan documents govern the administration of our benefit plans and contain more detailed information in explicit legal text. These documents are on file in the Global Total Rewards Department. If a question should arise concerning the nature of these benefits, the actual legal document of the plans will rule.

The named fiduciary for the Plan has the discretionary authority to determine eligibility under Plan terms, to interpret and apply the terms and provisions of the Plan, to resolve discrepancies and ambiguities, and to make final decisions on the appeal by a Plan participant of an initial claim denial. A decision made by the named fiduciary will be final and binding on all parties.

### Statement of ERISA Rights

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

- 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. A copy of this report is distributed annually and is also available on the web site https://associateportal.adp.com/
- Examine, without charge, at the Plan Administrator's office or at the office of your employer, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may charge a reasonable fee for the copies

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

No one, including ADP, your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

### Filing Health Claims Under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Beacon Health Options. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

### Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision no later than 72 hours after the claim is received.

“A claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the
ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

### Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision no later than 15 days after receipt of the pre-service claim. For other claims (post-service claims), you will be notified of the decision no later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days
(within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

### Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

### Filing an Appeal of an Adverse Benefit Determination

You may file an appeal in writing to LifeCare. The appeal should be sent to:

Employee Assistance Program
151 Farmington Ave, Appeals 1250
Hartford, CT 06156
Mail Code: RSAA
Phone 1-855-812-9333

### LifeCare

If your appeal is of an urgent nature, you may call LifeCare at 1-866-608-8368. Your request should include the group name (that is, your employer), your name, Social Security number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Your appeal will be acknowledged within five working days of receipt. A LifeCare representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to LifeCare. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to 1-866-608-8368. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision no later than 36 hours after the appeal is received.

The Claims Administrator will have full power to administer and interpret the Plan in all of its details, subject to applicable requirements of law. Benefits under the Plan shall be paid only if the Claims Administrator decides, in its discretion, that the applicant is entitled to them.

You may not file an action at law or in equity for benefits under the Plan until the administrative appeal rights described herein have been exercised and exhausted in full, and the Plan benefits requested in your appeal have been denied in whole or in part.

### Deadline for Filing Lawsuits

If the Claims Administrator denies your appeal, the Plan's decision to deny your claim will be final. When this occurs, you have exhausted your appeal rights and, if you still disagree with the denial, you have the right to file a lawsuit under Section 502(a) (1) (B) of ERISA. **You have 90 days from the date of the notice denying your appeal in which to file a lawsuit. If you do not file a lawsuit within this 90-day period, you will have no further right to contest the denial of your claim.**

### Administrative Details

The information furnished in this guide constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also being furnished.

The following plans provide benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates (ADP).

| Plan Number | Plan 503 |
|---|---|
| Plan Name and Coverage | The Employee Assistance Plan is a participating plan in the Automatic Data Processing, Inc. Flex 2000 Plan, a consolidated welfare benefits program. |
| Claims Administration | LifeCare<br>1-866-608-8368<br>www.lifecare.com |
| Plan Administration | ADP administers benefits in conjunction with its agreement with LifeCare |
| Plan Year (for Fiscal and Other Records) | January 1 through December 31 |
| Plan Sponsor | Automatic Data Processing, Inc. |
| Source and Method of Plan Financing | Corporate assets of ADP |
| Plan Administrator and Address | Automatic Data Processing, Inc.<br>One ADP Boulevard, M/S C237<br>Roseland, NJ 07068<br>Telephone: 973-974-5000<br>Identification Number 22-1467904 |
| Agent for Services of Legal Process | ADP or where appropriate the insurance company or provider of service or the supervisory official of the insurance department of the state where you reside. |

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

### DOL Locations

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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 contacting the Employee Benefits Security Administration toll free at 1-866-444-3272 or online at www.dol.gov/ebsa.

# Retirement and Savings Plan (401(k) Plan)

## 401(k) Plan Overview

The Automatic Data Processing, Inc. Retirement and Savings Plan (the "401(k) Plan" or the "Plan") is sponsored by Automatic Data Processing, Inc. (the "Company" or "ADP"). The 401(k) Plan may be an important way to help you[1] achieve your[1] financial goals. The Plan reflects ADP's commitment to help you reach your long-term goals and build a bright future. The Plan is intended to be a qualified retirement plan under the Internal Revenue Code of 1986, as amended ("Internal Revenue Code"), and in compliance with the requirements of the Employee Retirement Income .Security Act of 1974, as amended ("ERISA"). The Plan is a profit-sharing plan, which provides for 401(k) Plan salary reduction Before-Tax Contributions, Roth Contributions, and After-Tax Contributions by associates, and Matching Contributions by the Company. The Plan is administered by the ADP 401(k) Plan Committee (the "Committee").

Your decision to contribute to the 401(k) Plan is completely voluntary. However, new ADP associates will be automatically enrolled in the Plan if no active election is made within your initial 60-day period of employment. If you do not want to participate, you must opt out of the Plan before the 60-day period ends. Any funds that are deposited into the Plan via payroll deductions cannot be refunded. Generally, a distribution is only available upon termination of employment.

The Plan gives you the flexibility to invest in several different investment funds. Each investment fund has a specific investment objective, level of risk, and potential return. You have the choice to change the amount you contribute and adjust how your contributions are invested at any time by calling 1-877-401-5237 or the Plan website at www.401kadp.com.

This document constitutes the Summary Plan Description ("SPD") called for by ERISA. This SPD is an overview of the Plan document including amendments made through December 10, 2024. This SPD advises Plan participants of their rights and obligations under the Plan, but it does not contain every detail of the Plan. A more detailed explanation of the Plan terms is provided in the Plan document. While every attempt has been made to ensure that the information in this document is accurate, the Plan is governed by the Plan document. If there is any discrepancy between this SPD and the official Plan document, the Plan document controls. You can request a copy of the Plan document or additional information about the Plan by sending a request to Automatic Data Processing, Inc., One ADP Boulevard, Roseland, NJ 07068, Attention: ADP 401(k) Plan Committee, Telephone: 1-973-974-5000.

Nothing contained in this SPD creates or is intended to create a contract of employment between any associate and the Company. Nothing in the Plan or this SPD gives any person the right to be employed by the Company nor does it interfere with the Company's right to discharge an associate at any time.

[1] The terms "you" and "your" as used in this Summary Plan Description refer to a Company associate who meets all the Plan's eligibility and participation requirements. Receipt of this Summary Plan Description does not guarantee that the recipient is in fact a participant under the Plan and/or otherwise eligible for benefits under the Plan.

## Your 401(k) Plan Account Highlights

### Contributions

You can choose whether you want your contributions to be Before-Tax Contributions, Roth Contributions, or After-Tax Contributions or, if you wish, to divide your contributions among the three types of contributions. Before-Tax Contributions, Roth Contributions, and After-Tax Contributions will be deposited into separate subaccounts. Any Before-Tax Contributions will be deposited into your Before-Tax Contribution account. Any Roth Contributions will be deposited into your Roth Contribution account while any After-Tax Contributions will be deposited into your After-Tax Contribution account.

You can contribute between 1% and 50% of your pay in combined Before-Tax and Roth Contributions to the Plan each pay period. However, your combined Before-Tax and Roth contributions will be limited to 12% of your pay if you are a Highly Compensated Employee (as defined by the Internal Revenue Code).

If your earnings from ADP were more than $160,000 in 2025, you will be considered a Highly Compensated Employee in 2026. In addition, your After-Tax Contribution election can be between 1% and 99% of your eligible pay each pay period.

ADP will make a Matching Contribution to the Plan on your behalf, subject to the terms and conditions of the Plan. Before-Tax, Roth and After-Tax contributions are eligible for the Matching Contribution. The Matching Contribution is $1.00 for every dollar you contribute to the Plan, up to 6% of your pay.

For purposes of computing your Matching Contribution for 2025, your pay is limited to $350,000. The Company does not match contributions you make during the first 6 months of employment. This means that Matching Contributions will not be made before the first of the month coincident with or next following the six-month anniversary of your hire date.

The Matching Contribution will be deposited into your Matching Contribution account each pay period. All participants must contribute at least 6% each pay period to receive the maximum Matching Contribution. You must be employed on the last day of the plan year (December 31st) to retain the Matching Contribution for the year. However, if you terminate your employment during the Plan year and have attained age 55 and completed 5 years of vesting service, you will retain any Matching Contribution you earned during the Plan year.

You can roll over amounts from other qualified retirement plans or Individual Retirement Accounts (IRAs) into the Plan. Certain requirements must be satisfied for amounts to qualify as a Rollover Contribution. Rollover Contributions will be deposited into your Rollover Contribution account, which is a separate subaccount under the Plan. Rollover Contributions are not eligible for Matching Contributions.

### Investing in the 401(k) Plan

You may choose to invest the balance of your accounts in any of the investment funds available under the Plan. The Trustee (as defined in the Plan), in accordance with the Plan terms, is responsible for selecting the investment funds.

Each investment fund offered under the Plan has a specific investment objective, level of risk and potential return. You decide which investment funds to invest in based on your personal financial goals.

In the event you do not direct the investment of your accounts, your accounts will be invested in a qualified default investment alternative. The qualified default investment alternative under the Plan is the appropriate JPMCB SmartRetirement Passive Blend Fund (the "Target Fund") based on your age, which satisfies the requirements of a "target retirement date" qualified default investment alternative set forth in the Department of Labor regulations. The Target Fund is generally designed for investors who plan to retire close to the year indicated in the Target Fund's name. The Plan offers Target Funds with various target retirement dates. A brief description of the Target Fund's investment objectives and other information can be obtained in the Benefits Section of the ADP Associate Portal or the Plan website at www.401kadp.com. You may elect to transfer your accounts out of the qualified default investment alternative in accordance with rules and procedures adopted by the Committee. You will be notified if the Plan's qualified default investment alternative changes.

ERISA imposes certain duties on the parties who are responsible for the operation of the Plan. These parties, called fiduciaries, have a duty to invest Plan assets in a prudent manner. However, an exception exists for plans that comply with ERISA Section 404(c) and permit participants to exercise control over the assets in their accounts and choose from a broad range of investment alternatives. The Plan is intended to be an ERISA Section 404(c) plan. This means that you, and not the Plan fiduciaries, are responsible for the investment decisions relating to the assets in your individual account under the Plan.

## Accessing Your Account

### Where to Go for Information

The Plan website at www.401kadp.com allows you to:

1. Check your current account balance
2. Check your current contributions
3. Check your current investment information
4. Request a loan
5. Receive loan information
6. Request withdrawal or distribution information
7. Enroll for the first time or make changes to your account
8. Change your investment elections
9. Receive general Plan information, including investment fund performance
10. Change your password and security questions/answers for online access

All these transactions are also available from the ADP 401(k) Service Center, 1-877-401-5237. This automated voice response system has live Customer Service Representatives during the business day (Monday through Friday, 8:00 a.m. to 9:00 p.m. ET on days that the stock market is open).

You will have access to a statement on a quarterly basis which reflects the activity in your accounts during the previous quarter. You can also contact the ADP 401(k) Service Center or the Plan website at www.401kadp.com to obtain additional information.

## Eligibility and Participation

### Eligibility

You are eligible to participate in the 401(k) Plan if you are a full-time or part-time associate. You are first eligible to become a participant on the pay date next following your date of employment.
You cannot participate in the 401(k) Plan if you fall into any of the following categories:

- You are covered by a collective bargaining agreement.
- You are a leased employee, independent contractor or consultant.
- You are a non-resident alien of the United States who does not receive earned income from sources within the United States.
- You are an associate excluded from benefit coverage as part of an employment contract or agreement.
- You are an associate who is covered by any other qualified savings plan sponsored by the Company or any subsidiary or affiliate.
- You are a Temporary Associate. A Temporary Associate is any individual who is employed by the Company with the understanding that his or her employment will be terminated no later than upon completion of a specific assignment. A Temporary Associate may be offered and may accept a new temporary assignment with ADP and retain his or her status as a Temporary Associate.
- You are a Worksite Associate. A Worksite Associate is any individual designated by ADP or a participating affiliate, in accordance with standard payroll practice, as an associate or co-employee of a corporation or other entity that is not a member of the ADP controlled group.
- You are an associate whose home country is not the United States of America.

