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# What You Need to Do: Open Enrollment 2012–2013

Open Enrollment for 2012–2013 Plan Year – when you'll update your benefit elections for the coming Plan Year – is here. Here's what you need to do.

**ANSWER THIS QUESTION: Do I Need to Enroll?**

**Yes, you need to enroll if:**

- You want to participate in a Health Care or Dependent Care Flexible Spending Account.
- You want to change benefit plans, or your current plan is no longer available.

**No, you don't need to enroll if:**

- You don't want to participate in a Health Care or Dependent Care Flexible Spending Account.
- You want to keep your current benefit plans (at 2012–2013 rates) and they're still available.
- You only want to change your PCP or PCD (please contact your insurance carrier directly for this request).

**Don't Forget …**

If you want to participate in a Health Care or Dependent Care FSA, you must enroll in it each Plan Year.

**If you need to enroll, follow these steps. If you are only eligible to enroll in an FSA, please skip to Step 2.**

## STEP 1. REVIEW

You'll need to know what's changing and what your options are for the 2012–2013 Plan Year. Here are the key pages to review:

- Your Current Benefits – shows your current benefit elections.
- Plan Availability/Offering Changes – shows what plans (specific to you) are changing.

## STEP 2. CHOOSE

You can enroll online or by using the enclosed enrollment form.

- **To Enroll Online:**
  - Read the enrollment instructions in this kit.
  - Follow the step-by-step directions on the Web site.
- **To Enroll by Paper Form:**
  - Read the enrollment instructions in this kit.
  - Complete the Health and Welfare Benefits Enrollment Form. If a carrier-specific enrollment form is in this kit, you must also complete it.

## STEP 3. TAKE ACTION

**You must enroll online or submit your paper enrollment form before your enrollment deadline, shown on the cover of this kit.** If you do not enroll by the deadline, your new benefit elections will not be recorded or your new coverage may be delayed.

If your current medical or dental plan is being replaced and you are being enrolled in an HMO, QPOS, POS/OA HMO or DMO replacement plan, you must elect a primary care physician (PCP) or primary care dentist (PCD) **before your June 1 plan effective date** by calling the insurance carrier directly. If you don't, your coverage may be interrupted, reducing your benefits. Each insurance carrier's phone number and Web site address is on the plan's respective benefit summary in this kit.

**Employee Service Center**
10200 Sunset Drive
Miami, FL 33173-3033
www.mytotalsource.com

# Health and Welfare Plan Open Enrollment 2012 - 2013

## YOUR DEADLINE FOR ENROLLMENT IS 05/07/2012

Dear Worksite Employee:

Open Enrollment 2012 - 2013 for the ADP TotalSource, Inc. Health and Welfare Plan is here! The effective date for the new Plan Year is June 1, 2012. Open Enrollment is a time for you to review and compare your current coverage to that which is available for the new Plan Year to ensure that your coverage is aligned with you and your family's health care needs for the upcoming Plan Year. Additionally, if you are not currently participating, this is your opportunity to take advantage of the valuable benefits offered through the ADP TotalSource Health and Welfare Plan. Simply review your Open Enrollment Kit and make your elections. Please refer to the instruction pages that follow for more details on the process.

## Important Information for 2012!

**Health Care Reform Legislation**

As you may know, Health Care Reform legislation known as the Patient Protection and Affordable Care Act (or PPACA) was passed early in 2010. As such, you may be asking how this will affect your health care benefits through ADP TotalSource. Your employer, through its partnership with ADP TotalSource, already offers comprehensive health care coverage for eligible employees and their eligible family members. We don't expect these measures to significantly affect your access to the valuable programs that support the health and well-being of you and your family. It's important to note that many of the legislations' requirements will be phased in over time, with some of the provisions taking effect in 2014 and later. ADP TotalSource is committed to keeping you informed if there's a provision that will impact your benefits. Please refer to the flyer included in this enrollment kit on specific Health Care Reform disclosures affecting your health care benefits for the plan year beginning June 1, 2012.

**Flexible Spending Account (FSA) Enrollment**

If you are currently enrolled in either the Health Care FSA or the Dependent Care FSA your participation will end on May 31, 2012. **You must make a new election for the June 1, 2012 - May 31, 2013 Plan Year. Your current FSA elections will not be carried forward.** The maximum contribution limit for the Health Care FSA is $3,500. The maximum contribution limit for the Dependent Care FSA is $5,000 ($2,500, if married filing separately), however, highly compensated employees will only be permitted to contribute up to $2000 per Plan Year to the Dependent Care FSA. Please note that participation by a Self-Employed Individual (SEI) in the Dependent Care FSA may be further limited by IRS guidelines. Please refer to the FSA benefit summaries in this kit for Plan details, the definition of a highly compensated employee, and SEI participation guidelines. For important Health Care Reform changes affecting the eligibility of Over-the-Counter medications to be reimbursed through the Health Care FSA, please refer to the FSA flyer and FSA benefit summary in this kit.

**Health Care FSA - OTC Changes**

Please note that in accordance with Health Care Reform legislation, effective January 1, 2011 individuals can no longer use the ADP TotalSource Health Care FSA for the cost of over-the-counter (OTC) medications unless prescribed by a physician. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription. Refer to the Health Care FSA flyer located in the Benefits Quick Links section at www.mytotalsource.com for more details on the revised rules and for a list of the most commonly used OTC items that are still eligible for reimbursement under the Health Care FSA.

**Self-Employed Individuals**

Please note if you are a Self-Employed Individual, there are certain tax rules and regulations which affect the taxable nature of the benefits which you may elect to receive through your employer and ADP TotalSource, Inc. Please refer to the Self-Employed Individual Benefit Participation Guide in the Benefits Quick Links section located on www.mytotalsource.com for further details.

**Dependent Eligibility**

The Health Care Reform Act requires group health plans and health insurance issuers to extend dependent coverage for adult children until age 26. Further details are provided within this enrollment kit. Additionally, several states have passed legislation allowing parents to extend health coverage for their over age dependent children beyond age 26 that meet certain eligibility criteria. Please refer to the Dependent Eligibility Reference Guide in the Benefits Quick Links section located on www.mytotalsource.com for further details.

**Dependents' Social Security Numbers Required for Enrollment**

The Centers for Medicare and Medicaid Studies (CMS) requires Social Security numbers (SSNs) for health plan subscribers and their dependents in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. The Act establishes mandatory insurer reporting requirements, which help the CMS enforce Medicare secondary payer rules. In order to ensure compliance with these mandatory reporting requirements, our health insurance carriers require worksite employees to provide SSNs for all covered dependents. **As such, we will be unable to process the health plan enrollments for your identified dependents without the required SSN information.** ADP TotalSource, as well as each of our health insurance carriers, takes strict precautions to ensure the security of your personal information, including your Social Security number. If you have questions about the security measures your health insurance carrier has in place, please call their Customer Service phone number before completing your enrollment elections.

Simply review your Enrollment Kit and make your elections. Please refer to the instruction pages that follow for more details on the process. If you do not have access to enroll online and are electing to make changes by completing the Health and Welfare Benefits Enrollment Form, please return the forms to the address or fax number indicated below.

ADP TotalSource
Attn: Benefits Center
10200 Sunset Drive
Miami, FL 33173
FAX: 1-866-616-8858

Thank you in advance for your cooperation.

# Health Care Reform Disclosures

**Health Care Reform legislation known as the Patient Protection and Affordable Care Act (or PPACA) was passed in early 2010 and requires disclosure of certain changes in coverage that are being made in the ADP TotalSource Health and Welfare Plan as required by PPACA.**

### EXTENSION OF DEPENDENT COVERAGE TO AGE 26 and NOTICE OF OPPORTUNITY TO ENROLL

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the ADP TotalSource health, dental and vision coverage provided through the ADP TotalSource Health and Welfare Plan effective June 1, 2011. You must request enrollment for any adult child that you wish to cover by the election deadline indicated in your benefits enrollment kit or 30 days following your receipt of the enrollment kit, whichever is later.

### ELIMINATION OF LIFETIME DOLLAR LIMITS and OPPORTUNITY TO RE-ENROLL

Any lifetime limit on the dollar value of an "essential health benefit," as defined in section 1302(b) of the Affordable Care Act and applicable regulations, under the Plan has been removed. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to re-enroll. However, you must request enrollment by the election deadline indicated in your benefits enrollment kit or 30 days following your receipt of the enrollment kit, whichever is later.

### PATIENT PROTECTION - PRIMARY CARE PHYSICIAN (PCP) AND OB/GYN SELECTION

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

In addition to the above disclosures, further health care reform provisions affecting the ADP TotalSource Health and Welfare Plan are detailed in the ***Summary of Material Modifications*** located in your benefits enrollment kit and in the Benefits Quick Links section of MyTotalSource located at www.mytotalsource.com. Further details can also be found in the applicable health insurance carrier's certificate of coverage booklet. If you have questions regarding the above disclosures or coverage you are eligible for through the ADP TotalSource Health and Welfare Plan, contact the ADP TotalSource Employee Service Center at 1-800-554-1802.

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# Action Section

If you are making a benefit election for the 2012–2013 Plan Year, please enroll online or complete, sign and return all the forms in this section before your enrollment deadline. If you are waiving benefits, you must either enter your waiver online or complete the ADP TotalSource Health & Welfare Enrollment Form in this section.

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# Enrollment Instructions: Plan Year 2012–2013

These instructions will help you quickly and easily enroll in your 2012–2013 benefits. Enrolling online is the fastest way to choose your benefits. If you don't have Internet access, see the next page for instructions on completing the paper enrollment form in this kit. Please be sure to enroll before the enrollment deadline.

## WHY ENROLL ONLINE?

The online enrollment system walks you through the process and helps you enroll quickly and correctly. There's even a tutorial available on My TotalSource®!

## TO ENROLL ONLINE:

- **Log in to My TotalSource (www.mytotalsource.com).**
  - If you're logging in to My TotalSource for the first time, follow the instructions below:
    1. Open a new browser window.
    2. Copy the following URL, paste it into the address bar of the browser and click **Go** or press the **Enter** key: https://totalsource.adp.com/ts/login.do
    3. Click on the **Register Now** link. *If you've already registered, please skip to step 9.*
    4. Enter your **registration pass code**. You can find your registration pass code on the front page of this enrollment booklet located on the upper right-hand side of the page.
    5. Click the **Next** button.
    6. Follow the online instructions and complete the registration.
    7. Close the browser window.
    8. Open a new browser window, copy the following URL, paste it into the address bar of your browser and click **Go**: https://totalsource.adp.com/ts/login.do
    9. Click the **Employee Login** button.
    10. Enter your new user ID and password on the next screen to log in.
- **Follow the step-by-step directions on the Web site to enroll.**
    1. Under **Quick Links**, select **My Benefits** and click on **Elect Benefits**.
    2. Click on **Enrollment Period**.
    3. Make your selections for each plan you wish to participate in by clicking the button next to your desired election category. Click **Continue** after you're finished making your elections. (**Hint:** Use your paper enrollment form as a guide.)
    4. Under **Add/Edit Dependent & Beneficiary**, add your dependent and beneficiary information and attach to appropriate plan type (medical, dental or vision). Click **Continue**.
    5. *For HMO and DMO elections:* Enter your chosen primary care physician (PCP) and/or primary care dentist (PCD) for each dependent on HMO/DMO plans. Click **Continue**.
    6. Enter your beneficiary benefit distribution percentage – (remember, that percentages must be allocated as whole numbers). Click **Continue**.
    7. Click on **Review Benefits** to review your benefit elections and coverage. If they're correct, click **Accept**. Congratulations – you're done!
- **For your records, print out the confirmation page and temporary insurance card, if applicable.**

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**The benefits you elect will be effective through May 31, 2013, and cannot be changed until the next annual Open Enrollment period, unless you experience an IRS-qualified change in status (see the Summary Plan Description for details).** After you make your election, you will receive a confirmation statement summarizing your benefit elections.

