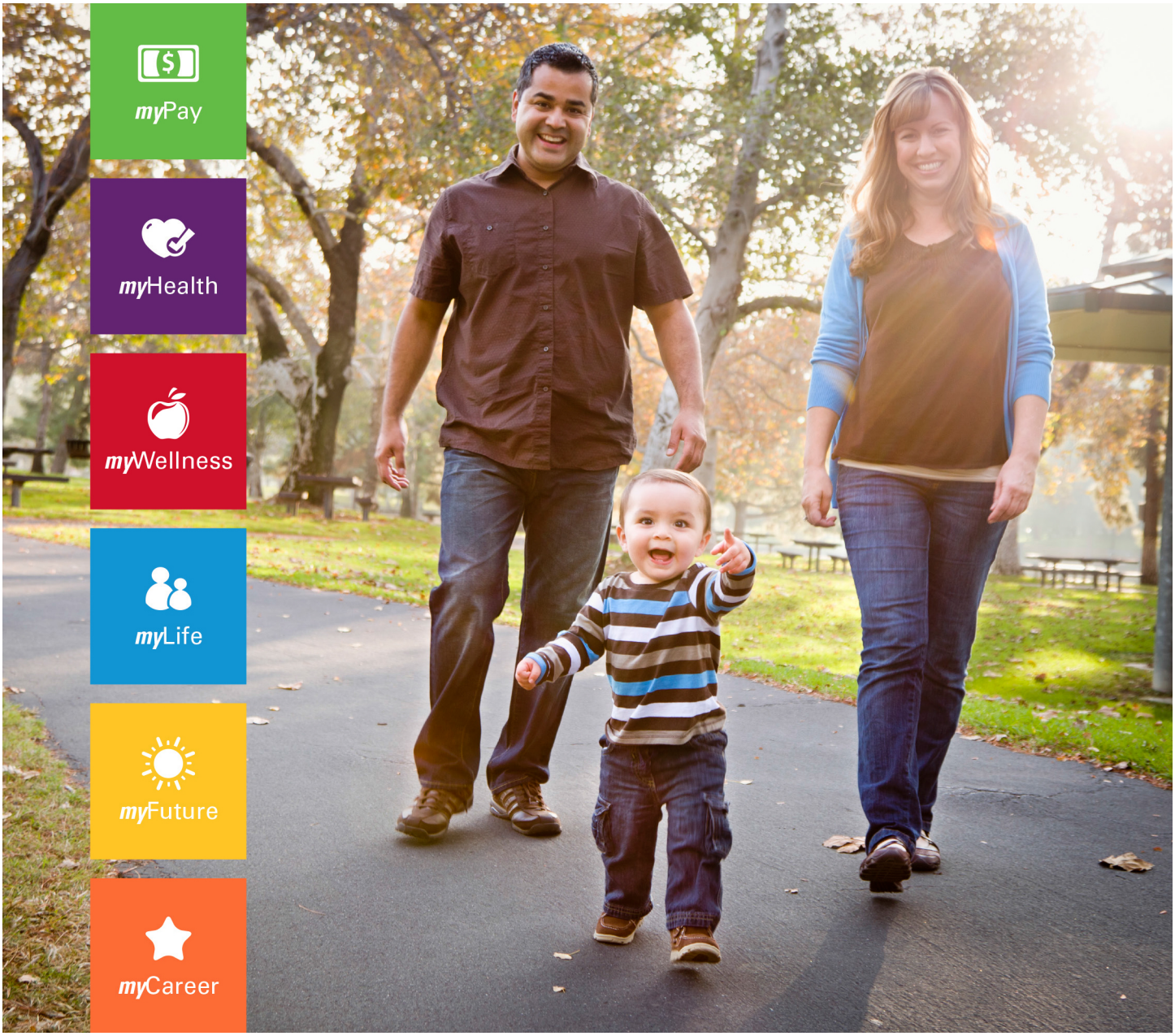
2014 Summary Plan Description



ADT *Health and Welfare Benefits*

Este SPD contiene un resumen en inglés de tus derechos y beneficios bajo el Plan de Ahorros e Inversión para el Retiro de ADT. Si tienes dificultad para entender alguna parte de este resumen, comunícate con EmployeeAccess. Para asistencia también puedes llamar al administrador de reclamaciones o al asegurador de los planes individuales. Para obtener información de contacto, consulta la sección de **Información de contacto**.

myRewards

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Overview

Welcome to the 2014 ADT Health and Welfare Benefits Plan Summary Plan Description (the "SPD").