### Enrollment

Each eligible associate may become a participant in the Plan at any time by calling the ADP 401(k) Service Center at 1-877-401-5237 or the Plan website at www.401kadp.com. Your decision to participate is completely voluntary. However, as discussed below, new ADP associates, including rehired associates, will be automatically enrolled in the Plan if no active election is made within their initial 60-day period of employment.

As an eligible associate, you will have four enrollment decisions:

1. Choosing what percentage of your pay to save;
2. Deciding whether your contributions will be Before-Tax Contributions, Roth Contributions, After-Tax Contributions, or any combination of the three;
3. Choosing your investment options; and
4. Naming your beneficiary.

### Automatic Enrollment

New ADP associates, including rehired associates, will be enrolled in the 401(k) Plan automatically. Unless you elect otherwise, after you have completed 60 days of employment, ADP will automatically begin deducting 3% from your paycheck on a pre-tax basis. This money will be deposited into your 401(k) Plan Before-Tax Contribution account and will be invested in the JPMorgan SmartRetirement Passive Blend Fund that corresponds with your approximate retirement date. Deductions will begin within approximately two paychecks after you have completed 60 days of employment.

If an associate is automatically enrolled into the Plan; they will also be enrolled in the Save Smart automatic contribution escalation feature and will have their contribution rate increased automatically by 1% each September until their contribution rate reaches a maximum of 6%.

You can change this default investment election immediately or at any time in the future.

If you do not want to participate in the 401(k) Plan, you will have to opt out by calling 1-877-401-5237 or logging into the Plan website at www.401kadp.com. Any funds that are deposited into the Plan via payroll deductions cannot be refunded. Generally, a distribution is only available upon termination of employment.

### Naming a Beneficiary

Your beneficiary is the person or entity who will be paid the proceeds of your account upon your death. If you are married, your beneficiary is your surviving spouse at the time of your death, unless your spouse previously consented to your designation of another person or entity as the named beneficiary in writing, properly witnessed by a notary public. In this event, the proceeds of your account will be paid to the beneficiary you have so designated.

If you are unmarried when designating a non-spouse or entity as a beneficiary, such designation will be revoked upon a later marriage or remarriage. Additionally, your designation may be superseded by a Qualified Domestic Relations Order indicating an alternate payee.

Absent a named or living spouse and/or beneficiary(ies), payment will be made to your estate.

The term "spouse" means a person of the opposite sex or the same sex to whom you are legally married or a person of the opposite sex with whom you live in a legal common law marriage. ADP will recognize a spouse from a legal common law marriage only if all the following criteria are satisfied:

- The associate's common law marriage must be established in a state that recognizes common law marriage, and the associate and the common law spouse must satisfy all criteria required to establish a common law marriage in that state.
- The associate and his or her common law spouse must cohabitate in a state which recognizes common law marriage.
- Third, the associate and his or her common law spouse must "hold themselves out as husband and wife." They must tell the world that they are husband and wife through their conduct, such as the woman's assumption of the man's surname.
- The associate and his or her common law spouse must file their federal income tax return as married filing jointly or married filing separately.

The associate will be required to provide proof of the common law marriage. Proof of the common law marriage may be provided in the form of a written declaration or administrative order from the state in which the common law marriage was established (for those states that issue such documentation). In addition, the associate and his or her common law spouse must produce his or her most recent federal income tax returns indicating that the associate and his or her common law spouse filed either as "married filing jointly" or as "married filing separately." ADP retains the right to request proof of an associate's filing status at any time. The associate must also produce any evidence of an agreement to be married, if such evidence exists.

## Participant Contributions

When you participate in the 401(k) Plan, you agree to have your salary reduced by the amount of your contributions. You will have your own individual 401(k) Plan account established in your name under your Social Security Number. ADP deposits your contributions directly to your 401(k) Plan account.

You may contribute a percentage of your pay in whole percentages, from between 1% and 50% of your pay in combined Before-Tax Contributions and Roth Contributions. Your After-Tax Contribution election can be between 1% and 99% of your eligible pay each pay period. For purposes of computing your contributions for 2025, your pay is limited to $350,000. This amount may be adjusted periodically by the Internal Revenue Service for cost-of-living increases. You can choose to make Before-Tax Contributions, Roth Contributions, After-Tax Contributions, or any combination of the three.

The maximum percentage of your pay that you may contribute on a combined Before-Tax and Roth basis is limited if you are a Highly Compensated Employee (as defined by the Internal Revenue Code). In general, you are a Highly Compensated Employee in 2025 if you earned more than $155,000 in 2024. The maximum amount you can contribute is based on your pay as of the preceding year as described below:

- If you are a Highly Compensated Employee, you will be able to contribute up to 12% of your pay in combined Before-Tax Contributions and Roth Contributions.
- If you are not a Highly Compensated Employee, you can contribute up to 50% of your pay in combined Before-Tax Contributions and Roth Contributions.

Total earnings are used to determine your maximum contribution percentage. Total earnings include compensation received by you for services rendered as an associate during the plan year, including commissions and sales contest cash awards and other like remuneration (e.g., pay received during a paid leave of absence), bonuses (including, without limitation, recruitment and stay-on bonuses), overtime pay, salary continuation payments, any differential wage payments, amounts not includible in your gross income under Section 125 of the Internal Revenue Code or by reason of Section 132(f)(4) of the Internal Revenue Code and amounts you defer under a salary deferral election or after-tax contribution election and contributed to the 401(k) Plan. Total earnings do not include employer contributions to or under this Plan or any other associate benefit plan, and any other forms of deferred, contingent, indirect, special remuneration, equity-based compensation or severance pay.

Participation in the Save Smart feature is completely voluntary. If you do not want to participate in the Save Smart feature, you can elect to opt out at any time by calling 1-877-401-5237 or by changing or suspending contributions to your account on the Plan website at www.401kadp.com.

The Internal Revenue Service ("IRS") limits the amount that may be deposited in your account during each year. See the "Contribution Limits" and "Special Internal Revenue Code Requirements" Sections below for additional details.

### Before-Tax Contributions

Before-Tax Contributions are deducted from your paycheck before taxes are determined on your income. Before-Tax Contributions are permitted to grow tax deferred until they are withdrawn, at which time your Before-Tax Contributions and earnings on these contributions are taxed at your ordinary income tax rate.

### Roth Contributions

Roth Contributions are deducted from your paycheck after taxes are withheld from your pay. Since you give up the immediate tax benefits offered under the Before-Tax Contribution option, you can eventually withdraw your Roth Contributions and earnings on these contributions tax-free, if certain conditions are met. (See the "Tax Consequences" Section below for additional details.)

### After-Tax Contributions
After-Tax Contributions are deducted from your paycheck after taxes are withheld from your pay. Since you give up the immediate tax benefits offered under the Before-Tax Contribution option, you can eventually withdraw your After-Tax Contributions tax-free. However, any earnings on After-Tax Contributions are taxed at your ordinary income tax rate upon withdrawal. (See the "Tax Consequences" Section below for additional details.)

### Catch-Up Contributions for Associates Age 50 and Older
If you are age 50 or older, or turn age 50 at any time during 2025, you will be eligible to make additional contributions. These additional contributions are commonly known as Catch-Up Contributions. The maximum amount of Catch-Up Contributions permitted for 2025 is $7,500 if you are age 50 or older. If you are between ages 60 – 63, the maximum amount of Catch-Up Contributions permitted for 2025 is $11,250. This amount may be adjusted periodically by the IRS. Catch-Up Contributions are not eligible for Company Matching Contributions.

Catch-Up Contributions are elected as a percentage of your gross pay and can be made either on a pre-tax basis only, a Roth basis only, or any combination of the two. Deductions will occur on a pay period basis. Your Catch-Up Contribution election can be between 1% and 99% of your eligible pay, but at no time will your Catch-Up Contributions each pay period be more than the Catch-Up Contribution limit for the year ($7,500 for 2025 if you are 50 or older; $11,250 if you are between ages 60 – 63). Any pre-tax Catch-Up Contributions will be deposited into your Before-Tax Contribution account. Any Roth Catch-Up Contributions will be deposited into your Roth Contribution account.

### Stopping Contributions
If you stop your contributions, ADP's Matching Contributions stop on the same date.

### Pay Change during the Year
Your contributions are based on a percentage of your pay with ADP. So, if your pay changes during the year, the dollar amount of your contributions will automatically change to reflect the percentage you elected.

### Contribution Limits
The IRS limits the amount that may be deposited to any participant's account during each year. One of these limits is a flat dollar limit, which applies to the combined amount of your Before-Tax and Roth Contributions. In 2025, the flat dollar limit is $23,500. This limit may be adjusted periodically by the IRS.

In addition to the flat dollar limit, the IRS has established overall dollar limitations on the total amount of contributions that may be allocated to your account for any year (the lesser of 100% of compensation or $70,000 for 2025, as adjusted from time to time). This limit considers not only Before-Tax and Roth Contributions, but also any After-Tax Contributions and Matching Contributions provided by ADP.

### Special Rules for Puerto Rico Associates
Before-Tax Contributions for Puerto Rico associates are limited to $23,500 for 2025. Associates who are age 50 or over can make Catch-Up Contributions of up to $1,500 for 2025.

## ADP Matching Contributions
ADP will match $1.00 for every dollar you save, up to 6% of your pay.

Before-Tax, Roth and After-Tax contributions are eligible for the Matching Contribution. All participants must contribute at least 6% each pay period to receive the maximum Matching Contribution. For purposes of computing your Matching Contribution for 2025, your pay is limited to $350,000.

The Company does not match contributions you make during the first 6 months of employment. This means that Matching Contributions will not be made before the first of the month coincident with or next following the six-month anniversary of your hire date.

The Matching Contribution will be deposited in your Matching Contribution account each pay period. You must be employed on the last day of the plan year (December 31st) to retain the Matching Contribution for the year. However, if you terminate your employment during the Plan year and have attained age 55 and completed 5 years of vesting service, you will retain any Company Matching Contribution you earned during the Plan year. However, if you die while you are an active ADP associate, you will receive a Matching Contribution on any contributions you made through payroll deductions up to the date of your death. In addition, if you become disabled while you are an active ADP associate, you will receive a Matching Contribution on any contributions you made through payroll deductions up to the date you were deemed disabled. Matching Contributions are made in cash and allocated based on your investment elections. The IRS requires that any Matching Contributions made on Roth or After-Tax Contributions be allocated to your Before-Tax Contribution account.

If you had your deferrals suspended because you reached the Code Section 402(g) deferral limit for the year, the Plan will adjust ("true up") your balance to account for the match you would have otherwise received.

The following examples illustrate how the 2025 Matching Contribution is determined for an associate with at least 6 months of service with ADP. Remember that no "match" is applied to contributions made before completing 6 months of service. Matching Contributions start at the beginning of the month following an associate's 6-month anniversary. For example, an associate who is hired on January 4, 2025 will begin receiving Matching Contributions with the first payroll in August 2025.