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## TO ENROLL BY PAPER FORM:

Follow the instructions below to complete the two-page Health and Welfare Benefits Enrollment Form in this kit. If a carrier-specific enrollment form is in this kit, you must complete it, also. Incomplete forms will delay the processing of your benefit elections.

### To Waive/Cancel All Coverage(s):

If you are not enrolling in **any** of the benefits offered:

- Complete the **Personal Information** section or verify the pre-printed information for accuracy.
- Check (√) **Waive/Cancel All Coverage(s)** above the **Medical Options** section.

*Continues on next page*

- Place a check (√) beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- Complete the **Beneficiary Information** section (if life insurance is offered to you).
- Sign and date the enrollment form.

**To Enroll in Benefits Coverage:**

- Complete the **Personal Information** section or verify the pre-printed information for accuracy.
- **Medical Options** – Place a check (√) beside the plan and coverage level you want. If you don't want to enroll in a medical plan, place a check (√) beside your reason for waiving coverage in the **Waive Medical Coverage** box.
- **Dental Options** – Place a check (√) beside the plan and coverage level you want, or check (√) **Waive Coverage**.
- **Vision Options** – Place a check (√) beside the plan and coverage level you want, or check (√) **Waive Coverage**.
- **Basic Life and AD&D / Long-Term Disability / Short-Term Disability Plans** – If these benefits are offered to you, the level of coverage is indicated. You don't need to do anything.
- **VTL Options** – If these benefits are offered to you, your options are shown. Place a check (√) beside the plan and coverage level you want, or check (√) **Waive Coverage**.
- **FSA Options** – Write in the amount you want to contribute for the 2012–2013 Plan Year, or check (√) **Waive**.
- **Health Savings Account (HSA) Option*** – If you're currently contributing to the JPMorgan Chase HSA and if the HSA remains available to you, you can change the amount you contribute on the enrollment form.
- Complete the entire **General Information** section.
- **Dependent Information and PCP Designation**** – All applicable fields in this section must be completed.
  - If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, indicate for yourself and each covered dependent a primary care physician (PCP) or primary care dentist (PCD) by name and identification number.
  - If you want dependent coverage under any benefit plans, you must provide each dependent's name, relationship to you, Social Security number, date of birth, and gender. Indicate with an "X" if they are to be enrolled in the medical, dental and/or vision plans (and provide PCP/PCD information, if applicable).
  - ADP TotalSource℠ and our health insurance carriers require worksite employees to provide dependents' SSNs in order to comply with Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.
- **Beneficiary Information** – Complete the table for each person you would like to designate as a beneficiary for basic life and AD&PL insurance, if applicable.
- **Authorization** – Sign and date the form at the bottom of page 2. If you reside in AZ, CA, ID, LA, NV, NM, TX, WA or WI, state law requires that your spouse also sign your enrollment form.

** If you are enrolling in the HSA for the first time, you must log in to the JPMorgan Chase Online Enrollment Web site. To access the site, log in to My TotalSource at www.mytotalsource.com and click the '**View My Benefits**' link.*

*** It is very important that you write the date of birth, Social Security numbers and the primary care physician/dentist name and identification number for each dependent to be covered, if applicable.*

**Information about PCPs:** If you're enrolling in an HMO, QPOS, POS/OA HMO or DMO plan, you must identify a primary care physician (PCP) or dentist (PCD) for you and each of your covered dependents by writing the provider's name and identification number (available in the plan's provider directory or on the plan's Web site) in the table. If you do not provide the PCP's or PCD's name and identification number, the carrier may assign a provider to you, or your plan identification cards will be delayed.

# Health and Welfare Benefits Enrollment Form (2012-2013 Plan Year)

**Enrollment Deadline is 05/07/2012**

**Effective Date: 06/01/2012**

## Personal Information

Name: _____
Address: _____
_____
Phone #:( )