This section of the SPD lists entities participating in the ADT Health and Welfare Benefits Plan (the "Plan") and provides a quick overview of the available benefits.

About This SPD

This ADT Health and Welfare Benefits Plan Summary Plan Description, in its entirety, is the current Summary Plan Description for the Plan and describes the health and welfare benefits provided to ADT LLC ("ADT," "The ADT Corporation," "an ADT employer," or "the Company") employees. It describes your health and welfare benefits in effect as of January 1, 2014. If you want to print this SPD, either the entire SPD or just a part of it, keep in mind that all of the sections are important parts of the SPD, and your benefits information is not complete without them.

This SPD is intended to serve as a general source of reference, outlining major provisions of certain ADT benefit plans or programs provided under the Plan as amended and restated, if applicable.

Some terms are defined as they are addressed. Others are defined in the **Glossary** section of this SPD.

Every effort has been made to make the information in this SPD as accurate as possible. If there is any discrepancy between this SPD and the official plan documents, the official plan documents govern.

The descriptions in this SPD cannot alter, modify, or change the controlling legal documents in any way. In addition, your participation in the benefit plans does not ensure you of continued (or renewed) employment. It also does not ensure you rights to benefits, except as specified under the terms of the Plan. This SPD is not a contract of employment.

The benefits and other principal provisions described in this SPD are effective only if you are eligible for coverage, become covered, and remain covered according to the provisions of the applicable underlying benefit plans described in this SPD.

No person has the authority to make any verbal statements of any kind at any time that are legally binding for ADT or any ADT employer with respect to the plans, or to alter the official plan and related contracts maintained in conjunction with the plans. In addition, ADT reserves the right to amend, modify, terminate or discontinue any or all of the plans described in this SPD at any time at its sole discretion.

You may examine copies of the official plan and related contracts, policies, and certificates of coverage without charge and obtain copies of them for a reasonable charge. To examine or obtain a copy of the plan documents or related documentation, contact the plan administrator.

This SPD contains a summary in English of your plan rights and benefits under the Plan. If you have difficulty understanding any part of this summary, contact **EmployeeAccess**. You may also call the claims administrator or insurer for the individual plans for assistance.

Este SPD contiene un resumen en inglés de sus derechos y beneficios bajo el Plan. Si usted tiene dificultad para entender alguna parte de este resumen, comuníquese con **EmployeeAccess**. También puede comunicarse con el administrador de reclamaciones o la compañía de seguros para los planes individuales de asistencia.

Participating Entities

In addition to ADT, the entities and individuals participating in the Plan are as follows:

- ADT Holdings, Inc.;
- Active full-time employees of a division not otherwise described in this section or any other business acquired after the effective date of this SPD, provided the Company, which includes such a division or which has acquired the business, has adopted these benefits; and
- Employees who are covered under a collective bargaining agreement are not eligible unless the collective bargaining agreement includes these benefits. (Benefits eligibility and plan provisions for employees covered under a collective bargaining agreement are specified in the collective bargaining agreement.)

What's Included in This SPD

The following list shows what you will find in each section of the 2014 ADT Health and Welfare Benefits SPD:

- **Eligibility**. Explains who is eligible to participate in the various plans and the tax treatment of benefits.
- **Enrollment**. Includes information on the enrollment process, paying for coverage, changing coverage, events that may affect your coverage, and when coverage ends.
- **Life Events**. Explains what coverage actions you may take if you experience certain life events (for example, marriage, divorce, birth or adoption of a child).
- **Medical**. Explains the medical coverage options available to you and how the Medical Plan works, requirements to receive the highest level of benefits, claims filing process, and legally required health care notices.
- **Prescription Drug**. Explains how the Prescription Drug Plan works, Medicare prescription drug coverage, and filing claims.
- **Wellness Programs**. Explains the programs/services included in the Wellness Programs including Nurseline, Health Advocate, Employee Assistance & Work/Life Program (EAP), Maternity Program, Wellness Portal, and Healthy Rewards Cash Rewards.
- **Dental**. Explains the dental coverage options available to you, how the Dental Plan works, and claims filing process.
- **Vision**. Explains how the Vision Plan works and claims filing process.