***Example 1*** **-** Joe, who earns $80,000 annually, contributed 10% of his compensation throughout the year to the 401(k) Plan.

| | Total |
|---|---|
| (a) Joe's Pay for 2025 | $80,000 |
| (b) Joe's contributions made to the Plan for 2025 | $8,000 |
| (c) 6% of pay | $4,800 |
| (d) Company match ( lessor of (b) or (c) ) | $4,800 |
| (e) Total Contribution to the 401(k) Plan for 2025 (b) + (d) | $12,800 |

***Example 2*** **-** Sally, who earns $80,000 annually, contributed 3% of her compensation throughout the year to the 401(k) Plan.

| | Total |
|---|---|
| (a) Sally's Pay for 2025 | $80,000 |
| (b) Sally's contributions made to the Plan for 2025 | $2,400 |
| (c) 6% of pay | $4,800 |
| (d) Company match ( lessor of (b) or (c) ) | $2,400 |
| (e) Total Contribution to the 401(k) Plan for 2025 (b) + (d) | $4,800 |

## Rollover Contributions

The Plan permits Rollover Contributions from other qualified retirement plans. Rollover Contributions allow you to put off paying taxes on the amounts distributed from your old plan. Rollover Contributions are not eligible for a Matching Contribution. An application form for a Rollover Contribution can be obtained from the 401(k) website. Rollover Contributions will be deposited in your Rollover Contribution account, which is a separate subaccount under the Plan, and can be withdrawn from the Plan at any time.

To be eligible, any Rollover Contribution must meet the following conditions and you must provide the required documentation:

- The rollover must be made in cash (company stock from other employers is not permitted).
- You can only roll over the taxable portion of the distribution unless an exception applies. Our record keeper will verify whether the rollover meets the applicable IRS requirements.

- The IRS allows rollovers from one qualified plan to another and from an IRA to a qualified plan. If you wish to make a rollover into your Roth Contribution account, the funds must come from another Roth elective deferral account under another tax-qualified retirement plan. If you wish to make a rollover into your After-Tax Contribution account, the funds must come from another after-tax elective deferral account under another tax-qualified retirement plan.
- A distribution statement from your former employer's plan or your IRA showing the amount of the distribution with a check made payable to The Northern Trust for the benefit of (your name). If the payment is from your former employer's plan, the statement must state that no part of your Rollover Contribution consists of:
  - A distribution that is a series of substantially equal periodic payments from your former employer's plan.
  - A distribution from your former employer's plan that is required because you have attained the minimum required distribution age.
  - Any other distribution not eligible for rollover.
- If the check from your former employer or IRA is payable to you, then the rollover must be completed within 60 days. If the check is made out to the Plan name, then the 60-day rule is not applicable.

## Service and Vesting

### Vesting

Vesting means ownership. You always have complete ownership of (or are fully vested) in the value of your Before-Tax Contributions, Roth Contributions, After-Tax Contributions, and Rollover Contributions, and any investment earnings on those contributions.

You become vested in Matching Contributions and any investment earnings on these contributions over time. ADP's Matching Contributions and their earnings fully "vest" over a three-year period of service with ADP. You are 50% vested after two years of service and 100% vested after three years of service. Matching Contributions provided to participants hired or rehired on or after January 1, 2015, will become 100% vested after three years of service.

Regardless of your service, Matching Contributions for all participants become 100% vested upon death or attainment of age 65.

Note that any Matching Contributions provided in the current calendar year will be forfeited upon termination of employment unless you have reached age 55 with 5 years of service.

### Length of Service

Service is a period of time beginning from the date of employment or reemployment with the Company to the date of severance from the Company, which is the earlier of:

- The date of discharge, retirement or death; or
- The first anniversary of the date continuous absence from work began for any reason other than a leave of absence or a period during which the Company makes severance payments.

A break in service will occur if you resign, are discharged, or retire. If you were not vested at the time you left, the years of service you earned can be lost and your Matching Contributions forfeited.

You will receive service for vesting purposes for a period of qualified military service if you die or become disabled while performing qualified military service.

### Break in Service / Reemployment

Service will be restored to your original service date if you are rehired within 12 months. If you are rehired after a 12-month period and you were 50% vested or 100% vested, your service will be restored on the date you are rehired. If you are rehired after 5 years and you were 0% vested, your service will not be restored.

If you leave ADP and receive payment of the vested portion of your Matching Contributions on or after your termination of employment, the non-vested portion of your Matching Contributions will be forfeited. If you later resume employment with the Company, the forfeited amount will be restored if you repay the full amount of the distribution before the earlier of:

- Five years after the date you are subsequently re-employed by the Company; or
- Five consecutive one-year breaks in service following the date of the distribution.

However, no matter when you leave, you will always be entitled to the value of your own contributions, tax savings, and any earnings on your contributions.

## Investment Choices

### 401(k) Plan Investment Funds

The funds selected by the Trustee (as defined in the Plan) are the investment funds under the Plan. You may invest your contributions in 1% increments divided among the investment funds available under the Plan. Each investment fund has a specific investment objective, level of risk and potential return. You decide which investment funds to invest in based on your personal financial goals. The chart below contains a summary of certain information about the investment funds provided under the Plan. Quarterly Fund Fact Sheets that are available on the Plan website (**www.401kadp.com**) provide additional information about each of the funds including information such as level of risk, investment strategy, historical returns and sector diversification.

| Fund Name | Investment Information - Objectives | Annualized 1-5-10 Year Returns | |
|---|---|---|---|
| Northern Trust Collective Government Short Term Investment Fund | Privately managed securities fund. Ticker symbol is NITXX. Can be viewed at www.northerntrust.com.<br><br>Investment vehicle for cash reserves, that offers a competitive rate of return through a portfolio of obligations of the US Government, its agencies or instrumentalities, and related money market instruments. The fund's objectives are principal reservation and liquidity management. | 1 Year[2]<br>5 Year<br>10 Year | N/A<br>N/A<br>N/A |
| Seix Intermediate Bond Fund | Privately managed fund. Intermediate-term fixed income fund. Ticker symbol is not available. Information can be viewed at **www.seixadvisors.com.**<br><br>To provide a premium return over money market instruments, and to maintain relatively low volatility by investing in intermediate-term bonds. | 1 Year<br>5 Year<br>10 Year | 3.32%<br>0.30%<br>1.18% |
| Northern Trust Aggregate Bond Index Fund – Non-Lending – Tier 4 | Privately managed fund. Domestic large cap index fund. Can be viewed at http://www.northerntrust.com.<br><br>To hold a portfolio representative of the overall United States bond and debt market as characterized by the Barclays US Capital Aggregate Bond Index | 1 Year<br>5 Year<br>10 Year | 2.62%<br>-0.26%<br>N/A |
| JPMorgan SmartRetirement Passive Blend Income Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The fund is designed for investors who are retired or expect to retire soon. | 1 Year<br>5 Year<br>10 Year | 9.88%<br>N/A<br>N/A |

| | | | |
|---|---|---|---|
| JPMorgan SmartRetirement Passive Blend 2025 Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The Smart Retirement funds are designed for investors who will retire in or around the targeted year and want a professional to determine the asset mix and fund selection in their portfolio. | 1 Year<br>5 Year<br>10 Year | 10.65%<br>N/A<br>N/A |
| JPMorgan SmartRetirement Passive Blend 2030 Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The Smart Retirement funds are designed for investors who will retire in or around the targeted year and want a professional to determine the asset mix and fund selection in their portfolio. | 1 Year<br>5 Year<br>10 Year | 12.32%<br>N/A<br>N/A |
| JPMorgan SmartRetirement Passive Blend 2035 Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The Smart Retirement funds are designed for investors who will retire in or around the targeted year and want a professional to determine the asset mix and fund selection in their portfolio. | 1 Year<br>5 Year<br>10 Year | 13.95%<br>N/A<br>N/A |
| JPMorgan SmartRetirement Passive Blend 2040 Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The Smart Retirement funds are designed for investors who will retire in or around the targeted year and want a professional to determine the asset mix and fund selection in their portfolio. | 1 Year<br>5 Year<br>10 Year | 15.23%<br>N/A<br>N/A |
| JPMorgan SmartRetirement Passive Blend 2045 Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The Smart Retirement funds are designed for investors who will retire in or around the targeted year and want a professional to determine the asset mix and fund selection in their portfolio. | 1 Year<br>5 Year<br>10 Year | 16.22%<br>N/A<br>N/A |
| JPMorgan SmartRetirement Passive Blend 2050 Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The Smart Retirement funds are designed for investors who will retire in or around the targeted year and want a professional to determine the asset mix and fund selection in their portfolio. | 1 Year<br>5 Year<br>10 Year | 16.65%<br>N/A<br>N/A |

| | | | |
|---|---|---|---|
| JPMorgan SmartRetirement Passive Blend 2055 Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The Smart Retirement funds are designed for investors who will retire in or around the targeted year and want a professional to determine the asset mix and fund selection in their portfolio. | 1 Year<br>5 Year<br>10 Year | 16.70%<br>N/A<br>N/A |
| JPMorgan SmartRetirement Passive Blend 2060 Fund – Class CF-D | Privately managed fund. Target retirement date fund. Ticker symbol is not available. Information can be viewed at **www.jpmorgansmartretirement.com/passiveblend.**<br><br>The fund invests in a combination of equity, fixed income and short-term JPMorgan Chase Bank, N.A. Commingled Pension Trust Funds and/or funds maintained by unaffiliated banks and trust companies, which includes vehicles with lower levels of active risk. The Smart Retirement funds are designed for investors who will retire in or around the targeted year and want a professional to determine the asset mix and fund selection in their portfolio. | 1 Year<br>5 Year<br>10 Year | 16.68%<br>N/A<br>N/A |
| Columbia Dividend Value Fund | Privately managed fund. Large cap value equity fund. Information can be viewed at **www.columbiafunds.com.**<br><br>To seek total returns consisting of current income and capital appreciation by investing primarily in a diversified portfolio of large cap common stocks. | 1 Year<br>5 Year<br>10 Year | 14.89%<br>11.70%<br>11.21% |
| Northern Trust S&P 500 Index Fund – Tier 4 | Privately managed fund. Domestic large cap index fund. Can be viewed at **www.northerntrust.com.**<br><br>To provide risk and return characteristics corresponding to the S&P 500 Index. This index is commonly used to represent the large cap segment of the U.S. equity market. | 1 Year[3]<br>5 Year<br>10 Year | 24.55%<br>N/A<br>N/A |
| American Century Small Cap Value Fund | Privately managed fund. Small cap value fund. Information can be viewed at **www.americancentury.com.** Call 1-800-345-3533.<br><br>To provide long-term growth with a secondary emphasis on income by investing in small companies that are believed to be undervalued at the time of purchase. | 1 Year<br>5 Year<br>10 Year | 9.73%<br>10.46%<br>8.87% |
| Northern Trust Extended Equity Index Fund – DC Non-Lending – Tier 4 | Privately managed fund. Domestic large cap index fund. Can be viewed at **www.northerntrust.com.**<br><br>To approximate the risk and return characteristics of the Dow Jones U.S. Completion Total Stock Market Index. This index is commonly used to represent the small and mid-cap segments of the U.S. equity market. | 1 Year<br>5 Year<br>10 Year | 14.80%<br>8.62%<br>N/A |
| WTC-CIF II growth (Series 4) Portfolio (Wellington Large Cap Growth) | Privately managed large cap growth fund.<br><br>To provide long-term total return in excess of the Russell 1000 Growth Index. | 1 Year<br>5 Year<br>10 Year | 33.59%<br>16.21%<br>N/A |
| Loomis Sayles Small Cap Growth Trust Fund – Class C | A privately managed collective investment trust.<br><br>Seeks to identify under exploited, high growth, small cap companies with positive fundamentals and attractive risk/reward profiles. Seeks to generate superior risk adjusted performance over a full market cycle relative to the Russell 2000 Growth Index. | 1 Year<br>5 Year<br>10 Year | 9.23%<br>N/A<br>N/A |
| FIAM Select International Plus – Commingled Pool Fund | International equity collective investment trust fund.<br><br>To provide excess returns relative to the MSCI ACWI ex US (Net) Index while maintaining similar fundamental characteristics. The available investment universe is comprised of stocks rated attractive in Japan, the United Kingdom, Europe ex UK, Pacific ex Japan, Canada, and emerging markets. | 1 Year<br>5 Year<br>10 Year | 11.91%<br>6.50%<br>3.94% |

| | | | |
|---|---|---|---|
| Northern Trust ACWI ex US Index – DC Non-Lending – Tier 4 | Privately managed fund. Domestic large cap index fund. Can be viewed at **www.northerntrust.com.**<br><br>To approximate the risk and return characteristics of the MSCI All Country World ex-US (MSCI ACWI ex-US) Index. This Index is commonly used to represent the large and medium cap segment of the non-US equity developed and emerging markets. | 1 Year<br>5 Year<br>10 Year | 11.68%<br>5.73%<br>N/A |
| American Century Global Growth (All Country) Trust– Class MP | Privately managed collective trust fund. Large cap growth fund. Information can be viewed at **www.americancentury.com.** Call 1-800-345-3533.<br><br>Fund managers search to identify companies that meet rigorous standards for sustainable, improving growth in earnings and revenue, regardless of sector or geographic region. | 1 Year[3]<br>5 Year<br>10 Year | N/A<br>N/A<br>N/A |

**Footnotes:**
[1] Figures shown are as of June 30, 2024, and those for 1-year return represent actual returns. All other figures represent annualized returns.
[2] Northern Institutional Treasury Portfolio was replaced by the Northern Trust Collective Government Short Term Investment Fund as of June 3, 2024.
[3] Fund was replaced by a new share class as of June 3, 2024.