SSN: - -
Gender: M / F
Date of Birth: / /
Date of Hire: / /

Company: Family Entertainment Group LLC
Paygroup: 14E / 395773
Region: Mid-West
HRG: Christine Stoehrmann
Ben Rep: Denise King
~~~~~~~~~~~~~~~~
Class Code: A / All Employees
Class State: OH
Waiting Pd: 30 Days

IMPORTANT: This form has multiple pages. All pages must be completed (including your signature on the last page) and submitted, or your benefit elections may be delayed.

**( ) Waive/Cancel All Coverage(s).** (Medical option waiver section must be completed)

**Medical Options**- Elect one (1) Medical plan or Waive coverage

| Plan Offering(s) | Plan Codes(s) | Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|---|---|
| UHC-CP 1LW 500/80%-A1-OH | AXKP1 | ( ) $ 96.00 | ( ) $ 525.00 | ( ) $ 470.00 | ( ) $ 886.00 |
| UHC-CP 2LD 1000/100%-A1-OH | AXKS1 | ( ) $ 108.00 | ( ) $ 550.00 | ( ) $ 494.00 | ( ) $ 923.00 |
| UHC-CP 2LF 2000/100%-A1-OH | AXKR1 | ( ) $ 54.00 | ( ) $ 434.00 | ( ) $ 386.00 | ( ) $ 754.00 |
| UHC-CP 2LU 3000/100%-A1-OH | AXLB1 | ( ) $ 26.00 | ( ) $ 376.00 | ( ) $ 331.00 | ( ) $ 670.00 |

**Waive Medical Coverage**

( ) I certify that I am declining medical coverage at this time because I am currently covered under another health plan.

( ) I certify that I am declining medical coverage at this time and I am NOT currently covered under another health plan

**Dental Options** - Elect one (1) Dental plan or Waive coverage

| Plan Offering(s) | Plan Codes(s) | Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|---|---|
| Guardian-Value Midwest | ACOU1 | ( ) $ 28.08 | ( ) $ 56.19 | ( ) $ 58.85 | ( ) $ 90.16 |

**Waive Dental Coverage**

( ) Waive Coverage

**Vision Options** - Elect or Waive Vision coverage

| Plan Offering(s) | Plan Codes(s) | Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|---|---|
| VSP- Choice Vision Plan | ASCX1 | ( ) $ 6.24 | ( ) $ 12.48 | ( ) $ 13.36 | ( ) $ 21.35 |

**Waive Vision Coverage**

( ) Waive Coverage

**Life and Disability Plan Options**

| Plan Type | Plan Offering(s) | Plan Eligibility |
|---|---|---|
| Life | Basic $10,000 | Life offered only to those who elect medical benefits |
| LTD | LTD Basic 50% $1,000/mo-180 | LTD offered only to those who elect medical benefits |

**Flexible Spending Account (FSA) Plan Options**

| | Minimum Contribution | Maximum Contribution | Plan Year Election |
|---|---|---|---|
| ( ) I wish to enroll in the Health Care Flexible Spending Account | $50 | $3,500.00 | $_____ |
| ( ) I wish to enroll in the Dependent Care Flexible Spending Account | $50 | $5,000.00 ($2,500 if married filing separately) | $_____ |

**Waive Flexible Spending Account Coverage**

( ) Waive Health Care FSA Coverage
( ) Waive Dependent Care FSA Coverage

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# Health and Welfare Benefits Enrollment Form (2012-2013 Plan Year)

**Effective Date: 06/01/2012**

**Company: Family Entertainment Group LLC**

**Enrollment Deadline is 05/07/2012**

**Paygroup: 14E / 395773 / Mid-West**

## DEPENDENT INFORMATION AND PCP DESIGNATION

In this section, list yourself and all of your eligible dependents whom you wish to cover under a benefit plan. Provide complete information for each dependent, and identify the benefit plan(s) in which you wish to enroll each dependent by marking "X" under the appropriate benefit plan option(s).

| Name | Relation | SS# | Date of Birth | Gender | ----------Election Information--------- Medical PCP | Dental PCD | Vision |
|---|---|---|---|---|---|---|---|
| | Employee | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## BENEFICIARY INFORMATION (List individual(s) you wish to designate as Basic Life Insurance beneficiaries)

| Name | Relation | SS# | Date of Birth | Address | Amt. or % | Basic Life | Primary or Contingent |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## AUTHORIZATION

**I have read the explanation of my Health and Welfare benefits options for the current Plan Year. I authorize the elections I have made, as well as any pre-tax payroll deductions required for these elections unless I complete an additional form requesting that benefit deductions be taken on a post-tax basis. I understand that during this or any future open enrollments if I do not make changes to my then-current health plan elections, my elections will default to either the same health plan election or a designated replacement health plan election specified in the personal statement for that enrollment period, and that such a default may result in a higher cost and increased deduction from my pay. By signing this Form, I am also authorizing any pre-tax deductions required to cover the defaulting elections.**

**I understand that if I am considered a Self-Employed Individual, according to the Internal Revenue Code, I am not eligible to pay for my benefits under the ADP TotalSource, Inc. Health and Welfare Plan ("Plan") on a pre-tax basis, except for the Dependent Care FSA, Additionally, I am not eligible to make contributions to the Health Care FSA.***

**I acknowledge that in the event of the termination of my employment, my health, dental, vision and group life insurance coverage will continue through the end of the month in which my termination occurs. Other coverage, such as disability and participation in the FSA plan (if applicable), will end on the date of my employment termination. I agree that upon my termination, the amount needed to cover my contributions to my insurance premium(s) for that month's coverage becomes immediately due and payable and will be deducted from my final paycheck(s). I understand that this final deduction amount may be higher than the amounts deducted in previous pay periods. I understand that I cannot change my elections before the next annual enrollment period, unless a qualified change in status occurs and my requested election change is consistent with the change in status event.* I understand that if I am a newly-eligible employee waiving medical coverage because I am covered under another medical plan, I must indicate this under the medical options section by choosing the first "Waive Coverage" option. Absence of this indication may affect my eligibility for HIPAA special enrollment period should I lose this other coverage at a later date.***

**I hereby certify that the above information is complete and accurate.**

**Worksite Employee Signature**_____ **Date**_____ **Spouse's Signature**_____ **Date**_____

Required only for married residents of AZ,CA,ID,LA,NV,NM,TX,WA and WI who are designating a non-spouse beneficiary for the life insurance option.

*Please see the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description for further details.

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# Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial (**877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

**If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility.**

| ALABAMA – MEDICAID | ALASKA – MEDICAD |
|---|---|
| **Web site:** http://www.medicaid.alabama.gov<br>**Phone:** (855) 692-54474 | **Web site:** http://health.hss.state.ak.us/dpa/programs/medicaid/<br>**Phone (Outside of Anchorage):** (888) 318-8890<br>**Phone (Anchorage):** (907) 269-6529 |
| **ARIZONA – CHIP** | **COLORADO – MEDICAID** |
| **Web site:** http://www.azahcccs.gov/applicants<br>**Phone (Outside of Maricopa County):** (877) 764-5437<br>**Phone (Maricopa County):** (602) 417-5437 | **Medicaid Web site:** http://www.colorado.gov/<br>**Medicaid Phone (In state):** (800) 866-3513<br>**Medicaid Phone (Out of state):** (800) 221-3943 |
| **FLORIDA – MEDICAID** | **GEORGIA – MEDICAID** |
| **Web site:** https://www.flmedicaidtplrecovery.com/<br>**Phone:** (877) 357-3268 | **Web site:** http://dch.georgia.gov/<br>Click on Programs, then Medicaid<br>**Phone:** (800) 869-1150 |
| **IDAHO – MEDICAID AND CHIP** | **INDIANA – MEDICAID** |
| **Medicaid Web site:** www.accesstohealthinsurance.idaho.gov<br>**Medicaid Phone:** (800) 926-2588<br>**CHIP Web site:** www.medicaid.idaho.gov<br>**CHIP Phone:** (800) 926-2588 | **Web site:** http://www.in.gov/fssa<br>**Phone:** (800) 889-9948 |

*Continues on next page*

| IOWA – MEDICAID | KANSAS – MEDICAID |
|---|---|
| **Web site:** www.dhs.state.ia.us/hipp/<br>**Phone:** (888) 346-9562 | **Web site:** http://www.kdheks.gov/hcf/<br>**Phone:** (800) 792-4884 |
| **KENTUCKY – MEDICAID** | **LOUISIANA – MEDICAID** |
| **Web site:** http://chfs.ky.gov/dms/default.htm<br>**Phone:** (800) 635-2570 | **Web site:** http://www.lahipp.dhh.louisiana.gov<br>**Phone:** (888) 695-2447 |
| **MAINE – MEDICAID** | **MASSACHUSETTS – MEDICAID AND CHIP** |
| **Web site:** http://www.maine.gov/dhhs/OIAS/public-assistance/index.html<br>**Phone:** (800) 572-3839 | **Web site:** http://www.mass.gov/MassHealth<br>**Phone:** (800) 462-1120 |
| **MINNESOTA – MEDICAID** | **MISSOURI – MEDICAID** |
| **Web site:** http://www.dhs.state.mn.us/<br>Click on Health Care, then Medical Assistance<br>**Phone:** (800) 657-3629 | **Web site:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>**Phone:** (573) 751-2005 |
| **MONTANA – MEDICAID** | **NEBRASKA – MEDICAID** |
| **Web site:** http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml<br>**Phone:** (800) 694-3084 | **Web site:** http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx<br>**Phone:** (877) 255-3092 |
| **NEVADA – MEDICAID** | **NEW HAMPSHIRE – MEDICAID** |
| **Medicaid Web site:** http://dwss.nv.gov/<br>**Medicaid Phone:** (800) 992-0900 | **Web site:** www.dhhs.nh.gov/ombp/index.htm<br>**Phone:** (603) 271-8183 |
| **NEW JERSEY – MEDICAID AND CHIP** | **NEW YORK – MEDICAID** |
| **Medicaid Web site:** http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>**Medicaid Phone:** (800) 356-1561<br>**CHIP Web site:** http://www.njfamilycare.org/index.html<br>**CHIP Phone:** (800) 701-0710 | **Web site:** http://www.nyhealth.gov/health_care/medicaid/<br>**Phone:** (800) 541-2831 |
| **NORTH CAROLINA – MEDICAID** | **NORTH DAKOTA – MEDICAID** |
| **Web site:** http://www.ncdhhs.gov/dma<br>**Phone:** (919) 855-4100 | **Web site:** http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>**Phone:** (800) 755-2604 |
| **OKLAHOMA – MEDICAID AND CHIP** | **OREGON – MEDICAID AND CHIP** |
| **Web site:** http://www.insureoklahoma.org<br>**Phone:** (888) 365-3742 | **Web site:** http://www.oregonhealthykids.gov<br>http://www.hijossaludablesoregon.gov<br>**Phone**: (877) 365-3742 |

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| PENNSYLVANIA – MEDICAID | RHODE ISLAND – MEDICAID |
|---|---|
| **Web site:** http://www.dpw.state.pa.us/hipp<br>**Phone:** (800) 692-7462 | **Web site:** www.ohhs.ri.gov<br>**Phone:** (401) 462-5300 |
| **SOUTH CAROLINA – MEDICAID** | **SOUTH DAKOTA – MEDICAID** |
| **Web site:** http://www.scdhhs.gov<br>**Phone:** (888) 549-0820 | **Web site:** http://dss.sd.gov<br>**Phone:** (888) 828-0059 |
| **TEXAS – MEDICAID** | **UTAH – MEDICAID AND CHIP** |
| **Web site:** https://www.gethipptexas.com/<br>**Phone:** (800) 440-0493 | **Web site:** http://health.utah.gov/upp<br>**Phone:** (866) 435-7414 |
| **VERMONT – MEDICAID** | **VIRGINIA – MEDICAID AND CHIP** |
| **Web site:** http://www.greenmountaincare.org/<br>**Phone:** (800) 250-8427 | **Medicaid Web site:** http://www.dmas.virginia.gov/rcp-HIPP.htm<br>**Medicaid Phone:** (800) 432-5924<br>**CHIP Web site:** http://www.famis.org/<br>**CHIP Phone:** (866) 873-2647 |
| **WASHINGTON – MEDICAID** | **WEST VIRGINIA – MEDICAID** |
| **Web site:** http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm<br>**Phone:** (800) 562-3022, Ext. 15473 | **Web site:** www.dhhr.wv.gov/bms/<br>**Phone:** (877) 598-5820, HMS Third Party Liability |
| **WISCONSIN – MEDICAID** | **WYOMING – MEDICAID** |
| **Web site:** http://www.badgercareplus.org/pubs/p-10095.htm<br>**Phone:** (800) 362-3002 | **Web site:** http://health.wyo.gov/healthcarefin/equalitycare<br>**Telephone:** (307) 777-7531 |

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323, Ext. 61565

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# TotalChoice Voluntary Benefits: Limited Time Enrollment

**This special limited time enrollment is available between April 1st and May 18th for an effective date of coverage of July 1st, 2012. Please visit www.adptsvoluntarybenefits.com to enroll. For questions, please call 1-800-557-1038.**

## Level Term Life Insurance

**Get up to $150,000 in 20-year level term coverage with no medical questions.**

The Humana Level Term Life Insurance Plan enables you and your loved ones to receive multiple benefits while you're living. And in the event of an unexpected death, a term life plan can help provide the financial security your family may need–such as everyday living expenses; housing, car payments, medical bills and future expenses like college tuition. The plan also offers you the option to increase your level of coverage over time.

## Critical Illness Insurance

**Get up to $30,000 in coverage with no medical questions (Pre-Existing Conditions Clause does apply).**

Make sure you don't limit your access to medical care by not having the financial safety net you need. We're all living longer, but sometimes that means living longer with illnesses that are life-threatening. And all that medical technology and advanced care costs money.

Wouldn't it be comforting to have enough financial protection to choose the best care? With Critical Illness Insurance, you can do that.

Critical Illness Insurance provides a lump-sum benefit payment to cover out-of-pocket medical expenses and the costs associated with life changes following a critical illness that is covered by health insurance.

## Accident Insurance

**Can help protect your income and defray medical expenses if you are hurt in an accident.**

Because accidents can strike without warning and result in loss of life or an income, Accident Insurance can help provide peace of mind should the unexpected happen. Whether you are on or off the job, traveling within the United States or its territories, or your children participate in sports programs, you, your spouse, and children can have coverage in the event of an unexpected accidental injury.