- **Spending Accounts**. Explains how the Flexible Spending Account (FSA) and the Dependent Care Account (DCA) work, tax information, and claims filing process.
- **Life and Accidental Death & Dismemberment (AD&D)**. Explains the life and AD&D coverage options available to you, how the Life and AD&D Plan works, beneficiary designations, Evidence of Insurability (EOI) requirements, claims filing process, and how to continue coverage when group coverage ends.
- **Disability**. Explains how the Short-Term Disability (STD) and Long-Term Disability (LTD) Plans work, what happens while you are on LTD, the LTD survivor benefit, claims filing process, and continuing LTD coverage when group coverage ends.
- **Additional Benefits**. Explains how the Tuition Reimbursement Program, Adoption Assistance Program, Legal Services Plan, Auto and Home Insurance Program, and BlueCard Worldwide® Program work.
- **Coordination of Benefits**. Explains which plan pays first when you have other medical and/or dental coverage.
- **Continuing Coverage under COBRA**. Explains how Medical, Dental and Vision coverage, and FSA and EAP participation may continue when active coverage and participation ends, important deadlines and time frames, and how to apply for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- **Claim Review and Appeal Processes**. Explains your appeal rights, processes, and time frames if your claim for benefits is denied, in whole or in part.
- **If You Reside in Puerto Rico—Triple-S Salud**. Outlines your benefits if you reside in Puerto Rico.
- **If You Reside in Hawaii—Hawaii Medical Service Association (HMSA)**. Outlines your benefits if you reside in Hawaii.
- **Special Notices**. Explains the Family and Medical Leave Act (FMLA) and the Uniformed Services Employment and Reemployment Rights Act (USERRA) in detail.
- **Administrative Information**. Includes plan information required under the Employee Retirement Income Security Act, as amended (ERISA).
- **Glossary**. Includes definitions of many terms used within this SPD.

Paying for Benefits Pre-Tax vs. After-Tax

Certain benefits are paid for in full by ADT. For other benefits, ADT pays for the majority of the coverage and you pay for the remaining cost of coverage with pre-tax dollars deducted from your paycheck each pay period. Using pre-tax dollars reduces your taxable income for federal, Social Security, and (in most cases) state income taxes. And, your income is not affected when determining your benefit levels for coverage(s) under other ADT-sponsored plans.

For other benefits, you pay the full cost of coverage on an after-tax basis. This means that you pay for the coverage(s) with your already-taxed dollars (your take-home pay). In other words, the coverage costs are included as income on your W-2 form for tax purposes.

Please note: Using pre-tax dollars can affect any Social Security benefits you may eventually receive. This is because you don't pay Social Security Federal Insurance Contributions Act (FICA) taxes on pre-tax dollars. For most people, the Social Security benefit reduction is just a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any concerns, or if you need additional information, contact your local Social Security Administration office.

The following chart shows whether you pay for each plan with pre-tax dollars, after-tax dollars, or if ADT pays the full cost.

Benefit	Pre-Tax	After-Tax	ADT Pays Full Cost
Medical (including Prescription Drug)	X		
Wellness Programs			X
Employee Assistance & Work/Life Program			X
Healthy Rewards Cash Reward Incentive*		X	
Dental	X		
Vision	X		
Flexible Spending Account	X		
Dependent Care Account	X		
Basic Term Life Insurance			X
AD&D Insurance			X
Supplemental Life Insurance		X	
Personal and Family AD&D Insurance		X	
Business Travel Accident Insurance			X
Short-Term Disability			X
Long-Term Disability		X	
Legal Services Plan		X	
Auto and Home Insurance Program		X	

*You must be enrolled in an ADT medical option to receive Healthy Rewards Cash Reward Incentives.

EmployeeAccess

EmployeeAccess is the primary source to answer your specific questions about the ADT Health and Welfare Benefits Plan including:

- Enrollment.
- Eligibility.
- Changing coverage(s) during the year.
- Designating a beneficiary.
- General plan information.

Contact **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**, Monday through Friday from 8 a.m. to 8 p.m. Eastern time or at **MyADTHR.com**.