## Fees and Expenses

Plan assets invested in funds may be assessed fees and expenses. You will receive a statement describing the fees and expenses that may be charged against your Plan account on an annual basis, and a statement identifying the fees and expenses that have been charged against your Plan account on a quarterly basis. You also have the right to request a copy of the statement describing fees and expenses.

## Diversification

To help achieve long-term retirement security, you should give careful consideration to the benefits of a diversified investment portfolio. Spreading your assets among different types of investments can help minimize the overall risk of your portfolio. This is because different asset classes--stocks, bonds, and money market funds--can yield different returns given the same market conditions. A diversified portfolio helps to reduce the risk that all your assets will react the same to a market moving event. Think of this as "not putting all of your eggs in one basket"—or spreading your money among different investment types. Although diversification is not a guarantee against loss, it is an effective strategy to help you mitigate investment risk.

In deciding how to invest your retirement savings, you should take into account all your assets, including any retirement savings outside the Plan. No single approach is right for everyone because, among other factors, individuals have different financial goals, different time horizons for meeting their goals, and different tolerances for risk.

It is also important to periodically review your investment portfolio, your investment objectives, and the investment options under the Plan to help ensure that your retirement savings will meet your retirement goals.

## Investment Advisory Services

The Plan provides investment management tools through a personalized advisory service provided by Edelman Financial Engines Advisors LLC. Edelman Financial Engines is an independent firm offering investment advice, managed account services, and other retirement management tools in 401(k) plans.

Edelman Financial Engines offers three types of services, Online Advice, a fee-based Management option, and a fee based Personal Advisor option.

The Online Advice service provides you with investment, savings, and retirement income recommendations for your 401(k) account. If you enroll in the fee-based Management service, Edelman Financial Engines will manage and monitor your 401(k) Plan investments on a discretionary basis. With the fee based Personal Advisor service, you will receive the services under the Management option along with access to a dedicated advisor, a comprehensive financial plan, and management of outside assets if you so choose.

The advisory fees charged by Edelman Financial Engines for Management and Personal Advisor are as follows:

| Portion of Account | Management Annual Rate | Personal Advisor Annual Rate* |
|---|---|---|
| Up to $100,000 | 0.38% | 0.90% |
| $100,000-$250,000 | 0.30% | 0.80% |
| $250,000-$500,000 | 0.20% | 0.70% |
| Over $500,000 | 0.10% | 0.70% |

*Minimum annual charge is $900

You can access Edelman Financial Engines online or over the phone. To get started online, log onto the 401(k) have questions or would like to sign up over the phone, contact the Edelman Financial Engines helpline at 1-844-861-0028.

### How to Change Your Investments

- Consider your financial goals.
- Take into account your age, career cycle, existing savings, future spending needs and willingness to take risk.
- Obtain copies of the investment fund information posted in the Benefits Section of the ADP Associate Portal or the Plan website at www.401kadp.com.
- Evaluate the investment fund choices, using the descriptions in this document and the Fund Fact Sheets to determine how closely the goals of each investment fund match your own goals.
- Choose your investment funds.
- If you need to enroll or make a change, call 1-877-401-5237 or visit the Plan website at www.401kadp.com.
- Remember, you can choose to change the investment of your current account balance under the 401(k) Plan and your future 401(k) Plan contributions (including Rollover Contributions) at any time.

### ADP Trade Control Policy

If you exchange an amount of $5,000 or greater out of any investment fund, you will be prohibited from purchasing units of the same investment fund through an exchange purchase transaction for 30 calendar days, unless your transaction falls under one of the exceptions listed below.

The ADP Trade Control Policy will not be triggered by or applied to the following:

(i) An exchange out of a money market fund for any reason

(ii) An exchange out of any investment fund that is the result of any of the following transactions:
   - Distributions and in-service withdrawals from the Plan (i.e., age 59-1/2 Withdrawals, Rollover, Withdrawals and Hardship Withdrawals)
   - Plan loans

(iii) An exchange purchase of any investment fund that is a result of any of the following transactions:
   - The initial investment of a new contribution, including participant salary reduction contributions, employer contributions and rollovers
   - The initial investment of loan repayments
   - The reinvestment of investment fund dividends or capital gains distributions

In addition, exchange transactions initiated by the ADP Automatic Rebalance feature will be exempt from the ADP Trade Control Policy. However, reallocation and rebalancing transactions initiated by you will not be exempt from the ADP Trade Control Policy.

Please note that the restrictions described above are in addition to any excessive trading policies that may be adopted by any of the investment funds offered under the Plan, or any transaction restrictions that an investment company or manager may direct the Plan's record keeper to impose upon a Plan participant.

## Distributions and Withdrawals

### Loans

The 401(k) Plan offers general loans, i.e., you are not asked why you want the loan. You can borrow money from your accounts on a pro-rata basis for any reason without incurring taxes or penalties. You repay your loan, with interest, via payroll deductions. The principal and interest go back into your account based on your current investment elections. For additional information on applying for a loan and repaying loans, please refer to ADP's separate loan policy.

You can borrow up to 50% of your vested account balance up to a maximum of $50,000. The minimum loan is $1,000. The maximum loan term is 5 years.

### Applying for a Loan

To apply for a loan, call the 401(k) Service Center at 1-877-401-5237 or the Plan website at www.401kadp.com.

The loan-modeling feature will provide you with:

- The amount you are eligible to borrow
- The current interest rate
- Your monthly repayment schedule

You can model different loan scenarios and determine which works best for you. When you decide on a loan, you may submit your request and receive a confirmation. By confirming your transaction, you acknowledge that you understand and agree to the terms of the loan. Once you confirm the amount and the terms of your loan, your loan will be processed.

The check and the promissory note will be mailed to your home by ADP Retirement Services. By cashing the check, you are agreeing to the terms of the loan. Loan deductions will commence within one to two pay periods following the date of your loan request.

### Loan Rules

- You can only have two outstanding loans at any time.
- The minimum amount you may borrow is $1,000.
- The maximum amount you may borrow is the lesser of $50,000 or 50% of your available vested account balance. If you had an outstanding loan within the past 12 months, the $50,000 is reduced by the highest outstanding balance in the past 12 months.
- The term of the loan can be up to a maximum of 60 months (5 years).
- You must make regular repayments through after-tax payroll deductions if you're an active associate.
- A check along with a promissory note will be mailed to you within 5 business days from the time you request the loan. The amortization schedule is updated monthly and is available on the Plan website at www.401kadp.com.
- The loan is secured by the balance of your accounts. You cannot pledge as security for a loan more than 50% of your vested account balance.

### Loan Interest

Please refer to ADP's loan policy for the specific interest rate on each loan.

### Repayment of Loans

The Committee is responsible for administering the loan program. The participant is responsible for any loss caused by non-payment or default of a loan.

### Repayment of an Outstanding Loan Balance at Termination

If you terminate employment for any reason, you have until the end of the calendar quarter following the quarter in which the first missed payment occurred to repay your outstanding loan in a lump sum payment. If your loan is not repaid within this period, the Plan considers your loan to be in default and the balance will be reported as a distribution. Defaulted loans are subject to taxes and penalties. Consult with your tax advisor for additional information on taxes and penalties.

If you take a distribution of your account within the time you can pay off your loan balance in full, any outstanding loan amount will be reported as a distribution (which may reduce your distribution value).

### Prepaying Your Loan

You may repay your loan in full at any time. Call 1-877-401-5237 and speak to a Customer Service Representative if you would like to prepay your loan.

### Withdrawals while you are with ADP

As an active associate, you also have access to your money in the form of a:

- Hardship Withdrawal
- In-Service Withdrawal after reaching Age 59-1/2
- In-Service Withdrawal of After-Tax Contributions
- Rollover Withdrawal
- Birth or Adoption of a Child Withdrawal

### Hardship Withdrawal

You may withdraw all available vested account balances from the Plan in the event of a severe financial hardship. A Hardship Withdrawal must comply with regulations established by the IRS.

Hardship Withdrawals are permitted for the following reasons:

- Medical expenses previously incurred or necessary to be incurred by the participant, the participant's spouse, any dependent of the participant or the participant's beneficiary, which are not covered by insurance;
- Payment necessary to prevent eviction from, or foreclosure on the mortgage of the principal residence of the participant;
- Costs directly related to the purchase of the principal residence of the participant (excluding mortgage payments);
- Payment of tuition related educational fees and room and board expenses for the next 12 months of post-secondary education for the participant, the participant's spouse, children, or dependents, or the participant's beneficiary;
- Payments for burial or funeral expenses for the participant's deceased parent, spouse, children or dependents, or the participant's beneficiary;
- Expenses for the repair of damage to the participant's primary residence that would qualify for the casualty deduction under Section 165 of the Internal Revenue Code (determined without regard to Section 165(h)(5) of the Code and whether the loss exceeds 10% of adjusted gross income); and
- Expenses and losses incurred because of a disaster declared by the Federal Emergency Management Agency ("FEMA"), provided that the participant's principal residence or principal place of employment at the time of the disaster was in an area designated by FEMA.

The amount of the withdrawal cannot be more than the amount you need to cover the immediate need. You must certify, under penalties of perjury, that your financial need cannot be relieved through any of the following resources:

- Through reimbursement or compensation by insurance or otherwise.
- By reasonable sale of your assets, to the extent that such sale would not itself cause an immediate and heavy financial need.
- By cessation of your Before-Tax Contributions, Roth Contributions, or After-Tax Contributions.
- By borrowing from commercial sources on reasonable commercial terms.
- By other currently available distributions under this Plan and all plans maintained by the Company or by any other employer.

A Hardship Withdrawal requires approval of the Committee and must comply with regulations established by the IRS. These regulations place certain restrictions/limitations on a Hardship Withdrawal. An application may be obtained by calling 1-877-401-5237 or the Plan website at www.401kadp.com. In addition, it is important to note that you may be subject to a 10% tax penalty if you take a Hardship Withdrawal and you are under the age of 59½ (see tax consequences section below for more details). Moreover, you may not repay the amount distributed to you as a Hardship Withdrawal back into the Plan, and the Hardship Withdrawal is not eligible to be rolled over into another plan or IRA. You should carefully review the application form and fully understand all the consequences of taking a Hardship Withdrawal before applying.

The vested portion of your account balances are available for Hardship Withdrawal. A Hardship Withdrawal may be taken from your Roth and After-Tax Contribution accounts only **after** all other amounts available for a Hardship Withdrawal have already been distributed.

### In-Service Withdrawals after Reaching Age 59-1/2

You can withdraw any or all of your vested account balance any time after reaching age 59-1/2. This gives you the ability to begin receiving your retirement savings without incurring any tax penalties. Before applying, you should carefully review the application form and fully understand all of the consequences of taking an in-service withdrawal after reaching age 59-1/2.