Accident Insurance provides useful coverage at a cost that's affordable to you. If you die as the result of a covered injury, the benefits can help pay the mortgage or help pay for your children's college. If you are injured in a covered accident, this insurance can help.

What you get:

- Coverage is guaranteed issue during this special enrollment period (listed on the front of your enrollment kit).
- 24 hour accident coverage.
- Protection for on or off the job accidental injuries.
- Protection if you change jobs. If you leave your employer you can continue your benefits, as long as premiums continue to be paid to Allstate Benefits (marketing name for American Heritage Life Insurance Company, the underwriting company and a subsidiary of The Allstate Corporation).
- Protection for your entire family. Worksite employee, spouse, and child(ren) coverage is available.

Accident coverage is provided by limited benefit, supplemental insurance. Limitations and exclusions apply.

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## Short Term Disability

**Can pay you up to 60%* of your base earnings if you are out of work due to an illness or injury.**

Nearly 27 million Americans suffer disabling injuries each year.[1] Accidents and illnesses that keep you off the job can happen to anyone and are more common than you might think. Unum's individual short term disability insurance replaces a portion of your income if you are unable to work due to a covered injury or illness. This coverage can pay a monthly benefit to provide some income during a time of need. Common reasons people us this coverage include injuries, a covered pregnancy[2], and digestive problems – such as gall bladder surgery.

The Unum Individual Short Term Disability Insurance replaces a portion of your income if you are unable to work due to a covered injury or sickness. This means you can have some income during a time of need.

Pre-existing condition limitation–if you have a pre-existing condition** within a 12-month[3] period before your coverage effective date, benefits will not be paid for a disability period if it begins during the first 12 months the policy is in force.

*[1] National Safety Council, Injury Facts, 2010. [2] Nine months after coverage becomes effective, pregnancy is covered the same as any other covered illness. The available monthly benefit will be paid upon fulfillment of the elimination period. Benefits will not be paid if the insured individual gives birth within nine months after the coverage becomes effective. However, medical complications of pregnancy may be considered as any other covered illness, subject to the pre-existing condition limitation.*
*[3] Six-month period applies in ID and NV.*
**Employees enrolled in group STD coverage are eligible for 20% to $3,000.*
***A pre-existing condition is a condition for which symptoms existed (within 12 months before your coverage effective date) that would cause a person to seek treatment from a physician or for which a person was treated or received medical advice from a physician, or took prescribed medicine. The determination on whether your condition qualified as pre-existing will be based on the date of disability and not the date you notify Unum.*
*No Giving Birth Exclusion in KS, MT, OK In CA, HI, NJ, NY, and RI (State Sickness Plans) the maximum benefit percentage is limited to 40% not to exceed $3k per month. This policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. See the actual policy or your Unum representative for specific provisions and details of availability.*

*This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 50%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy.*
*Underwritten by: Provident Life and Accident Insurance Company, Chattanooga, Tennessee*
*In New York, underwritten by: First Unum Life Insurance Company, New York, New York*
*©2012 Unum Group. All rights reserved. Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. Unum complies with state civil union and domestic partner laws when applicable.*
*CE-12470 (1-12)*

## Group Legal Services Program

**Access to a nationwide network of attorneys, financial counselors and other valuable resources to help you prevent and resolve legal matters.**

In today's world, no matter what point you are at in your life–starting your first job, approaching retirement, or somewhere in between, you're likely to experience a legal need, planned or unplanned, that has legal implications. In the past year alone, 7 out of 10 Americans had at least one legal need that required an attorney.[4]

For only $25.65 per month, you will have access to an experienced nationwide network of attorneys, financial counselors and other valuable resources to help you prevent and resolve everyday legal matters. And, when you work with an attorney in the network, the attorney fees for most covered matters are 100% paid-in-full.

The Group Legal Services Program includes:

- Legal Representation
- Telephone Legal Advice and Consultation
- Reduced Fee Services
- Online Legal Tools and Resources
- Identity Theft Services
- Immigration Assistance
- Financial Education and Counseling Services

*[4] "Legal Needs of Today's Multi-Generational Workforce," Conducted by Russell Research and commissioned by ARAG, September 2008.*

AR Ins. Lic. #245544 | CA Ins. Lic. #0633005
d/b/a in CA Seabury & Smith Insurance Program Management
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**This special limited time enrollment is available between April 1st and May 18th for an effective date of coverage of July 1st, 2012. Please visit www.adptsvoluntarybenefits.com to enroll. For questions, please call 1-800-557-1038.**

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# Employee Certification of Dependent Tax Status

**INSTRUCTIONS: Complete and return this form only if you are enrolling one or more dependents in the following categories for benefits coverage:**

- Same-sex spouses and their children
- Common-law spouses (same-sex) and their children
- Civil union partners and their children
- Adult children that have reached age 26

I understand that the following rules apply to the federal income tax treatment of benefits coverage provided for the above-listed dependents:

- If my above-mentioned dependent **is a tax dependent** under Internal Revenue Code Section 152 (as modified by Internal Revenue Code Section 105[b]), I will not be subject to federal or state income tax on the value of the coverage provided to my dependent.
- If my above-mentioned dependent **is not a tax dependent** as defined above, I will be subject to federal and, if applicable, state income tax on the value of the coverage provided to my dependent. The taxable value of the coverage is considered imputed income, and the amount of imputed income will be determined by ADP TotalSource℠ periodically during the Calendar Year. Because ADP TotalSource allows me to pay for coverage on a pretax basis, any imputed income requires an adjustment to my taxable income. ADP TotalSource will make this adjustment on periodic payrolls during the Calendar Year, and I will be notified prior to any payroll adjustments. I understand that this adjustment may increase my federal and, if applicable, state income tax liability.

Please consult with your tax advisor before certifying below whether your enrolled dependent is a tax dependent as defined by the Internal Revenue Code. List below any dependent(s) you are enrolling from the above-listed dependent categories and indicate their tax status.

| LAST NAME | FIRST NAME | DEPENDENT RELATIONSHIP | DEPENDENT TAX STATUS | |
|---|---|---|---|---|
| | | | ☐ Tax Dependent | ☐ Not a Tax Dependent |
| | | | ☐ Tax Dependent | ☐ Not a Tax Dependent |
| | | | ☐ Tax Dependent | ☐ Not a Tax Dependent |
| | | | ☐ Tax Dependent | ☐ Not a Tax Dependent |

I certify the tax status of my dependent(s) listed above as defined by the Internal Revenue Code. I understand that ADP TotalSource will rely on this certification to determine my federal income and employment taxes. I further understand that I must notify ADP TotalSource if conditions change that would cause my dependent(s) to no longer qualify as my tax dependent(s).

Employee Name

Last 4 digits of SSN or Employee I.D.

Employee Signature

Date

**FAX OR MAIL COMPLETED FORM TO:**
**ADP TOTALSOURCE**
**Attention: Benefits Center**
**10200 Sunset Drive**
**Miami, FL 33173**
**Fax: 1-866-616-8858**

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ADP TOTALSOURCE℠

# Reference Section

The contents of this section are for review only.
Nothing in this section needs to be returned.

# SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION FOR THE ADP TOTALSOURCE, INC. HEALTH AND WELFARE PLAN

Note: This document contains important information concerning your benefits. Please review this information carefully and retain with your benefit materials for future reference. Please note that eligibility varies by benefit option and your worksite employer's elections. Those benefit options you are entitled to are described in your benefits enrollment kit.

You previously received enrollment information for the Health and Welfare Plan ("Plan"). This document is a Summary of Material Modifications ("SMM") for the 2011-2012 and 2012-2013 Plan Years for your review and records, and it contains changes to the Summary Plan Description ("SPD") that you previously received. You may obtain a copy of the SPD by logging on to My TotalSource at www.adptotalsource.com or calling the Employee Service Center at (800) 554-1802 or by email at esc@adp.com.

This SMM is intended to summarize the Plan amendments. If there is a conflict between this SMM and the actual language of the Plan, the Plan language controls.

## Summaries of the Plan Modifications are as follows:

## EFFECTIVE JANUARY 1, 2010

**Change to the High Deductible Health Plan (HDHP) Deductible and Out-of-Pocket Maximums for 2010**

On page 12 of the Summary Plan Description under the section titled **High Deductible Health Plan (HDHP),** the stated annual deductible and out-of-pocket maximum requirements are changed effective January 1, 2010 for calendar year 2010 as follows:

- For self-only coverage, an HDHP has an annual deductible of at least $1,200 and an annual out-of-pocket expense (deductibles, co-payments and coinsurance, but not premiums) not exceeding $5,950.
- For family coverage, an HDHP has an annual deductible of at least $2,400 and an annual out-of-pocket expenses (deductibles, co-payments and coinsurance, but not premiums) not exceeding $11,900.

These maximums are subject to change by the IRS each January 1st.

**Change to the High Deductible Health Plan (HDHP) Out-of-Pocket Maximums for 2012**

On page 12 of the Summary Plan Description under the section titled **High Deductible Health Plan (HDHP),** the stated annual out-of-pocket maximum requirements are changed effective January 1, 2012 for calendar year 2012 as follows:

- For self-only coverage, an HDHP has an annual out-of-pocket expense (deductibles, co-payments and coinsurance, but not premiums) not exceeding $6,050.
- For family coverage, an HDHP has an annual out-of-pocket expenses (deductibles, co-payments and coinsurance, but not premiums) not exceeding $12,100.

These maximums are subject to change by the IRS each January 1st.

**Change to Health Savings Account (HSA) Note**

On page 28 of the Summary Plan Description under the section titled **Eligibility,** the note following the 3rd bullet is changed to read as follows: "If you choose to enroll in an HDHP and plan on contributing to an HSA any time during a given Plan Year, you are not eligible to participate in the Health Care FSA during that Plan Year. See page 24 for Limited Health Care FSA details."

**Change to Health Savings Account (HSA) Contribution Limits for 2010 and 2011**

On page 28 of the Summary Plan Description under the section titled **Contribution Limits,** the stated HSA contribution limits are changed effective January 1, 2010 for calendar year 2010 and 2011 as follows:

- Contribution limit for individual coverage in 2010 and 2011 is $3,050.
- Contribution limit for family coverage in 2010 and 2011 is $6,150.

**Change to Health Savings Account (HSA) Contribution Limits for 2012**

On page 28 of the Summary Plan Description under the section titled **Contribution Limits,** the stated HSA contribution limits are changed effective January 1, 2012 for calendar year 2012 as follows:

- Contribution limit for individual coverage in 2012 is $3,100.
- Contribution limit for family coverage in 2010 and 2011 is $6,250.

**Change to Dependent Care Flexible Spending Account (FSA) Contribution Limits for Highly Compensated Employees**

On page 26 of the Summary Plan Description under the section titled, **Contribution Limits for Highly Compensated Employees,** is changed to read as follows: "Highly compensated employees will only be permitted to contribute to the Dependent Care FSA up to the amount of $2,000 for the 2010-2011 Plan Year and each Plan Year thereafter. In addition, ADP TotalSource may, at any time before or during the Plan Year (June 1 – May 31), notify a highly compensated employee that he or she must discontinue pre-tax contributions to the Dependent Care FSA or that he or she must limit such pre-tax contributions to a particular dollar amount below the $2,000 maximum if ADP TotalSource determines in its discretion that such action is necessary or advisable in order to satisfy the nondiscrimination requirements applicable to the Dependent Care FSA.

For the **2010-2011 and 2011-2012 Plan Years**, a "highly-compensated employee" is defined by the IRS as "an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a Client Company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of $110,000 annually. The definition of a highly-compensated employee may change for future Plan Years."