### In-Service Withdrawal of After-Tax Contributions

You can withdraw all or a portion of your After-Tax Contribution account at any time. Before applying, you should carefully review the application form and fully understand all of the consequences of taking an In-Service Withdrawal of After-Tax Contributions, including but not limited to, rollover options, federal and state taxes that may be due as a result of your distribution, and additional tax penalties that may apply.

### Rollover Withdrawal

You can withdraw any or all balances that you previously rolled into the ADP Plan at any time. This provides you the freedom to access your retirement savings while you are an active associate. You should understand the consequences of taking a Rollover Withdrawal prior to applying for this type of withdrawal from the Plan.

### Birth or Adoption of a Child Withdrawal

A participant can withdraw up to $5,000 within a 1-year period following the birth or legal adoption of each child. The withdrawal will not be subject to any early withdrawal penalties and can be repaid back to the Plan in the form of a Rollover Contribution.

### Distributions

The entire vested balance remaining in your Plan accounts is payable upon your retirement or termination of employment. You are permitted to make a separate election as to the form of the distribution of your Roth Contribution account and the rest of your Plan account.

### Death

If you die, the balance in your Plan accounts will be paid to your beneficiary, as explained in the "Naming a Beneficiary" Section above. If death occurs after termination of employment, the beneficiary is responsible for notifying the Plan administrator of the participant's death.

### Retirement or Other Termination of Employment

If you leave the Company for any reason, you will be entitled to a distribution of your Plan accounts as described below.

If your vested account balance (including your Roth and After-Tax Contribution accounts) exceeds $7,000, you may defer the distribution of your account balance and leave the funds in the Plan. If you defer your distribution in this way, you have the option to request a distribution later. You will be required to take a distribution of your funds by the end of the calendar quarter following the quarter in which you attain age 65.

Please note that absent an election to receive your vested amount in the form of a single lump sum payment or to have the amount paid as a Direct Rollover to your IRA or to another employer's tax qualified plan, amounts less than or equal to $7,000 will be transferred to an IRA established with Inspira Financial.

Your account balance will be invested in an investment product designed to preserve the principal and provide a reasonable rate of return. Fees and expenses for the IRA will be charged against your account unless you contact Inspira Financial and request to make payment of the fees out-of-pocket. Inspira Financial can be reached by phone at 1-877-682-4727 or by mail at: Inspira Financial, 2001 Spring Road, Suite 700, Oak Brook, IL 60523.

The Plan administrator will attempt to work with you prior to such distribution or transfer to allow you time to establish a rollover account if desired.

If you are receiving differential wage payments, you will be treated as having terminated employment for purposes of taking a distribution during any period you perform military service while on active duty for a period of more than 30 days. If you elect to take a distribution during this period, you will not be permitted to make a Before-Tax, Roth or After-Tax Contribution during the 6-month period beginning on the date of the distribution.

### Payments

You may choose how you wish to receive your account balance. The Plan offers two payment options:

- Direct Rollover to a qualified plan of a new employer or to a personal IRA
- Lump sum payment to you

### Direct Rollover

With this option, the taxable portion of your distribution is rolled over to another tax-qualified plan or IRA. If you are making a rollover from your Roth or After-Tax Contribution accounts, the rollover may be made to another after-tax account under a tax-qualified retirement plan or to a Roth IRA. If you elect the rollover option, you must make the rollover deposit within 60 days after you receive payment.

### Lump Sum Payment

This is a one-time payment of your entire vested account balance payable to you.

### How to Request Payment If You Have Terminated Employment

- Call the ADP 401(k) Hotline at 1-877-401-5237 or access the Plan website at www.401kadp.com to request a Final Distribution Form or initiate a distribution.
- You can speak to a Customer Service Representative at any time to discuss your payment options.
- Your request for a distribution cannot be processed earlier than 30 days following your termination. You should receive your check within an additional 10 days.
- The check will be mailed to the current address on file; the check stub explains what portion is taxable and provides other important information.
- In January of the following year, IRS Form 1099-R will be mailed to you, which will indicate what amounts to report on your tax return for the year.

## Tax Consequences

The Plan is intended to be a qualified plan under Section 401(a) of the Internal Revenue Code and to utilize the special tax-deferral features of Section 401(k) of the Internal Revenue Code. Assuming the Plan is "qualified," the federal income tax consequences of participating in the Plan under current tax law will be, in general, as described in this section. ADP, as plan sponsor, is entitled to a tax deduction, within limits, for contributions made to the Plan.

The following summary of federal income tax consequences is included for general information only and is not a complete description of all federal or other tax aspects of the Plan. The summary is based on the law in effect as of the date of this summary. The summary should not be regarded as tax advice, nor does the summary describe state, local, or estate tax consequences or non-US tax consequences, if any. All participants and their beneficiaries are urged to consult their own tax advisors to determine the tax consequences - federal, state, and local - which may result from their participation in the Plan.

### In General
When you or your beneficiary receives distributions other than loans from the Plan, income taxes may be due. However, as discussed below, income taxes may not be due with respect to distributions you or your beneficiary receives from your After-Tax account or Roth Contribution account to the extent certain requirements are met.

### Before-Tax Contribution Account
Before-Tax Contributions and the returns on those contributions are subject to taxes when you withdraw them from the Plan. There are ways you may reduce or defer your tax liability if funds are received due to retirement, termination of employment, death, or disability. For example:

- If you are in the Plan until retirement, you may be in a lower tax bracket than during your active career; or
- You may directly transfer your Before-Tax Contribution account to an IRA or another qualified plan that accepts rollovers and avoid paying taxes until you withdraw the amounts.

If you do not roll over the taxable portion of your distribution directly to either a qualified plan or IRA, ADP is required by law to automatically withhold 20% for federal income tax.

The IRS may impose an additional 10% tax on early withdrawals (before age 59½) from the Plan. This tax does not apply to distributions made due to disability, for certain medical expenses or to payments made to beneficiaries or other alternate payees.

### Roth Contribution Account
Your designated Roth Contributions and the returns on these contributions can be withdrawn tax-free if your distribution is considered "qualified." A qualified distribution is generally a distribution that is made after a 5-taxable-year period of participation beginning on the date you first make a Roth Contribution to the Plan and that either:

- Is made on or after the date you attain age 59½,
- Is made after your death, or
- Is attributable to you being disabled.

Distributions that do not meet the qualification requirements may be subject to federal income tax and/or early withdrawal penalties in the same manner as those in your Before-Tax Contribution account.
Your Roth Contribution account can be rolled over into a personal Roth IRA or into another qualified plan that accepts Roth Contribution rollovers.

### After-Tax Contribution Account
Your designated After-Tax Contributions are not taxable when withdrawn or distributed. However, any investment earnings on those contributions are subject to taxation and may also be subject to tax penalties for early withdrawal.

Your After-Tax Contribution account can be rolled over into another qualified plan that accepts After-Tax Contribution rollovers. You may also convert your After-Tax account into a personal Roth IRA. Any investment returns will be subject to taxes at the time of the conversion.

It is best to consult a tax advisor concerning the tax laws as they apply to your situation before requesting a distribution.

## Special Internal Revenue Code Requirements
### Nondiscrimination Requirements
Limitations are also set by law on the amount (measured as a percent of compensation) of Before-Tax and Roth Contributions that may be contributed to the Plan on behalf of certain individuals classified as Highly Compensated Employees in any years that the Plan does not meet the requirements for a "safe harbor" plan under the Internal Revenue Code. You are considered a Highly Compensated Employee in 2025 if you earned more than $155,000 in 2024, the prior calendar year. The IRS may increase this amount in future years. If these limitations affect you, you will be notified, and certain corrective actions (specified in the Plan document) will be taken by the Plan administrator.

### Maximum Contributions
In addition to these limits, the IRS has established overall dollar limitations on the total amount of contributions that may be allocated to your account for any year (the lesser of 100% of compensation or $70,000 for 2025, as adjusted from time to time). If an allocation to be made to your account would cause the limits to be exceeded, you will be notified, and the allocations will be reduced.

### Top Heavy Rules
Each year, ADP is responsible for determining whether the 401(k) Plan is a "Top Heavy" plan, which means that certain "key" employees have been allocated more than 60% of the contributions under the Plan. If the Plan becomes top heavy in any one plan year, special rules apply. Among these rules is the fact that the minimum contribution rate to be allocated to any participant would be the lesser of:

- The highest rate of the matching contribution credited to any key employee; or
- 3% of total earnings.

You will be informed if this provision goes into effect.

## Miscellaneous Provisions
### Maximum Contributions and Benefits
ERISA and the Internal Revenue Code impose certain limitations on the amount of ADP contributions and 401(k) participant contributions and forfeitures under the plans. The application of these limitations is monitored by the Committee, which will notify any affected participant. Specific information about these limitations is available from the Committee.

### Loss or Denial of Benefits
Once you become vested in your accounts under the Plan, you cannot lose your right to the vested portion. Of course, the value of the investments may fluctuate.

### Non-assignment of Benefits
You may not assign the benefits provided to you by the Plan, nor are these benefits subject to the claims of any creditor, unless otherwise provided by law. One exception to this rule is a Qualified Domestic Relations Order. A Qualified Domestic Relations Order is defined as a judgment, decree or court order approving property settlement agreements, and/or relating to child support, alimony or marital property rights of a spouse, child or other dependent of a participant. To be binding, a Qualified Domestic Relations Order must specify certain required legal information and cannot alter the amount or form of plan benefits. No plan benefits will be paid pursuant to a Qualified Domestic Relations Order earlier than the earliest retirement age defined by Section 414(p) of the Internal Revenue Code. Plan benefits payable due to a Qualified Domestic Relations Order will be paid on a pro-rata basis from your Plan accounts unless otherwise provided in the Qualified Domestic Relations Order.

### Rights to Re-employment
The existence of the Plan does not affect the employment rights of any associate or the right of ADP to discharge an associate.

### Military Service
If you die while performing qualified military service, your survivors are entitled to any benefits (including benefit accruals relating to the period of qualified military service, subject to certain rules provided under the Plan had you resumed and then terminated employment because of death.
In addition, if you die or become disabled while performing qualified military service, you will be treated as having resumed employment on the day preceding death or disability (as the case may be) and terminated employment on the actual date of death or disability.

### Plan Administration
The Plan is administered by the ADP 401(k) Plan Committee. In general, the ADP 401(k) Plan Committee is responsible for administering and interpreting the Plan. The ADP 401(k) Plan Committee is also responsible for carrying out the Plan's provisions. The ADP 401(k) Plan Committee has discretionary power to interpret and administer the Plan. The ADP 401(k) Plan Committee's decisions will generally be final and binding.

Questions relating to the administration of the Plan may be directed to: Automatic Data Processing, Inc., Attention: ADP 401(k) Plan Committee, One ADP Boulevard, Roseland, NJ 07068, Telephone: 1-973-974-5000.

## Your ERISA Rights and Incorporated Documents

### General Information

At some time, you, your beneficiary, spouse or other person (called "Claimant") may not agree about a benefit. In that case, the Plan allows the Claimant to file an application for a review of the issue with the Committee, on a form provided for that purpose.

If the Claimant's application is denied, the Committee will so notify the Claimant within 90 days of receipt of the original claim giving reasons for the denial. This notice will refer to the specific provisions on which the denial is based, will explain the review procedure, and will specify whether additional information is needed from the Claimant.

Within 60 days after receiving the denial, the Claimant may submit a written request to the Committee for reconsideration of the application. Documents or records relied on by the Claimant should be filed with the request. The Claimant may review relevant documents and submit issues and comments in writing.

The Committee will review the claim and within 60 days (or 120 days if a hearing is held) will provide a written response to the appeal. The response will explain the reasons for the decision and refer to the provisions of the Plan on which the decision is based. This decision of the Committee is the final one under this Claims Procedure.

### Benefit Claims Procedures

Under the Plan, you receive your benefit as a matter of course if you apply for it at your retirement age. After you leave ADP, you will receive explanations of the payment forms available to you and the differences between them. At the time you wish benefits to begin, you will be asked to complete any required forms or applications.

In order to file a claim for benefits, you or your designated beneficiary must file a written claim to the Retirement Committee. If your claim for benefits is denied in full or in part, you or your designated beneficiary will be notified within 90 days of the Retirement Committee's receipt of the claim for benefits. This time limit may be extended for up to another 90 days in special cases, but you will be notified of the reasons for the delay.

If you receive notice that your claim for benefits has been denied, either in full or in part, the notice will explain the reasons for the denial, including:

- the specific reason or reasons for the denial,
- a specific reference to the pertinent provisions upon which the denial is based,
- a description of any additional material or information necessary to perfect the claim for benefits together with an explanation of why such material or information is necessary,
- an explanation of the claim review procedure, and
- a statement regarding your right to bring a court action following a denied appeal under ERISA Section 502(a).

After receiving a denial, you or your beneficiary must submit, within 60 days, a written request for reconsideration. Any such request should be accompanied by documents or records in support of the appeal. Within 60 days receipt of the appeal (or 120 days under special circumstances), the Committee shall deliver to you or your beneficiary a written decision with respect to the appeal.

If any judicial proceeding is undertaken to appeal the denial of a claim, challenge the amount of any benefit under the Plan or bring any other action under ERISA other than a breach of fiduciary duty claim, any such judicial proceeding must be filed within the earlier date of the following: (a) 90 days after the final decision on any administrative claim for benefits submitted to the Committee; or (b) within 3 years after the date when the participant or beneficiary submits their authorization to commence payment of the Plan benefits at issue in the judicial proceeding.

The evidence presented in such a judicial proceeding will be strictly limited to the evidence timely presented to the Committee (or its designee). You may not file an action at law or in equity for benefits under the Plan until the administrative appeal rights described herein have been exercised and exhausted in full, and the Plan benefits requested in your appeal have been denied in whole or in part.

### Plan Documents versus SPD

One of the primary purposes of this SPD is to provide ADP associates with a clear, concise description of their benefits. The material contained in this SPD has been carefully prepared and avoids complex language and legal terms wherever possible. ADP wants its associates to know the benefits that have been made available to them, to understand the coverages, and to have all the essential information concerning these plans.

Plan documents on file in the Global Total Rewards Department contain more detailed information in explicit legal text that governs the administration of our plans. If a question should arise concerning the nature of these benefits, the actual legal document of the plans, and not the contents of this SPD, will rule.

### The Pension Benefit Guaranty Corporation

Under ERISA, the Plan is defined as an "individual account plan." The Pension Benefit Guaranty Corporation does not insure individual account plans and, thus, benefits under the Plan are not insured by that Federal agency.

### Plan Continuation

While ADP hopes and expects to continue the Plan indefinitely, it reserves the right to terminate, discontinue making contributions to, and amend or modify the Plan at any time. The Plan may be terminated by written resolution of the Board of Directors of the Company because of business conditions, changes in the law or if the Company determines it is in its best interests to terminate the Plan.

### Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protection under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- 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 the summary annual report.
- Obtain a statement telling you whether you have a right to receive a vested benefit at normal retirement age (age 65) or earlier and, if so, the amount of your benefit if you stop working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you must work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. Plan fiduciaries are the people who operate your Plan and have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA. If your claim for a pension benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial.

### Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied, or ignored, in whole or in part, you may file in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### Assistance with Your Questions

If you have any questions about your Plan, you should contact your Plan administrator. If you have any questions about this document or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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.

- Atlanta Regional Office - 61 Forsyth Street, S.W., Ste. 7B54, Atlanta, GA 30303 (404) 302-3900
- Boston Regional Office – JFK Federal Bldg., 15 Sudbury St, Rm 575, Boston, MA 02203 (617) 565-9600
- Chicago Regional Office – John C. Kluczynski Federal Bldg., 230 S. Dearborn Street, Ste 2160, Chicago, IL 60604 (312) 353-0900
- Cincinnati Regional Office - 1885 Dixie Hwy, Ste. 210, Ft. Wright, KY 41011-2664 (859) 578-4680
- Dallas Regional Office - 525 South Griffin Street, Room 900, Dallas, TX 75202-5025 (972) 850-4500
- Kansas City Regional Office – 2300 Main St, Ste 1100, Kansas City, MO 64108 (816) 285-1800
- Los Angeles Regional Office – 35 N. Lake Ave., Ste 300, Pasadena, CA 91101 (626) 229-1012
- Miami District Office – 1000 S Pine Island Road, Ste 100, Plantation, FL 33324 (954) 424-4022
- New York Regional Office – 33 Whitehall St, Ste 1200, New York, NY 10004 (212) 607-8600
- Philadelphia Regional Office – 1835 Market Street, 21st Floor, Mailstop EBSA/21, Philadelphia, PA 19103-2968 (215) 861-3500
- San Francisco Regional Office – 90 7th St, Ste 11-300, San Francisco, CA 94103 (415) 625-2481
- Seattle District Office – 300 Fifth Avenue, Ste 1110, Seattle, WA 98103 (206) 757-6781
- Washington D.C. District Office – 1335 East-West Hwy, Ste 200, Silver Spring, MD 20910 (202) 693-8700

## Administrative Details

This document constitutes the SPD that is required by Federal Law. To comply with the law, the following additional information is provided.

The plan described below provides benefits for certain associates of ADP and its participating Affiliates.

| Plan Number | Plan 002 |
|---|---|
| Plan Name | Automatic Data Processing, Inc. Retirement and Savings Plan |
| Plan Administration | A Retirement Plan Committee (the "Retirement Committee" or "Committee") |
| Funding Medium | Automatic Data Processing, Inc. Retirement and Savings Plan Custodial Account |
| Plan Year (for Fiscal and Other Records) | January 1st to December 31st |
| Plan Sponsor | Automatic Data Processing, Inc. |
| Plan Administrator | The Retirement Plan Committee |
| Address | Automatic Data Processing, Inc., One ADP Boulevard,<br>M/S C237, Roseland, NJ 07068 - Telephone: 973-974-5000<br>Identification Number: 22-1467904 |
| Agent for Service of Legal Process | Michael Bonarti, Esq. Chief Administrative Officer,<br>c/o Automatic Data Processing, Inc. |
| Plan Fiduciaries | The named Plan Fiduciary is the Retirement Plan Committee. |

# Pension Retirement Plan

## Pension Plan Overview

Automatic Data Processing, Inc. (the "Company") is contributing funds to the Automatic Data Processing, Inc. Pension Retirement Plan (the "Plan") today to help you prepare for your future retirement. This Summary Plan Description (the "SPD") is designed to be your resource and contains information about benefits under the Plan.

The Plan was closed to new participants effective January 1, 2015, and was frozen as of July 1, 2020. Participants retain their accrued benefits as of June 30, 2020, with no future accruals due to pay and/or service.

Prior to the Plan freeze, the amount ADP contributed to your Plan account each year was based upon your length of service with ADP and your pay. Access the individual Plan document to understand more about how ADP's contributions to your account were determined. You are also credited with interest on your account each year, based on the 10-year treasury rate for September of the preceding year.

The Plan is intended to be a qualified retirement plan under the Internal Revenue Code. The Plan is a type of defined benefit plan called a cash balance plan.

A more detailed explanation of all Plan provisions is provided in the individual Plan document. While every attempt has been made to ensure that the information in this SPD is accurate, this Plan is governed by the Plan document as stated, effective as of June 30, 2020. If there is any discrepancy between this SPD and the official Plan document, the terms of the Plan document will govern.

Nothing contained in this SPD creates or is intended to create a contract of employment between any employee and ADP. Nothing in the Plan or this SPD gives any person the right to be employed by ADP nor does it interfere with ADP's right to discharge an employee at any time.

### Accessing Your Account

The Plan's website is located at www.myplansconnect.com/adppension. The site allows you to:

- Check your current account balance
- Model retirement benefits
- Name your beneficiary
- Change your password and security questions/answers for online access
- Get information on managing your money

These transactions are also available by calling the Pension Service Center at 1-844-237-7367. Pension Service Center Representatives are available between 8:00 a.m. and 6:00 p.m. ET any business day to assist you and answer your questions.

### Eligibility and Enrollment

Regular full-time and part-time associates hired on or before July 1, 2013, were automatically enrolled in the Plan on January 1st following the completion of six months of service. Associates hired on or after July 2, 2013 ,and on or before December 31, 2014 were automatically enrolled in the Plan on January 1, 2015. Regular and part time associates hired on or after January 1, 2015, will not be eligible to participate in the Plan. Associates rehired on or after January 1, 2015, will no longer be eligible to earn additional contributions under the Plan but will continue to earn interest on any prior balance that remains in the Plan. In addition, as of July 1, 2020, full-time and part-time associates hired prior to January 1, 2015, will no longer earn additional contributions under the Plan but will continue to earn interest on any prior balance that remains in the Plan.

In addition, the following individuals are not eligible to participate in the Plan:

- An employee who at the time was covered by a collective bargaining agreement, unless such agreement expressly provides for such person's coverage under the Plan;
- Any individual designated by ADP or any affiliate (in accordance with their respective standard personnel practices) as a leased employee, independent contractor or consultant, regardless of whether such person may thereafter be held to be a common law employee of any employer by a court, the Internal Revenue Service or any other relevant, federal, state or local governmental authority or agency;
- Any individual who is otherwise a "Leased Employee" (within the meaning of Section 414(n)(2) of the Internal Revenue Code (the "Code"));
- Any nonresident alien of the United States who does not receive earned income from sources within the United States (within the meaning of Section 861 (a)(3) of the Code);
- Any employee excluded from benefit coverage as part of an employment contract or agreement;
- Any employee of the subsidiaries or any non-participating affiliate or its subsidiaries;
- Any Temporary Employees. "Temporary Employees" are persons who are employed by the Company on a full or part-time basis, with the understanding that his or her employment will be terminated no later than upon completion of a specific assignment. A temporary employee may be offered and may accept a new temporary assignment with ADP and retain his or her status as a temporary employee;
- Any Worksite Employee. A "Worksite Employee" is any individual designated by ADP or a participating affiliate, in accordance with standard payroll practice, as an employee or co-employee of a corporation or other entity that is not a member of ADP's controlled group;
- Any employee whose home country is not the United States of America.

### Your Account

Effective July 1, 2020, you will no longer earn additional contributions under the Plan but will continue to earn interest on any balance that remains in the Plan. The Plan's interest credit rate for the calendar year is the greater of 3.25% and the average 10-year treasury rate for the month of September of the previous calendar year. For 2025, plan balances will earn 3.72% interest. After you leave ADP, your account continues to grow with interest, until you commence payments.

Below is an example of how your account will grow:

| | |
|---|---|
| 1. 12/31/2024 Account Balance | $50,000 |
| 2. Interest at 3.72% (0.0372 x (1)) | $1,860 |
| 3. 12/31/2025 Account Balance: (1) + (2) | $51,860 |

When you retire, you choose how you want to receive the money from your account. If you terminate after you are vested but before you retire, and you have more than $7,000 in your account, the money must remain in the Plan until you retire. If you terminate after you are vested but before you retire and the value of your account is $7,000 or less, you may elect to receive a lump sum payment at termination, or it will be paid to you as described more fully below under "Claiming Your Benefits".

### Enhanced Benefit

An enhanced benefit was provided to certain regular and part time associates who terminated on or after January 16, 2018 and on or before January 16, 2019; or who voluntarily retired on or after January 16, 2018, and on or before March 14, 2018; or elected to retire during the Voluntary Early Retirement Program that was open from March 15, 2018, through May 1, 2018. See Appendix I for additional information about the enhanced benefit.