For the **2012-2013 Plan Year**, a "highly-compensated employee" is defined by the IRS as "an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a Client Company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of $115,000 annually. The definition of a highly-compensated employee may change for future Plan Years."

## EFFECTIVE JUNE 1, 2010

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

On page 8 of the Summary Plan Description a new section titled, **Michelle's Law** – **Continuation of Group Health Coverage for Certain Dependents,** is added to read as follows: "Michelle's Law allows continuation of group health coverage for up to one year for students who are on medically necessary leaves of absence from a post-secondary educational institution. Refer to the **Coverage While on a Leave of Absence** section located on page 41 for further details regarding this law."

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

On page 41 of the Summary Plan Description a new section titled, **Michelle's Law** – **Continuation of Group Health Coverage,** is added to read as follows: "Michelle's Law allows for continuation of group health coverage for a dependent child if the child takes a leave of absence from a post-secondary education institution, or has a change in enrollment status, that: (1) begins while the child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the child to lose student status for purposes of coverage under the plan.

A "dependent child" for purposes of Michelle's Law is a child who (1) is a dependent child of a participant or beneficiary under the terms of the plan, and (2) was enrolled in the plan on the basis of being a student at a post-secondary educational institution immediately before the medical leave of absence began.

The child's coverage will be continued for up to one year after the leave of absence begins or, if earlier, until coverage would have otherwise terminated under the terms of the plan, regardless of student status. The level of coverage and premium provided to the dependent child during Michelle's Law continuation will be the same as the benefits the child would have received if the child had continued as a covered student."

## EFFECTIVE DECEMBER 1, 2010

**Change to Dependent Eligibility**

On page 8 of the Summary Plan Description under the section titled **Dependents,** the following is added: "The Patient Protection and Affordable Care Act (PPACA) includes a provision requiring group health plans and health insurance issuers offering dependent coverage for children to continue providing that coverage for adult children until age 26. This requirement is effective for the ADP TotalSource Health and Welfare Plan on June 1, 2011, however, there are select carriers that have implemented this provision prior to the TotalSource required effective date as follows:

- Effective December 1, 2010 the following carriers allow dependent coverage up to age 26: United Health Care, Neighborhood Health Plans, and Pacificare.

- Effective January 1, 2011 the following carriers allow dependent coverage up to age 26: Blue Cross Blue Shield of Michigan and Blue Care Network."

## EFFECTIVE JANUARY 1, 2011

**Change to Health Care Flexible Spending Account (FSA) Eligible Expenses List**

On page 24 of the Summary Plan Description under the section titled **Eligible Expenses,** the first paragraph is changed to read as follows: "IRS Publication 502 Medical and Dental Expenses provides guidance on what medical expenses are eligible. However, some expenses that are deductible under IRS Publication 502 may not be reimbursable under the Health Care FSA (such as insurance premiums) and some expenses that are not deductible may be reimbursed under the Health Care FSA."

Also, on page 25 of the Summary Plan Description under the section titled **Eligible Expenses,** the following bullet item is **deleted** effective January 1, 2011:

- over-the-counter drugs (excluding cosmetic, dietary supplements or other drugs that are merely beneficial to your general health)

Effective January 1, 2011 In accordance with the Patient Protection and Affordable Care Act (PPACA) individuals will be prohibited from using the ADP TotalSource, Inc. Health Care FSA for the cost of over-the-counter medications that are not otherwise prescribed by a physician. Insulin and diabetic supplies remain eligible without a prescription.

**Change to Health Care Flexible Spending Account (FSA) Ineligible Expenses List**

On page 25 of the Summary Plan Description under the section titled **Ineligible Expenses,** the following bullet item is **added** effective January 1, 2011:

- over-the-counter drugs (including cosmetic, dietary supplements or other drugs that are merely beneficial to your general health)

Effective January 1, 2011 In accordance with the Patient Protection and Affordable Care Act (PPACA) individuals will be prohibited from using the ADP TotalSource, Inc. Health Care FSA for the cost of over-the-counter medications that are not otherwise prescribed by a physician. Insulin and diabetic supplies remain eligible without a prescription.

**Change to Health Savings Account (HSA) Eligible Expenses List**

On page 29 of the Summary Plan Description under the section titled **FACTS ABOUT HSAs,** the following is added effective January 1, 2011: "In accordance with the Patient Protection and Affordable Care Act (PPACA) starting on January 1, 2011 you will no longer be able to use HSA funds for over-the-counter ("OTC") medications unless they are prescribed by a physician. Insulin and diabetic supplies remain eligible without a prescription.

**Change to Health Savings Account (HSA) Penalty for Non-Qualified Medical Expenses**

On page 30 of the Summary Plan Description the response to the question **"What happens if I use my HSA to pay for non-qualified medical expenses?"** is changed to read as follows: "A distribution of funds for reasons other than qualified medical expenses prior to age 65 is taxable and subject to a 20-percent additional penalty. The HSA account holder would need to report this on the tax return for the corresponding tax year."

## EFFECTIVE JUNE 1, 2011

**Change to Dependent Eligibility**

On page 8 of the Summary Plan Description under the section titled **Dependents,** the following is added: "The Patient Protection and Affordable Care Act (PPACA) includes a provision requiring group health plans and health insurance issuers offering dependent coverage for children to continue providing that coverage for adult children until age 26. This requirement is effective for the ADP TotalSource Health and Welfare Plan on June 1, 2011, therefore, all health plan offerings under the ADP TotalSource Health and Welfare Plan will include coverage for adult children until age 26 effective June 1, 2011. In addition, although not required by PPACA, the TotalSource dental and vision plan offerings will include coverage for adult children until age 26.

**Important Notice Regarding Annual Dollar Limits**

On page 10 of the Summary Plan Description in the section titled **Plan Disclosures** the following language is added: In accordance with applicable law, none of the annual dollar limits (except to the extent they exceed $750,000 in 2011) that may be included in a health plan offering shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act of 2010. The law defines "essential health benefits" to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitatitve and habilitative services and devices, and laboratory services. The determination as to whether a benefit constitutes an "essential health benefit" will be made by the applicable insurance carrier.

**Important Notice Regarding Lifetime Limits**

On page 10 of the Summary Plan Description in the section titled **Plan Disclosures** the following language is added: In accordance with applicable law, none of the lifetime dollar limits that may be included in a health plan offering shall apply to "essential health benefits", as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act of

2010. The law defines "essential health benefits" to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitatitve and habilitative services and devices, and laboratory services. The determination as to whether a benefit constitutes an "essential health benefit" will be made by the applicable insurance carrier.

**Patient Protection – Primary Care Physician (PCP) and OB/GYN Selection**

On page 11 of the Summary Plan Description a new section titled **Patient Protection – Primary Care Physician (PCP) and OB/GYN Selection**, is added effective June 1, 2011 to read as follows: "The ADP TotalSource health plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the ADP TotalSource health insurance carriers or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health insurance carrier at the phone number indicated on the Benefit Summary provided in your benefits enrollment kit."

**Change to Pre-Existing Condition Exclusions**

Effective June 1, 2011, no preexisting condition exclusion or limitation under the Plan will apply to any child under age 19. On page 17 of the Summary Plan Description under the section titled **Pre-existing Conditions,** the 3rd paragraph, and 4th bullet is changed to read: "Pre-existing exclusions cannot be applied to any eligible child enrolled in the Plan under age 19."

**New Claims and Appeals Procedures**

On page 19 of the Summary Plan Description in the section titled **Medical, Dental and Vision Claim Processing** the following language is added: Effective June 1, 2011, there are some enhancements to the claims and appeals process for medical claims. This includes that if your internal appeal of a claim for medical benefits (not related to employee classifications) under the Plan is denied, you will have the right to appeal to an independent reviewer. Additional information about the new internal and external claims and appeals process for medical claims will be furnished in a future communication as well as a future version of the Plan's SPD, and in any written denial you receive.

**Change to Flexible Spending Accounts (FSAs) Deadline to File Claims**

On page 21 of the Summary Plan Description under the section titled **Requesting Reimbursement**, the 4th paragraph, second sentence is changed to read: "Therefore, the last day to file a claim for the Plan year is **July 30th**."

**Rescission of Coverage Rights**

On page 27 of the Summary Plan Description in the section titled **When Coverage Under the Plan Ends** the following language is added: ADP TotalSource and its contracted insurance carriers reserve the right to terminate the health care coverage of you/and your dependent(s) prospectively without notice for cause (as determined by ADP TotalSource and/or the applicable insurance carrier), or if you and/or your dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your dependent commits fraud or intentional misrepresentation in an application for health coverage under the Plan, in connection with a benefit claim or appeal, or in response to any request for information by ADP TotalSource or its delegees (including ADP TotalSource or its contracted insurance carriers), ADP TotalSource or the applicable insurance carrier may terminate your coverage retroactively upon 30 days notice. Failure to inform any such persons that you or your dependent is covered under another group health plan or knowingly providing false information in order to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan.

**Change to Taxation of Non-Tax Qualified Dependents**

On page 28 of the Summary Plan Description under the section titled **Taxation of Same Sex Spouse/Domestic Partner Benefits & Other Non-Tax Qualified Dependent**, the last sentence is changed to read: "This includes, but is not limited to, same-sex spouses, same-sex common law spouses, civil union dependents, adult children (age 26 and older) and ex-spouse dependents (enrolled only as required in select states)."

## EFFECTIVE JANUARY 1, 2012

**Change to Health Savings Account (HSA) Contribution Limits for 2012**

On page 28 of the Summary Plan Description under the section titled **Contribution Limits,** the stated HSA contribution limits are changed effective January 1, 2012 as follows:

- Contribution limit for individual coverage in 2012 is $3,100.
- Contribution limit for family coverage in 2012 is $6,250.

**Change to the High Deductible Health Plan (HDHP) Out-of-Pocket Maximums for 2012**

On page 12 of the Summary Plan Description under the section titled **High Deductible Health Plan (HDHP),** the stated annual out-of-pocket maximum requirements are changed effective January 1, 2012 for calendar year 2012 as follows:

- For self-only coverage, an HDHP has an annual out-of-pocket expense (deductibles, co-payments and coinsurance, but not premiums) not exceeding $6,050.
- For family coverage, an HDHP has an annual out-of-pocket expenses (deductibles, co-payments and coinsurance, but not premiums) not exceeding $12,100.

These maximums are subject to change by the IRS each January 1st.

## EFFECTIVE JANUARY 1, 2013

**Change to Health Care FSA Contribution Limits for 2013**

On page 24 of the Summary Plan Description under the section titled **Contribution Limits,** the first paragraph is changed to read as follows: "Effective January 2013, Health Care Reform requires that Health Care FSA contributions are limited to $2,500 per taxable year. Therefore, effective January 1, 2013 if you elect to participate in the Health Care FSA, you can contribute up to $2,500, but not less than $50, per Plan Year toward your medical expenses.

## IMPORTANT ANNUAL BENEFIT NOTICE(S)

**Annual Notice Regarding the Women's Health and Cancer Rights Act**

**This law requires plans that provide medical and surgical benefits for mastectomies to provide coverage for the following procedures, as requested from the patient in consultation with her physician:**

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