### Maximum Benefit
Federal law sets annual limits on the amount you may receive from the Plan each year. In 2025, this indexed limit is $280,000. Your benefit may not exceed either this federal limit or 100% of your Average Annual Compensation, whichever is less. The federal limit applies as of the date your full Social Security benefits begin. If your pension benefit under this Plan begins before that date, the limit is reduced based on federal law. The federal limit may also be reduced if you participated in the Plan for fewer than 10 years, or if you receive your benefit in a form other than a Straight Life Annuity or a Joint and Survivor Annuity with your spouse as beneficiary.

### Vesting and Service
Vesting is a term that denotes ownership. When you are vested in your pension, it means you are entitled to a benefit from the Plan. If you leave the Company before you retire, you may still be entitled to receive a retirement benefit under the Plan's vesting provision. Although you earn a percentage of your base income for each year you are enrolled in the Plan, you must complete at least three years of Vesting Service to be "vested" (that is, to acquire ownership) of the amounts that you earn. If you leave the Company before you become vested, you will not be eligible to receive a benefit under this Plan.

In general, Vesting Service under the Plan is the period beginning from your date of employment with ADP to the date of your severance from the Company, which is the earlier of:

- The date of discharge, retirement, or death; or
- The first anniversary of the date continuous absence from work began for any reason other than a leave of absence.

If you are absent from work but return within 12 months, the period of your absence will count toward Vesting Service even though a part or all of this absence may have occurred after termination from service. A period of military service will count towards vesting if you return to work during the period while law protects your rights. Also, years of service rendered with an employer prior to merger with or acquisition by ADP or an ADP affiliate are included in determining your Vesting Service.

### Break In Service
A break in service occurs if you resign, are discharged, or retire. If you were not vested at the time you left, the years of vesting service you earned may be lost and your benefit forfeited.

However, Vesting Service will be restored to your original service date if you are rehired within 12 months. If you are rehired after a 12-month period, your Vesting Service will be restored after you complete one year of service, provided your severance period was less than five years.

## Claiming Your Benefits
### Normal Retirement
Normal Retirement under the Plan is age 65. If you joined ADP after age 60, your normal retirement date is on the 5th anniversary after your hire date. At normal retirement, you will receive:

- The annual benefit you earned through December 31, 1989, if any; and,
- Your account balance plus interest earned after January 1, 1990.

### Early Retirement
You may choose to retire and receive Plan benefits at any time after age 55 if you have 5 years of service. If you retire early you will receive:

- The annual benefit you earned, if any, as of December 31, 1989, actuarially reduced to consider your current age. For example, if you retired at age 60, you would receive about 67% of your December 31, 1989 benefit.
- Your account balance plus interest earned after January 1, 1990.

### Late Retirement

You may remain employed past your Normal Retirement Date. In that case, if you retire late, you'll receive the following:

- The annual benefit you earned through December 31, 1989, if any, actuarially increased to consider your current age; and,
- Your account balance plus interest earned after January 1, 1990.

### Marital Status

The term "spouse" means anyone to whom you are legally married. It also means, for purposes under the Plan, "same-sex spouse" means a same- sex partner who is legally married to the associate. ADP will recognize and a spouse from a legal common law marriage only if all the following criteria are satisfied:

- The associate's common law marriage must be established in a state that recognizes common law marriage, and the associate and the common law spouse must satisfy all criteria required to establish a common law marriage in that state
- The associate and his or her common law spouse must cohabitate in a state which recognizes common law marriage
- The associate and his or her common law spouse must "hold themselves out as husband and wife". They must tell the world that they are husband and wife through their conduct, such as the woman's assumption of the man's surname
- The associate and his or her common law spouse must file their federal income tax return as married filing jointly or married filing separately
- The associate will be required to provide proof of the common law marriage. Proof of the common law marriage may be provided in the form of a written declaration or administrative order from the state in which the common law marriage was established (for those states that issue such documentation). In addition, the associate and his or her common law spouse must produce his or her most recent federal income tax returns indicating that the associate and his or her common law spouse filed either as "married filing jointly" or as "married filing separately". ADP retains the right to request proof of an associate's filing status at any time. The associate must also produce, if such exists, any evidence of an agreement to be married.

### Domestic Partner

The term "domestic partner" is defined in ADP's Domestic Partner Benefit Policy for the Automatic Data Processing, Inc. Flex 2000 Plan.

### Payment Options

There are various methods by which benefits may be distributed to you from the Plan. The method depends upon the value of your benefit, your marital status, as well as elections you and your spouse make or that you make on behalf of yourself and your domestic partner. At the time of retirement, you will be provided with information regarding your payment options and the required forms for making the necessary elections.

Please note that if you are married when you retire and elect a form of payment other than the Joint and Survivor annuity, your spouse must consent in writing to the waiver in the presence of a notary public or a plan representative. You may revoke any waiver before the payments begin.

If you have a domestic partner when you retire, you may elect (without the consent of your domestic partner) to receive your distribution in any of the forms of payment described below.

1. **Lump Sum Payment** - Under this option you will receive a one-time lump sum payment that can be paid directly to you or as a direct rollover to another tax-qualified plan or an IRA. If you have the payment made directly to you, you can still decide to roll over all or part of it to an IRA or to another tax-qualified plan, but that decision must be made within 60 days after you receive payment. Since payment choices have tax implications, you should consult a tax advisor with any questions you may have.

2. **Straight Life Annuity** - Single associates (including those with a domestic partner) and married associates (with spousal consent) who choose this option will receive payments over their lifetime only. This is the normal form of payment for single associates.
3. **Joint and Survivor Annuity** - Under this option, you will receive a monthly payment over your lifetime but with the added protection that if you should die, a percentage of your payment (either 50%, 75% or 100%) will continue to your spouse or domestic partner for the remainder of their lifetime. Married associates will automatically receive a 50% Joint and Survivor Annuity, unless they elect otherwise. Note that the greater the amount of continuation to your surviving spouse or domestic partner, the greater the reduction to your benefit.
4. **Life Annuity with Ten-Year Guaranteed Payment** - Single associates (including those with a domestic partner) and married associates (with spousal consent) may elect this option. Under this option, you will receive payments for your lifetime but with the added protection that, if you should die during the ten-year guaranteed period (120 months), payments will be continued to your designated beneficiary for the balance of the period. Again, this option provides a smaller monthly benefit to you than a Straight Life Annuity.

### Lump Sum Payment of Pre-1990 Benefits

In addition to any of the payment options mentioned above, single associates (including those with domestic partners) and married associates (with spousal consent) may elect to receive the pre-1990 benefit as a lump sum if monthly payments are less than $50. Otherwise, the benefit must be paid in the form of an annuity.

### Naming a Beneficiary

The beneficiary of your Plan account is the person or trust that you designate to receive your Plan benefit in the event of your death. To designate a beneficiary, you must complete and submit a beneficiary designation form, which is available at www.myplansconnect.com/adppension.

If you are married, your beneficiary is automatically your spouse. If you wish to designate a beneficiary other than or in addition to your spouse, you must obtain your spouse's written, notarized consent. If you die without naming a beneficiary, and you are not married, your estate will receive the value of your Plan benefit as further described below.

### If You Die Before You Retire

If you die while you are an active ADP associate, you will be considered fully vested in your pension benefit.

If you are married and die before retirement, your spouse will automatically receive any benefits earned. The death benefit payable on benefits earned through December 31, 1989, to your spouse will be in the form of a 50% Joint and Survivor Annuity, which provides monthly payments over the life of your spouse. If you are not married and die before retirement, any benefits earned through December 31, 1989, will be forfeited. If you have a domestic partner and die before retirement, any benefits earned through December 31, 1989, will be paid in the form of a 50% Joint and Survivor Annuity to your domestic partner, so long as you have designated your domestic partner as your beneficiary. Otherwise, these benefits will be forfeited.

Benefits earned on or after January 1, 1990, will be paid to your spouse or beneficiary in the form of either a Pre-retirement Survivor Annuity or a lump sum payment. If there is no spouse or beneficiary named, payment will be made in a lump sum to your estate.

If you die before you retire, the commencement of the benefits paid to your spouse, beneficiary, or estate are as follows:

- If your surviving spouse is your sole beneficiary and you die prior to your Normal Retirement Date, but at a time when you are eligible for Early Retirement, then the lump sum or Pre-retirement Survivor Annuity can commence on the date of your Normal Retirement Date or as of the first day of the month designated by your spouse, but not later than the calendar year after which you would have attained age 73.
- If your surviving spouse is your sole beneficiary and you die on or after your Normal Retirement Date, the Pre-retirement Survivor Annuity will commence on the first day of the month coincident with or next following your death.

- If your surviving spouse is your sole beneficiary and you die prior to being eligible for Early Retirement, then the Pre-retirement Survivor Annuity will commence on the date of your Normal Retirement Date or, if elected by your Spouse, as of the first day of the month after your Early Retirement Date, but not later than the calendar year after which you would have attained age 73.
- If your surviving spouse is not your sole designated beneficiary, then the Pre-retirement Survivor Annuity will commence for non-spousal beneficiaries (including domestic partners) no later than the December 31st of the calendar year immediately following the calendar year in which you died.
- If your non-spousal beneficiary elects to be paid your death benefit as a lump sum payment or your death benefit is to be paid to your estate, the lump sum payment will be paid no later than the December 31st of the calendar year containing the fifth anniversary of your death.

### Employment Termination

Payment of the benefits you earned under the Plan is generally made upon retirement. However, if your employment terminates and your vested benefit is $7,000 or less, you may elect to receive a lump sum payment at employment termination.

Absent an election to receive your vested benefit in the form of a single lump sum payment or to have your vested benefit paid as a "direct rollover" to your IRA or to another employer's tax qualified plan, vested amounts less than or equal to $7,000 will be transferred to an IRA established in your name with Inspira Financial. Your vested benefit will be invested in an investment product designed to preserve principal and provide a reasonable rate of return. Fees and expenses for the IRA will be charged against your account unless you contact Inspira Financial and request to make payment of the fees out-of-pocket. Inspira Financial can be reached by phone at 877-682-4727 or by mail at: Inspira Financial, 2001 Spring Road, Suite 700, Oak Brook IL 60523.

Please note that the automatic rollover provision stated above does not apply to those associates who have already reached the Plan's Normal Retirement Age upon termination. The Plan Administrator will attempt to work with you prior to such distribution or transfer to allow you time to establish a rollover account if desired.

### Returning To Work After You Retire

You may choose to retire, and then decide to return to work, or you may continue working after age 65. If you do this, there might be an effect on your Social Security status. If you are rehired and you are receiving an annuity from the Plan, effective as of January 1, 2020, you will continue to receive such annuity payments.

### Social Security and Your Pension Plan

Social Security is a retirement plan sponsored by the federal government and paid for by you and your employer. You'll need to apply for Social Security benefits by contacting the local Social Security Administration office.

### Taxes

Current federal tax laws indicate the following tax status of Plan payments:

### Retirement Income to Participants

Payments made from this Plan would usually be included as ordinary income for federal tax purposes.

### Payments to Survivors

Payments received from this Plan by a survivor are similarly taxable as ordinary income for federal tax purposes.

### Withholding Taxes

Generally, payments from the Plan are subject to taxation at earned income rates. When you are ready to begin collecting your pension benefit, you will have the opportunity to elect your tax-withholding amount subject to applicable laws and regulations.

### Plan Funding
ADP pays the full cost of the Plan. Associate contributions are not required or permitted. ADP's actual cash contribution to the Plan in any year is actuarially determined.

# Your ERISA Rights

### General Information
At some time, you, your beneficiary, spouse or other person (called "Claimant") may not agree about a benefit. In that case, the Plan allows the Claimant to file an application for a review of the issue with the Committee, on a form provided for that purpose.

If the Claimant's application is denied, the Committee will so notify the Claimant giving reasons for the denial. This notice will refer to the specific provisions on which the denial is based, will explain the review procedure, and will specify whether additional information is needed from the Claimant.

Within 60 days after receiving the denial, the Claimant may submit a written request to the Committee for reconsideration of the application. Documents or records relied on by the Claimant should be filed with the request.