**HIPAA Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 60 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Also, under the Children's Health Insurance Program Reauthorization Act you or your dependent that is eligible, but not enrolled in the Plan, may enroll if either of the following two conditions are met:

(1) You or your dependent are covered under a Medicaid plan or under a State child health plan and the coverage is terminated due to loss of eligibility and you request coverage under the Plan no later than 60 days after the loss of eligibility; or

(2) Your or your dependent become eligible for assistance for coverage under the Plan, Medicaid plan or State child health plan and you request coverage under the Plan no later than 60 days after you or your dependent are determined to be eligible for assistance.

**PATIENT PROTECTION - PRIMARY CARE PHYSICIAN (PCP) AND OB/GYN SELECTION**

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

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LSG INSURANCE PARTNERS

2012/2013

**Plan Description:** UHC-CP 1LW 500/80%-OH
**Product:** POS
**Network:** Choice Plus

**Provider:** United Healthcare (UHC)
**Member Services Phone #:** 1-800-357-0978
**Plan Website Address:** http://www.uhc.com/

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **General Plan Information** | | |
| Lifetime Maximum | • Unlimited | • Unlimited |
| Calendar Year Deductible - Individual | • $500 | • $1,000 |
| Calendar Year Deductible - Family | • $1,500 | • $3,000 |
| Coinsurance | • 80% | • 60% |
| Calendar Year Out-of-Pocket Max - Individual (incl ded) | • $3,000 | • $6,000 |
| Calendar Year Out-of-Pocket Max - Family (incl ded) | • $6,000 | • $12,000 |
| **Office Visits** | | |
| Primary Care Physician Visit | • $25 copay per visit | • Covered at 60% after deductible |
| Specialist Visit | • $50 copay per visit | • Covered at 60% after deductible |
| Specialist Referral Required | • No | • No |
| **Hospital Care** | | |
| Hospital Care - Inpatient | • Covered at 80% after deductible | • Covered at 60% after deductible |
| Hospital Care - Outpatient | • Covered at 80% after deductible | • Covered at 60% after deductible |
| **Emergency Care** | | |
| Emergency Room (In-Area) | • $250 copay per visit | • $250 copay per visit |
| Urgent Care Facility | • $75 copay per visit | • Covered at 60% after deductible |
| Ambulance | • Covered at 80% after deductible | • Covered at 80% after deductible |
| **Prescription** | | |
| Tier 1 Retail | • $15 copay | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 2 Retail | • $40 copay/$100 Specialty | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 3 Retail | • $75 copay/$300 Specialty (OOP Max: ind $3,500/fam $10,500 - combined for all tiers) | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 4 Retail | • Not applicable | • Not applicable |
| Mail Order | • $37.50/$100/$187.50 copay (Specialty Rx not covered through mail order) | • $37.50/$100/$187.50 copay (Specialty Rx not covered through mail order) |
| Medicare Part D Compatible | • Yes | • Yes |
| **Maternity Care** | | |
| Pregnancy and Maternity Care (Pre-Natal Care) | • $25 copay for initial visit only. Inpatient hospital covered at 80% after deductible | • Covered at 60% after deductible |
| **Preventive Care** | | |
| Preventive Lab | • Covered at 100% | • Covered at 60% after deductible |
| Physical Examinations | • Covered at 100% | • Covered at 60% after deductible |
| Prostate Screening | • Covered at 100% | • Covered at 60% after deductible |
| Gynecology Exam | • Covered at 100% | • Covered at 60% after deductible |
| Mammograms | • Covered at 100% | • Covered at 60% after deductible |
| Well Baby Care and Immunizations | • Covered at 100% | • Covered at 60% after deductible |
| **Other Services** | | |
| Diagnostic X-Ray, Scans & Lab | • Covered at 80% after deductible | • Covered at 60% after deductible |
| Chiropractic Care | • $25 copay per visit. Limited to 20 visits. | • Covered at 60% after deductible. Limited to 20 visits per calendar year. |
| **Substance Abuse** | | |
| Inpatient Detoxification | • Covered at 80% after deductible | • Covered at 60% after deductible |
| Substance Abuse - Inpatient | • Covered at 80% after deductible | • Covered at 60% after deductible |
| Substance Abuse - Outpatient | • $25 copay. | • Covered at 60% after deductible |
| **Mental Health** | | |
| Mental Health - Inpatient | • Covered at 80% after deductible | • Covered at 60% after deductible |
| Mental Health - Outpatient | • $25 copay. | • Covered at 60% after deductible |

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LSG INSURANCE PARTNERS

2012/2013

**Plan Description:** UHC-CP 2LD 1000/100%-OH
**Product:** POS
**Network:** Choice Plus

**Provider:** United Healthcare (UHC)
**Member Services Phone #:** 1-800-357-0978
**Plan Website Address:** http://www.uhc.com/

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **General Plan Information** | | |
| Lifetime Maximum | • Unlimited | • Unlimited |
| Calendar Year Deductible - Individual | • $1,000 | • $2,000 |
| Calendar Year Deductible - Family | • $3,000 | • $6,000 |
| Coinsurance | • 100% | • 80% |
| Calendar Year Out-of-Pocket Max - Individual (incl ded) | • $1,000 | • $5,000 |
| Calendar Year Out-of-Pocket Max - Family (incl ded) | • $3,000 | • $10,000 |
| **Office Visits** | | |
| Primary Care Physician Visit | • $25 copay per visit | • Covered at 80% after deductible |
| Specialist Visit | • $50 copay per visit | • Covered at 80% after deductible |
| Specialist Referral Required | • No | • No |
| **Hospital Care** | | |
| Hospital Care - Inpatient | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Hospital Care - Outpatient | • Covered at 100% after deductible | • Covered at 80% after deductible |
| **Emergency Care** | | |
| Emergency Room (In-Area) | • $250 copay per visit | • $250 copay per visit |
| Urgent Care Facility | • $75 copay per visit | • Covered at 80% after deductible |
| Ambulance | • Covered at 100% after deductible | • Covered at 100% after deductible |
| **Prescription** | | |
| Tier 1 Retail | • $15 copay | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 2 Retail | • $40 copay/$100 Specialty | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 3 Retail | • $75 copay/$300 Specialty (OOP Max: ind $3,500/fam $10,500 - combined for all tiers) | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 4 Retail | • Not applicable | • Not applicable |
| Mail Order | • $37.50/$100/$187.50 copay (Specialty Rx not covered through mail order) | • $37.50/$100/$187.50 copay (Specialty Rx not covered through mail order) |
| Medicare Part D Compatible | • Yes | • Yes |
| **Maternity Care** | | |
| Pregnancy and Maternity Care (Pre-Natal Care) | • $25 copay for initial visit only. Inpatient hospital covered at 100% after deductible | • Covered at 80% after deductible |
| **Preventive Care** | | |
| Preventive Lab | • Covered at 100% | • Covered at 80% after deductible |
| Physical Examinations | • Covered at 100% | • Covered at 80% after deductible |
| Prostate Screening | • Covered at 100% | • Covered at 80% after deductible |
| Gynecology Exam | • Covered at 100% | • Covered at 80% after deductible |
| Mammograms | • Covered at 100% | • Covered at 80% after deductible |
| Well Baby Care and Immunizations | • Covered at 100% | • Covered at 80% after deductible |
| **Other Services** | | |
| Diagnostic X-Ray, Scans & Lab | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Chiropractic Care | • $25 copay per visit. Limited to 20 visits. | • Covered at 80% after deductible. Limited to 20 visits per calendar year. |
| **Substance Abuse** | | |
| Inpatient Detoxification | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Substance Abuse - Inpatient | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Substance Abuse - Outpatient | • $25 copay. | • Covered at 80% after deductible |
| **Mental Health** | | |
| Mental Health - Inpatient | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Mental Health - Outpatient | • $25 copay. | • Covered at 80% after deductible |

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LSG INSURANCE PARTNERS

2012/2013

**Plan Description:** UHC-CP 2LF 2000/100%-OH
**Product:** POS
**Network:** Choice Plus

**Provider:** United Healthcare (UHC)
**Member Services Phone #:** 1-800-357-0978
**Plan Website Address:** http://www.uhc.com/

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **General Plan Information** | | |
| Lifetime Maximum | • Unlimited | • Unlimited |
| Calendar Year Deductible - Individual | • $2,000 | • $4,000 |
| Calendar Year Deductible - Family | • $6,000 | • $12,000 |
| Coinsurance | • 100% | • 80% |
| Calendar Year Out-of-Pocket Max - Individual (incl ded) | • $2,000 | • $8,000 |
| Calendar Year Out-of-Pocket Max - Family (incl ded) | • $6,000 | • $16,000 |
| **Office Visits** | | |
| Primary Care Physician Visit | • $25 copay per visit | • Covered at 80% after deductible |
| Specialist Visit | • $50 copay per visit | • Covered at 80% after deductible |
| Specialist Referral Required | • No | • No |
| **Hospital Care** | | |
| Hospital Care - Inpatient | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Hospital Care - Outpatient | • Covered at 100% after deductible | • Covered at 80% after deductible |
| **Emergency Care** | | |
| Emergency Room (In-Area) | • $250 copay per visit | • $250 copay per visit |
| Urgent Care Facility | • $75 copay per visit | • Covered at 80% after deductible |
| Ambulance | • Covered at 100% after deductible | • Covered at 100% after deductible |
| **Prescription** | | |
| Tier 1 Retail | • $15 copay | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 2 Retail | • $40 copay/$100 Specialty | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 3 Retail | • $75 copay/$300 Specialty (OOP Max: ind $3,500/fam $10,500 - combined for all tiers) | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 4 Retail | • Not applicable | • Not applicable |
| Mail Order | • $37.50/$100/$187.50 copay (Specialty Rx not covered through mail order) | • $37.50/$100/$187.50 copay (Specialty Rx not covered through mail order) |
| Medicare Part D Compatible | • Yes | • Yes |
| **Maternity Care** | | |
| Pregnancy and Maternity Care (Pre-Natal Care) | • $25 copay for initial visit only. Inpatient hospital covered at 100% after deductible | • Covered at 80% after deductible |
| **Preventive Care** | | |
| Preventive Lab | • Covered at 100% | • Covered at 80% after deductible |
| Physical Examinations | • Covered at 100% | • Covered at 80% after deductible |
| Prostate Screening | • Covered at 100% | • Covered at 80% after deductible |
| Gynecology Exam | • Covered at 100% | • Covered at 80% after deductible |
| Mammograms | • Covered at 100% | • Covered at 80% after deductible |
| Well Baby Care and Immunizations | • Covered at 100% | • Covered at 80% after deductible |
| **Other Services** | | |
| Diagnostic X-Ray, Scans & Lab | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Chiropractic Care | • $25 copay per visit. Limited to 20 visits. | • Covered at 80% after deductible. Limited to 20 visits per calendar year. |
| **Substance Abuse** | | |
| Inpatient Detoxification | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Substance Abuse - Inpatient | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Substance Abuse - Outpatient | • $25 copay. | • Covered at 80% after deductible |
| **Mental Health** | | |
| Mental Health - Inpatient | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Mental Health - Outpatient | • $25 copay. | • Covered at 80% after deductible |

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LSG INSURANCE PARTNERS

2012/2013

**Plan Description:** UHC-CP 2LU 3000/100%-OH
**Product:** POS
**Network:** Choice Plus

**Provider:** United Healthcare (UHC)
**Member Services Phone #:** 1-800-357-0978
**Plan Website Address:** http://www.uhc.com/

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **General Plan Information** | | |
| Lifetime Maximum | • Unlimited | • Unlimited |
| Calendar Year Deductible - Individual | • $3,000 | • $6,000 |
| Calendar Year Deductible - Family | • 2X Individual | • 2X Individual |
| Coinsurance | • 100% | • 80% |
| Calendar Year Out-of-Pocket Max - Individual (incl ded) | • $4,000 | • $12,000 |
| Calendar Year Out-of-Pocket Max - Family (incl ded) | • 2X Individual | • 2X Individual |
| **Office Visits** | | |
| Primary Care Physician Visit | • $30 copay per visit | • Covered at 80% after deductible |
| Specialist Visit | • $60 copay per visit | • Covered at 80% after deductible |
| Specialist Referral Required | • No | • No |
| **Hospital Care** | | |
| Hospital Care - Inpatient | • 100% after $500 per occurrence deductible and annual deductible | • 80% after $500 per occurrence deductible and annual deductible |
| Hospital Care - Outpatient | • 100% after $250 per occurrence deductible and annual deductible | • 80% after $250 per occurrence deductible and annual deductible |
| **Emergency Care** | | |
| Emergency Room (In-Area) | • $250 copay per visit | • $250 copay per visit |
| Urgent Care Facility | • $100 copay per visit | • Covered at 80% after deductible |
| Ambulance | • Covered at 100% after deductible | • Covered at 100% after deductible |
| **Prescription** | | |
| Tier 1 Retail | • $15 copay | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 2 Retail | • $40 copay/$100 Specialty | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 3 Retail | • $75 copay/$300 Specialty (OOP Max: ind $3,500/fam $10,500 - combined for all tiers) | • Reimbursed at the in-network pharmacy contracted rate less the in-network copay |
| Tier 4 Retail | • Not applicable | • Not applicable |
| Mail Order | • $37.50/$100/$187.50 copay (Specialty Rx not covered through mail order) | • $37.50/$100/$187.50 copay (Specialty Rx not covered through mail order) |
| Medicare Part D Compatible | • Yes | • Yes |
| **Maternity Care** | | |
| Pregnancy and Maternity Care (Pre-Natal Care) | • $30 copay for initial visit only. Inpatient hospital covered at 100% after $500 per occurrence deductible and annual deductible | • Covered at 80% after deductible |
| **Preventive Care** | | |
| Preventive Lab | • Covered at 100% | • Covered at 80% after deductible |
| Physical Examinations | • Covered at 100% | • Covered at 80% after deductible |
| Prostate Screening | • Covered at 100% | • Covered at 80% after deductible |
| Gynecology Exam | • Covered at 100% | • Covered at 80% after deductible |
| Mammograms | • Covered at 100% | • Covered at 80% after deductible |
| Well Baby Care and Immunizations | • Covered at 100% | • Covered at 80% after deductible |
| **Other Services** | | |
| Diagnostic X-Ray, Scans & Lab | • Covered at 100% after deductible | • Covered at 80% after deductible |
| Chiropractic Care | • $30 copay per visit. Limited to 20 visits. | • Covered at 80% after deductible. Limited to 20 visits per calendar year. |
| **Substance Abuse** | | |
| Inpatient Detoxification | • 100% after $500 per occurrence deductible and annual deductible | • 80% after $500 per occurrence deductible and annual deductible |
| Substance Abuse - Inpatient | • 100% after $500 per occurrence deductible and annual deductible | • 80% after $500 per occurrence deductible and annual deductible |
| Substance Abuse - Outpatient | • Covered at 100% | • Covered at 80% after deductible |
| **Mental Health** | | |
| Mental Health - Inpatient | • 100% after $500 per occurrence deductible and annual deductible | • 80% after $500 per occurrence deductible and annual deductible |
| Mental Health - Outpatient | • Covered at 100% | • Covered at 80% after deductible |

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2012/2013

**Plan Description:** Guardian Value Midwest
**Product:** Dental - PPO
**Network:** DentalGuard Preferred
**Provider:** Guardian Dental
**Member Services Phone #:** 1-800-541-7846
**Plan Website Address:** http://www.guardianlife.com

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Deductibles & Maximum Amounts** | | |
| Calendar Year Benefit Maximum | • $1,000 | • $1,000 |
| Calendar Year Deductible - Individual | • $50 | • $50 |
| Calendar Year Deductible - Family | • $150 | • $150 |
| **Preventive & Diagnostic Services** | | |
| Preventive & Diagnostic Services | • 100% | • 100% of In-Network Established Fee |
| **Basic / Restorative Services** | | |
| Basic / Restorative Services | • Deductible then 80% | • Deductible then 80% of In-Network Established Fee |
| **Major Services** | | |
| Major Services | • Deductible then 50% | • Deductible then 50% of In-Network Established Fee |
| **Orthodontic Services** | | |
| Orthodontic Lifetime Maximum | • $1,000 lifetime maximum for child(ren) under age 19. Adult ortho not covered | • $1,000 lifetime maximum for child(ren) under age 19. Adult ortho not covered |
| Orthodontic Deductible | • None | • None |
| Orthodontic Coinsurance | • 50% | • 50% of In-Network Established Fee |
| Diagnosis | • 50% | • 50% of In-Network Established Fee |
| Initial Placement of Orthodontic Appliance | • Covered as part of Active and Retention Treatments | • Covered as part of Active and Retention Treatments |
| Active and Retention Treatments | • 50% | • 50% of In-Network Established Fee |
| **Services** | | |
| Oral Examination Copay / Coinsurance | • 100% | • 100% of In-Network Established Fee |
| Dental X-Rays | • 100% | • 100% of In-Network Established Fee |
| Prophylaxis - Adult | • 100% | • 100% of In-Network Established Fee |
| Prophylaxis - Child | • 100% | • 100% of In-Network Established Fee |
| Topical Application of Fluoride | • 100% | • 100% of In-Network Established Fee |
| Topical Application of Sealants | • 100% | • 100% of In-Network Established Fee |
| Fillings | • Deductible then 80% | • Deductible then 80% of In-Network Established Fee |
| Periodontic Services | • Deductible then 80% | • Deductible then 80% of In-Network Established Fee |
| Extractions | • Simple and Surgical Extractions: Deductible then 80% | • Deductible then 80% of In-Network Established Fee |
| Endodontics | • Deductible then 80% | • Deductible then 80% of In-Network Established Fee |
| Oral Surgery | • Deductible then 80% | • Deductible then 80% of In-Network Established Fee |
| Inlays | • Deductible then 50% | • Deductible then 50% of In-Network Established Fee |
| Crowns | • Deductible then 50% | • Deductible then 50% of In-Network Established Fee |
| Dentures | • Deductible then 50% | • Deductible then 50% of In-Network Established Fee |
| Bridges | • Deductible then 50% | • Deductible then 50% of In-Network Established Fee |

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2012/2013

**Plan Description**: Choice Vision Plan
**Product:** Vision
**Network:** VSP Choice

**Provider:** VSP
**Member Services Phone #:** 1-800-877-7195
**Plan Website Address:** http://www.vsp.com

| | In-Network | Out-of-Network ** |
|---|---|---|
| **General Plan Information** | | |
| Well Vision Exam | • $5 copay | • Up to $45 |
| Prescription Glasses (material) | • $10 copay | • Not applicable |
| **Prescription Glasses (Lenses)** | | |
| Single Vision | • Covered at 100% | • Up to $45 |
| Lined Bifocal | • Covered at 100% | • Up to $65 |
| Lined Trifocal | • Covered at 100% | • Up to $85 |
| Polycarbonate lenses for children | • Covered at 100% | • Not applicable |
| Lens Options | • Average 20% savings on all non-covered lens options | • Not applicable |
| **Prescription Glasses (Frames)** | | |
| Allowance for frame | • $180 allowance | • Up to $70 allowance |
| Discount off the amount exceeding the allowance | • 20% | • Not applicable |
| **Contacts (instead of glasses)** | | |
| Allowance for contacts and fitting evaluations (You may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses) | • $150 allowance | • $150 allowance for Elective Contact Lens/ $210 allowance for Necessary Contact Lens |
| **Laser Vision Correction (instead of glasses or contacts)** | | |
| Allowance for both eyes | • $150 allowance | • $150 allowance |
| Discount off regular price or | • 15% | • Not applicable |
| Discount on promotional price from VSP contracted facilities | • 5% | • Not applicable |
| Low Vision | • Up to $1,000 every two years | • Not applicable |
| If you have had laser surgery, you can use your frame allowance (if eligible) for non-prescription sunglasses from a VSP doctor. | | |
| **Extra Savings and Discounts** | | |
| Prescription Glasses | • 20% off additional glasses and sunglasses, including lens options from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam* | |
| Contacts | • 15% off cost of contact lens exam (fitting and evaluation)* | • Not applicable |

** Available from any VSP doctor within twelve months of your last eye exam.*
*Frequency: Every year beginning in June*
***In Network copays apply to billed amounts for out of network services and materials*

**This benefit summary has been prepared by a licensed Insurance carrier or broker based on documents provided by the applicable licensed Insurance carrier. Please refer to the Plan Document and Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment If there is any conflict between this benefit summary and the Plan Document or COC, the Plan Document and COC govern**

IN THE BUSINESS OF YOUR SUCCESS℠

# Your VSP Vision Benefits Summary

ADP TotalSource and VSP provide you with an affordable eyecare plan.

**VSP Coverage Effective Date:** 06/01/2012
**VSP Doctor Network:** VSP Choice

***Visit vsp.com for more details on your vision benefit and for exclusive savings and promotions for VSP members.***

| BENEFIT | DESCRIPTION | COPAY | FREQUENCY |
|---|---|---|---|
| **Your Coverage with a VSP Doctor** | | | |
| **WellVision Exam** | • Focuses on your eyes and overall wellness | $5 | Every plan year* |
| **Prescription Glasses** | | **$10** | **See frame and lenses** |
| **Frame** | • $180 allowance for a wide selection of frames<br>• 20% off amount over your allowance | Included in Prescription Glasses | Every plan year |
| **Lenses** | • Single vision, lined biofocal, and lined trifocal lenses<br>• Polycarbonate lenses for dependent children | Included in Prescription Glasses | Every plan year |
| **Lens Options** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average 20–25% off other lens options | $55<br>$95 – $105<br>$150 – $175 | Every plan year |
| **Contacts (instead of glasses)** | • $150 allowance for contacts and contact lens exam (fitting and evaluation)<br>•15% off contact lens exam (fitting and evaluation)<br>• (instead of glasses or Laser VisionCare)<br>• Average 20–25% off other lens options | $0 | Every plan year |
| **Laser VisionCare Preferred Program** | | | |
| **Laser VisionCare Preferred Program** | • $150 allowance both eyes for LASIK, Custom LASIK, and PRK (instead of contact lenses or glasses)<br>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities<br>• After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor | $0 | Every plan year |
| **Extra Savings and Discounts** | **Glasses and Sunglasses**<br>• 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam | | |

## Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

| | | | |
|---|---|---|---|
| Exam ..... up to $45 | Single Vision Lenses..... up to $45 | Lined Trifocal Lenses..... up to $85 | Contacts ... up to $150 |
| Frame..... up to $70 | Lined Biofocal Lenses..... up to $65 | Progressive Lenses ..... up to $65 | |

** Plan year begins in June*
*VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.*

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IN THE BUSINESS OF YOUR SUCCESS℠

2012/2013

**Plan Description**: Basic Life $10K
**Product:** Life Plan

**Provider:** AETNA
**Member Services Phone #:** 1-800-554-1802
**Plan Website Address:** http://www.aetna.com/group/giweb

| | |
|---|---|
| **Eligibility** | Covers a regular full-time or part-time employee eligible for the Basic plan who is residing or working in the United States; is scheduled to work a minimum of 30 hours per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer. |
| **Date Coverage Starts** | Coverage starts on the first day of the month coinciding with or following completion of the worksite employer's waiting period; or the day the worksite employer becomes covered under the plan. If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day. |
| **Benefit Options** | An amount equal to $10,000 for Life; $10,000 for Accidental Death & Personal Loss (AD&PL) |
| **Age Reduction** | Total amount of Term automatically reduces as follows: 65% at age 65 to 69, 50% at age 70 to 74,and 35% at age 75 and over. Employee Reduction Rule will be based on age as of the June 1st that coincides with or follows the member's birth date. |
| **Benefit Features** | |
| Conversion | Employee will have the opportunity to convert their term life insurance to an individual policy at termination, if no longer eligible for coverage, or if coverage reduces due to age. There is a 60-day conversion application period. Should the employee die during the conversion period, benefits will be payable equal to the maximum amount the employee had a Right to Convert, whether or not he or she applied for an individual policy. |
| Portability | Employees can port their Life coverage and the Accidental Death rider in the same amount at termination. There is a 60-day conversion application period. Associates may NOT port coverage for themselves if they are sick or injured and away from active work when their life insurance coverage ends. Coverage ported will reduce starting at age 65 and reduced amounts may be converted. |
| Accelerated Death Benefit (ADB) | If the employee has a terminal illness with a life expectancy of no longer than 24 months, the policy will pay, while employee is still alive - 75% of the life insurance benefit to a maximum of $500,000.00.<br><br>This benefit can help with expenses not covered by the employee's medical plan, pay other bills, enable the employee to visit relatives and help the employee get his or her affairs in order.<br><br>It pays an advance benefit and ensures that the employee's beneficiary will receive the rest of the life insurance benefit upon the employee's death. Repayment is not required should the employee recover within 24 months.<br><br>The advance benefit may be requested once for the employee and it is not subject to income tax. |
| Passenger Restraint and Airbag | In the event that a covered person is properly using a passengers restraining device and an airbag is activated and neither contributes to saving the person's life, this benefit will supplement the accidental death benefit. |
| Repatriation of Remains | In the unfortunate event that a covered person dies while 200 or more miles from home, this benefit offers financial assistance for preparation and return of the deceased's body to a mortuary. For additional benefit features, please refer to the Certificate of Coverage. |
| Premium Waiver | If the employee is less than age 60 and has been permanently and totally disabled for at least 6 months (as approved by Aetna), premium payments are waived until the employee recovers or reaches age 65. |

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.

2012/2013

**Plan Description**: LTD Basic 50% $1,000/mo-180
**Product:** Long Term Disability

**Provider:** AETNA
**Claim Service Number #:**1-800-554-1802
**Plan Website Address:** http://www.aetna.com/group/giweb

| | |
|---|---|
| **Eligibility** | Covers an active member of an employer that elected to provide LTD benefits to its employees under the Policyholder's Flexible Benefits Plan and is regularly working a minimum of 30 hours per week; is in an eligible class; has satisfied the plan's Actively at Work Provision; and has satisfied the worksite employer's specified waiting period from the date of hire with the worksite employer. |