The Claimant may review relevant documents and submit issues and comments in writing. The Committee will review the claim and within 60 days (or 120 days if a hearing is held) provide a written response to the appeal. The response will explain the reasons for the decision and refer to the provisions of the Plan on which the decision is based. This decision of the Committee is the final one under this Claims Procedure.

### Benefit Claims Procedures
Under the Plan, you receive your benefit as a matter of course if you apply for it at your retirement age. After you leave ADP, you will receive explanations of the payment forms available to you and the differences between them. At the time you wish benefits to begin, you will be asked to complete any required forms or applications.

To file a claim for benefits, you or your designated beneficiary must file a written claim to the Retirement Committee. If your claim for benefits is denied in full or in part, you or your designated beneficiary will be notified within 90 days of the Retirement Committee's receipt of the claim for benefits. This time limit may be extended for up to another 90 days in special cases, but you will be notified of the reasons for the delay.

If you receive notice that your claim for benefits has been denied, either in full or in part, the notice will explain the reasons for the denial, including:

- the specific reason or reasons for the denial,
- a specific reference to the pertinent provisions upon which the denial is based,
- a description of any additional material or information necessary to perfect the claim for benefits together with an explanation of why such material or information is necessary,
- an explanation of the claim review procedure, and
- a statement regarding your right to bring a court action following a denied appeal under ERISA Section 502(a).

After receiving a denial, you or your beneficiary must submit, within 60 days, a written request for reconsideration. Any such request should be accompanied by documents or records in support of the appeal. Within 60 days receipt of the appeal (or 120 days under special circumstances), the Committee shall deliver to you or your beneficiary a written decision with respect to the appeal.

If any judicial proceeding is undertaken to appeal the denial of a claim, challenge the amount of any benefit under the Plan or bring any other action under ERISA other than a breach of fiduciary duty claim, any such judicial proceeding must be filed within the earlier date of the following: (a) 90 days after the final decision on any administrative claim for benefits submitted to the Committee; or (b) within 3 years after the date when the participant or beneficiary submits their authorization to commence payment of the Plan benefits at issue in the judicial proceeding.

The evidence presented in such a judicial proceeding will be strictly limited to the evidence timely presented to the Committee (or its designee). You may not file an action at law or in equity for benefits under the Plan until the administrative appeal rights described herein have been exercised and exhausted in full, and the Plan benefits requested in your appeal have been denied in whole or in part.

### Plan Documents versus SPD

One of the primary purposes of this SPD is to provide associates of ADP with a clear, concise description of their benefits. The material contained has been carefully prepared and avoids complex language and legal terms wherever possible. ADP wants its associates to know the benefits that have been made available to them, to understand the coverage, and to have all the essential information concerning these Plans.

Plan documents on file in the Global Total Rewards Department contain more detailed information in explicit legal text that governs the administration of our Plans. If a question should arise concerning the nature of these benefits, the actual legal document of the Plans, and not the contents of this SPD, will rule.

### Pension Benefit Guaranty Corporation

Your pension benefits under this Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their Plan, but some people may lose certain benefits.
The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the Plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates; (2) some or all of benefit increases and new benefits based on Plan provisions that have been in place for fewer than 5 years at the time the Plan terminates; (3) benefits that are not vested because you have not worked long enough for the Company; (4) benefits for which you have not met all of the requirements at the time the Plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your Plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

### Plan Continuation

While ADP hopes and expects to continue the Plan indefinitely, it reserves the right by written resolution of the Board of Directors of the Company to terminate, discontinue making contributions to, amend or modify the Plan at any time.

If ADP should find it necessary to fully or partially terminate the Plan, you will be 100% vested in the Retirement Benefit, which you have accrued to the date of termination. If such a termination occurs, the Trust Fund would be used principally to provide Retirement Benefits to you and your beneficiaries. Only when all accrued Retirement Benefits and expenses of the Plan have been satisfied, will any surplus due to actuarial error be returned to the Company except for the portion (if any) attributable to employee contributions.

If the trust assets would not be sufficient to provide all the Retirement Benefits, which have been vested, ERISA has established the following order for their distribution: Benefits attributable to employee contributions:

- To all participants and their beneficiaries who have been receiving or were eligible to receive benefits in the three years prior to the date of Plan termination;
- To all participants who are eligible for Early Retirement at least three years prior to the date of Plan termination;
- To all other participants, up to the amount of Retirement Benefits guaranteed by the PBGC;
- To fully fund Retirement Benefits of these other participants; and then
- To participants who would not otherwise be vested.

Your Retirement Benefit will be distributed in the normal form, unless you elect an optional form of distribution.

### Statement of ERISA Rights

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

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- 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.

Obtain a statement telling you whether you have rights to receive a vested benefit at normal retirement age (age 65) or earlier and if so, what the amount your benefit would be if you stop working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. Plan fiduciaries of the Plan are the people who operate your Plan and have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA. If your claim for a pension benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial.

### Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied, or ignored, in whole or in part, you may file in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### Assistance with Your Questions

If you have any questions about your Plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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.

- Atlanta Regional Office - 61 Forsyth Street, S.W., Ste. 7B54, Atlanta, GA 30303 (404) 302-3900
- Boston Regional Office – JFK Federal Bldg., 15 Sudbury St, Rm 575, Boston, MA 02203 (617) 565-9600
- Chicago Regional Office – John C. Kluczynski Federal Bldg., 230 S. Dearborn Street, Ste 2160, Chicago, IL 60604 (312) 353-0900
- Cincinnati Regional Office - 1885 Dixie Hwy, Ste. 210, Ft. Wright, KY 41011-2664 (859) 578-4680
- Dallas Regional Office - 525 South Griffin Street, Room 900, Dallas, TX 75202-5025 (972) 850-4500
- Kansas City Regional Office – 2300 Main St, Ste 1100, Kansas City, MO 64108 (816) 285-1800
- Los Angeles Regional Office – 35 N. Lake Ave., Ste 300, Pasadena, CA 91101 (626) 229-1000
- Miami District Office – 1000 S Pine Island Road, Ste 100, Plantation, FL 33324 (954) 424-4022
- New York Regional Office – 33 Whitehall St, Ste 1200, New York, NY 10004 (212) 607-8600
- Philadelphia Regional Office – 1835 Market Street, 21st Floor, Mailstop EBSA/21, Philadelphia, PA 19106-2968 (215) 861-3500
- San Francisco Regional Office – 90 7th St, Ste 11-300, San Francisco, CA 94103 (415) 625-2481
- Seattle District Office – 300 Fifth Avenue, Ste 1110, Seattle, WA 98104 (206) 757-6781
- Washington D.C. District Office – 1335 East-West Hwy, Ste 200, Silver Spring, MD 20910 (202) 693-8700

### Loss or Denial of Benefits

Once you become vested in benefits under the Plan, you cannot lose your right to these benefits. However, if you elect a single life annuity and die, there will be a forfeiture since no additional benefits are payable to a beneficiary.

### Non-assignment of Benefits

You may not assign the benefits provided for you by the Plan, nor are these benefits subject to the claims of any creditor, unless otherwise provided by law. One exception to this rule is the "Qualified Domestic Relations Order." A Qualified Domestic Relations Order is defined as a judgment, decree or court order approving property settlement agreements, and/or relating to child support, alimony or marital property rights of a spouse, child or other dependent of a participant. To be binding, a Qualified Domestic Relations Order must specify certain required legal information and cannot alter the amount or form of Plan benefits. No Plan benefits will be paid pursuant to a Qualified Domestic Relations Order earlier than the earliest retirement age defined by section 414(p) of the Internal Revenue Code.

### Rights to Re-employment
The existence of the Plan does not affect the employment rights of any associate or the right of ADP to discharge an associate.

### Top Heavy Rules
Each year, ADP is responsible for determining whether the Plan is a "Top Heavy" plan, meaning that the present value of benefits for "key" employees is 60% higher than for all other employees.

If the Plan becomes "top heavy" in any plan year, then special rules apply. Among these rules is the following: non-key employees will have their vested benefits determined under the better of the Plan's vesting schedule (3 years of service) or the following schedule.

| Years of Service | Percentage |
|---|---|
| 2 | 20 |
| 3 | 40 |
| 4 | 60 |
| 5 or more | 100 |

### Administrative Details
The information furnished constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional information is also furnished.

The Plan below provides benefits for certain associates of Automatic Data Processing, Inc. and its participating Affiliates ("ADP").

| Plan Number | Plan 001 |
|---|---|
| Plan Name and Coverage | Automatic Data Processing, Inc. Pension Retirement Plan |
| Plan Administration | A Retirement Plan Committee (the "Retirement Committee" or "Committee") |
| Funding Medium | Automatic Data Processing, Inc. Pension Retirement Plan Custodial Account |
| Plan Year (for Fiscal and Other Records) | January 1st to December 31st |
| Plan Sponsor | Automatic Data Processing, Inc. |
| Plan Administrator | The Retirement Plan Committee |
| Plan Address | Automatic Data Processing, Inc.<br>One ADP Boulevard M/S C237, Roseland, NJ 07068<br>Telephone: 973-974-5000<br>Identification Number: 22-1467904 |
| Agent for Service of Legal Process | Michael Bonarti, Esq. , Chief Administrative Officer, c/o Automatic Data Processing, Inc. |
| Plan Fiduciaries | The named Plan Fiduciary is the Retirement Plan Committee. |

## Appendix I

# Enhanced Benefit for Certain Members

### Eligibility

Regular full-time and part time associates who (1) attained age fifty-five (55) and completed ten (10) years of Vesting Service as of June 30, 2018, or (2) would have attained age fifty-five (55) and completed ten (10) years of Vesting Service as of June 30, 2018, if such Member had continued in active service through that date; is not an Excluded Member; and met one of the following conditions is eligible for an Enhanced Benefit:

- "Involuntary Termination"
  - On or after January 16, 2018, and on or before January 16, 2019, the associate was terminated by the Company other than for Cause or because of a unit of the Company being sold in a corporate transaction.
- "Voluntary Termination"
  - On or after March 15, 2018, and on or before May 1, 2018, the associate elected to retire during the Voluntary Early Retirement Program window or dies before making an election during the Voluntary Early Retirement Program window.
  - On or after January 16, 2018, and on or before March 14, 2018, the associate voluntarily retires

Excluded Member means any Member who (1) is a letter grade executive with designation E or above as of February 28, 2018; (2) terminated employment and had his or her last day of work before January 16, 2018, or had a severance from employment before January 16, 2018; (3) permanently resides and works outside the U.S. as of February 28, 2018, and has a benefit under the Plan from prior service performed in the U.S.; (4) terminated employment and received a distribution of all benefits under the Plan, and was rehired on or after January 1, 2015; (5) was rehired on or after January 1, 2015 and is receiving distributions from the Plan; or (6) notifies the Company on or after January 16, 2018, and on or before March 14, 2018, of the intent to voluntarily terminate employment for reasons other than retirement and has his or her last day of work on or after January 16, 2018.

To be eligible for an Enhanced Benefit, an associate must execute all agreements specified by the Company and satisfy all applicable requirements.

### Involuntary Termination—How Your Enhanced Benefit is Determined

The Enhanced Benefit, rounded up to the next highest $100 increment, is equal to the difference, if any between (1) and (2).

(1) The greater of (i) and (ii):

(iv) The product of (A) the product of (I) 3/52 and Base Income and (B) years of Vesting Service as of June 30, 2018, or

(v) The product of (A) 40/52 and (B) Base Income

(2) Is the total of severance and other payments (excluding annual incentive bonus payments) payable by the Company, if any.

### Voluntary Termination—How Your Enhanced Benefit is Determined

The Enhanced Benefit, rounded up to the next highest $100 increment, is equal to the greater of (1) and (2).

(1) The product of (A) the product of (I) 3/52 and Base Income and (B) years of Vesting Service as of June 30, 2018, or

(2) The product of (A) 40/52 and (B) Base Income.