| **Date Coverage Starts** | Coverage starts on the first day of the month coinciding with or next following completion of the worksite employer's waiting period; or day worksite employer becomes covered under the plan.<br><br>If not actively at work on the effective date, coverage will not take effect until employee returns to active work for one full day. |
| **Elimination Period** | To be eligible for benefits, the employee must be out of work for 180 continuous days due to an occupational or non-occupational injury or illness. |
| **Monthly Benefit** | The plan provides income protection to replace up to 50% of the employee's pre-disability monthly earnings. |
| **Minimum Monthly Benefit** | $100 or 10% of gross monthly benefit level, whichever is greater. |
| **Maximum Monthly Benefit** | $1,000 *(combined with other income benefits, as specified, in the Certificate Booklet/ Summary).* |
| **Benefit Duration** | As long as the employee remains totally disabled, LTD benefit payments will continue according to the certificate booklet.<br><br>**Normal retirement age means the Social Security normal retirement age as stated in the 1983 according revision of the United States Social Security Act.*<br><br>** Mental Health & Substance Abuse are limited to 24 months. See the Certificate Booklet/Summary for more details.* |
| **Disability Provision** | **Own Occupation Period is the first 24 months for which LTD Benefits are paid. Any Occupation Period is from the end of the Own Occupation period to the end of the Maximum Benefit Period.** |
| **Feature and Limitations**<br>Rehabilitation | Our ultimate goal is to help the employee return to gainful employment. Our consultants review each Disability claim and determine if Aetna rehabilitation services would be appropriate and effective. After reviewing the employee's claim, if Aetna feels the employee would benefit from our services, we will contact the employee. |
| Pre-existing Conditions | A disease or injury if, during the 3 months prior to the employee's effective date of coverage:<br>-it was diagnosed or treated; or<br>-services were received for the diagnosis or treatment of the illness or injury; or the employee took drugs or<br>-the employee took drugs or medicines prescribed or recommended by a physician for that condition and the employee has been covered under The Plan for 12 consecutive months. |
| **Benefit Coordination & Deductible Income** | **LTD benefits are coordinated with Social Security, Workers Compensation, State or Federal government disability or retirement benefits. For details regarding coordination of benefits please refer to the Certificate Booklet/Summary** |
| **Conversion Option** | None |
| | This benefit option may not be available to all industries |

This Benefits Highlight Sheet and the accompanying Brochure and Enrollment Form explain the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with other important papers.

IN THE BUSINESS OF YOUR SUCCESS℠

ADP TOTALSOURCE℠

# Why Enroll in Flexible Spending Accounts (FSAs)?

## Enroll in the Health Care FSA During Open Enrollment 2012–2013 and Get a $25 Credit

**Health Care and Dependent Care FSAs are tax-advantaged accounts that you can use to pay for everyday expenses tax-free. And this year, Health Care FSA participants receive an additional $25 credit[1] just for enrolling during Open Enrollment.**

The tax advantages of the Health Care and Dependent Care FSAs make enrolling in them a good idea every year. FSAs can save you up to 35% (depending on your tax bracket) on health care expenses like deductibles and copays, as well as certain qualifying dependent care expenses like day care for your children or elder care.

Please note that in accordance with health care reform legislation, individuals cannot use the ADP TotalSource℠ Health Care FSA for the cost of over-the-counter (OTC) medications unless prescribed by a physician. This rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription. Refer to the Health Care FSA flyer located in the Benefits Quick Links section at www.mytotalsource.com for more details on the revised rules and for a list of the most commonly used OTC items that are still eligible for reimbursement under the Health Care FSA.

Additionally, health care reform legislation includes a provision that limits the amount of salary reduction contributions an individual can make to a Health Care FSA to $2,500 per taxable year beginning January 1, 2013. Please note that this change will not affect the Health Care FSA contribution maximum for the 2012–2013 Plan Year. For the 2013–2014 Plan Year, the maximum amount of salary reduction contributions an individual can make to a Health Care FSA will change in a manner so that the $2,500 limit will not be exceeded.

**Health Care and Dependent Care Flexible Spending Accounts are tax-advantaged accounts that you can use to pay for everyday expenses tax-free. Here's how they work:**

1. **Enroll** in a Health Care and/or Dependent Care FSA during Open Enrollment.
   - Use the Health Care FSA calculator at www.flexdirect.adp.com to help you decide how much to contribute to a Health Care FSA. For the 2012–2013 Plan Year, you can contribute up to $3,500 to the Health Care FSA.
   - Dependent care expenses are usually more predictable. Determine what you spend on qualifying dependent care each week, and then multiply by 52 to get your annual amount. For the 2012–2013 Plan Year, you can contribute up to $5,000 ($2,500 if married filing separately) to the Dependent Care FSA.

**Important Note for Highly Compensated Employees:** For the 2012–2013 Plan Year, highly compensated employees will only be permitted to contribute up to $2,000 to the Dependent Care FSA. For further details, please see the *Dependent Care Flexible Spending Account Summary* on My TotalSource®.

2. **Contribute** to your FSA(s) over the course of the 2012–2013 Plan Year (via pretax payroll deductions) and build up a balance in your account(s).
3. **File claims** on the easy-to-use, secure FlexDirect Web site (accessible via www.mytotalsource.com) as you incur eligible health or dependent care expenses.[2] If you sign up for direct deposit, tax-free reimbursements will be deposited right into your checking account.

| HEALTH CARE FSA | DEPENDENT CARE FSA* |
|---|---|
| Health plan deductibles, copays and co-insurance | Day care for dependent children under age 13 |
| Prescription medications not covered by a health plan and over-the-counter medications (if prescribed by a physician) | Elder care for dependent parents |
| Dental and vision expenses (such as braces and laser vision correction) not covered by a health plan | Care for disabled dependents of any age |

*[1] The $25 Health Care FSA credit is our way of encouraging worksite employees to participate in this valuable benefit. ADP TotalSource is not obligated to extend this offer in the future, and there is no guarantee that ADP TotalSource will extend the offer again. The one-time $25 credit will be added to all Health Care FSAs opened during Open Enrollment for the 2012–2013 Plan Year.*

*[2] The deadline for filing claims incurred during the Plan Year is July 30.*

*[3] Note: The Dependent Care FSA does not cover medical expenses for you or your dependents.*

***Please note that beginning January 1, 2013, the Internal Revenue Code will limit the amount of salary reduction contributions an individual can make to a Health Care Flexible Spending Account (FSA) to $2,500 per taxable year.***

IN THE BUSINESS OF YOUR SUCCESS℠

2012-2013

Plan Description: Health Care Flexible Spending Account Summary
Product: Health Care FSA

Member Services Phone #: 1-800-554-1802
Website Address: www.mytotalsource.com

## Health Care Flexible Spending Accounts

| | |
|---|---|
| Plan Year | June 1 – May 31 |
| Maximum Plan Year Contribution[1] | $3,500 |
| Who Is Covered? | Employee plus eligible dependents |
| How Are Contributions Processed? | Payroll deduction from pretax income |
| **Health Care FSA**<br>What expenses are eligible? | The following expenses are eligible for reimbursement if they are not otherwise covered by insurance or any other source:<br>• Medical or dental copayments, deductibles and/or co-insurance payments<br>• Medical expenses[2]<br>• Prescription drug expenses<br>• Over-the-counter medications (if prescribed by a physician)[3]<br>• Dental and orthodontic treatment<br>• Vision care, including eyeglasses and contact lenses<br>• Routine physicals, vaccinations and screening tests<br>• Medical monitoring/testing devices and supplies, including for diabetes<br>**PLEASE NOTE:** If you choose to enroll in a High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) any time during the 2012–2013 Plan Year, you are not eligible to participate in the Health Care FSA. See below for Limited Health Care FSA details. |
| **Limited Health Care FSA**<br>What expenses are eligible? | You can participate in the **Limited Health Care FSA** if you enroll in a qualified High Deductible Health Plan (HDHP) and plan on contributing to a Health Savings Account (HSA) at any time during the 2012–2013 Plan Year. You can use this account to pay for eligible **dental and vision** expenses with tax-free dollars. The Limited Health Care FSA will not reimburse medical expenses. Federal regulations do not allow individuals to receive reimbursement for medical expenses tax-free through a Health Care FSA **and** contribute to an HSA during the same Plan Year.<br>The following expenses are eligible for reimbursement under the Limited Health Care FSA:<br>• Dental and vision copayments, deductibles and/or co-insurance payments<br>• Dental and orthodontic treatment<br>• Vision care, including eyeglasses and contact lenses<br>• Certain preventive care expenses, such as immunizations and routine examinations and procedures |

**NOTE:** Outlined above are examples of eligible expenses. For complete details, please refer to the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description and Summary of Material Modifications located on My TotalSource® at www.mytotalsource.com.

[1] As you may know, health care reform legislation known as the Patient Protection and Affordable Care Act (or "PPACA") was passed early in 2010. This legislation includes a provision that limits the amount of salary reduction contributions an individual can make to a Health Care Flexible Spending Account (FSA) to $2,500 per taxable year beginning January 1, 2013. Please note that this change will not affect the Health Care FSA contribution maximum for the 2012–2013 Plan Year. For the 2013–2014 Plan Year, the maximum amount of salary reduction contributions an individual can make to a Health Care FSA will change in a manner so that the $2,500 limit will not be exceeded.

[2] If you plan on contributing to a Health Savings Account at any time during the 2012–2013 Plan Year, you can only elect to enroll in the Limited Health Care FSA. Only eligible dental and vision expenses can be submitted for reimbursement under the Limited Health Care FSA. The Limited Health Care FSA **will not** reimburse medical expenses.

[3] In accordance with health care reform legislation, individuals cannot use the ADP TotalSource Health Care FSA for the cost of over-the-counter (OTC) medications unless prescribed by a physician. This rule does not apply to reimbursements for the cost of insulin, which are permitted, even if the insulin is purchased without a prescription.

IN THE BUSINESS OF YOUR SUCCESS℠

2012-2013

Plan Description: Dependent Care Flexible Spending Account Summary
Product: Dependent Care FSA

Member Services Phone #: 1-800-554-1802
Website Address: www.mytotalsource.com

| Dependent Care Flexible Spending Accounts | |
|---|---|
| Plan Year | June 1 – May 31 |
| Maximum Plan Year Contributions | $5,000 ($2,500 if married filing separately[1]) |
| (Highly Compensated Employees)[2] Maximum Plan Year Contributions | $2,000 |
| Who Is Covered? | Employee and spouse (if applicable) who need dependent care in order to work or look for work. |
| How Are Contributions Processed? | Payroll deduction from pretax income<br>• A self-employed individual (SEI) may only participate on a post-tax basis and only if he or she is receiving W-2 wages. |
| What Expenses Are Eligible? | Care of a dependent[3] under 13 years of age, including fees charged by:<br>• Qualified child care centers or nursery schools<br>• In-home babysitters or nannies<br>• After-school programs that enable employee and spouse to hold gainful employment<br>• Non-nursing care of a dependent age 13 or older who is physically or mentally incapable of self-care<br>• Nonmedical care of an elderly dependent whose caregiver spends at least 8 hours a day at the taxpayer's home |

**IMPORTANT NOTE:** Outlined above are examples of eligible expenses. Qualified expenses under the Dependent Care FSA include eligible dependent care costs that you must pay to enable you to work or look for work. **The Dependent Care FSA does NOT cover medical expenses for you or your dependents.** For complete details, please refer to the ADP TotalSource, Inc. Health and Welfare Plan Summary Plan Description and Summary of Material Modifications located on My TotalSource® at www.adptotalsource.com.

[1] Note that if more than $5,000 ($2,500 if married filing separately) is contributed to the Plan during a single Calendar Year, the excess amount will be included in your taxable income.

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

For the 2012–2013 Plan Year, a "highly compensated employee" is defined by the IRS as an individual that (a) owns (or constructively owns) more than 5% of the stock, capital or profits interest of a client company on any day during the Plan Year, or (b) will be paid compensation by ADP TotalSource in excess of $115,000 annually. Please note that the definition of a highly compensated employee may change for future Plan Years.

[3] Certain IRS rules apply with respect to caregiver/provider eligibility.