Eligibility

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Eligibility

Your Eligibility

Eligible Employees

You are eligible to participate in the ADT Health and Welfare Benefits Plan (the "Plan") if you are:

- In an employer-employee relationship with ADT, its participating subsidiaries/affiliates or divisions, and classified by the Company as a regular employee;
- On a U.S. domestic payroll; and
- Scheduled to work at least 20 hours per week, 48 weeks per year.

If you are an expatriate and meet the above eligibility requirements and are on the U.S. domestic payroll, you are eligible to participate in all of the non-health benefit plans available. Medical, Prescription Drug, Dental, and Vision Plan coverage available to you is different and is specifically designed for your unique needs. Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** for additional information on the health plans available to expatriates.

An expatriate is an ADT employee who has been transferred on assignment outside of the United States, but who continues to be paid by ADT or through an ADT employer's U.S. payroll.

Employees who are covered under a collective bargaining agreement are eligible for coverage under the Plan **only** when coverage is included as part of the collective bargaining agreement. The benefits for employees covered under a collective bargaining agreement are governed by that agreement and may vary from the benefits described in this Summary Plan Description (SPD).

Ineligible Employees

You are not eligible to participate in the Plan if:

- You are a part-time employee working less than 20 hours per week;
- Your employment is seasonal or temporary;
- You work outside of the United States and are not an expatriate;
- You are a leased employee or an independent contractor;
- You are a non-resident alien with no U.S.-sourced income; or
- You are an individual in any other group defined as being ineligible, as determined by ADT.

Please note: Pursuant to Massachusetts law, part-time Massachusetts employees who average at least 65 hours of work per month may be eligible to purchase health care coverage through the state on a pre-tax basis. For more information about the state program, call **1-877-MA-ENROLL** (**1-877-623-6765**) or visit the state's website (**mahealthconnector.org**).

Your Family's Eligibility

Eligible Spouse/Domestic Partner and Child(ren)

If you are an eligible employee and you enroll in coverage, you may also enroll your eligible spouse/domestic partner and/or child(ren) in the Medical, Dental, Vision, Supplemental Life Insurance, and Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance Plans. **Please note:** If you add a spouse/domestic partner to a plan, you may potentially incur imputed income. (See the "Tax Treatment of Benefits" section for more details on imputed income.)

See the **Glossary** section of this SPD for the definition of "child(ren)."

Eligible spouse/domestic partner and child(ren) include:

- Your spouse as evidenced by a marriage certificate or other legal document provided that you and your spouse are not legally separated or divorced. "Spouse" also includes a same-sex individual to whom you are legally married regardless of whether you live in a jurisdiction/state that recognizes same-sex marriage. In this case, you and your same-sex spouse will be treated as married for all federal purposes, including employee benefits and claiming a child tax credit. Your same-sex spouse's child(ren) who meet the "eligible child(ren)" requirements would also be eligible for coverage.
- Your eligible unrelated same- or opposite-sex domestic partner to whom you are **not** legally married and his/her eligible child(ren) or step child(ren).
- For Medical Plan coverage, your child(ren) (including child[ren] of your domestic partner), regardless of student, residence, or marital status, until they reach age 26.
- For Dental, Vision, Supplemental Life Insurance, and P&F AD&D Insurance coverage, your unmarried dependent child(ren), as defined below, living with you until they reach age 19 (or reach age 24 if full-time students) or the unmarried dependent child(ren), as defined below, of your domestic partner until they reach age 19 (or reach age 24 if full-time students).
- Your mentally or physically disabled child(ren) who are solely dependent on you for support or the mentally or physically disabled child(ren) of your domestic partner who are solely dependent on you or your domestic partner for support are eligible, regardless of age.

Civil union and common law spouses may be enrolled as domestic partners.

Ineligible Spouse/Domestic Partner and Child(ren)

Your spouse/domestic partner and/or child(ren) are not eligible for coverage under the plans if they meet any of the following ineligibility provisions:

- For Dental, Vision, Supplemental Life Insurance, and P&F AD&D Insurance, are child(ren) who are married and/or living outside of your household.
- Are child(ren) who have reached the age limit for the specific coverage, unless they are solely dependent on you due to a mental or physical disability.
- Are on active military duty.

- Live outside the United States.
- Elect coverage as an employee of ADT (This does not apply to Life and AD&D Insurance. A domestic partner and his/her child(ren) who are ADT employees can be covered for Life and AD&D Insurance as an employee and/or dependent.)

Eligibility Verification

When you enroll your spouse/domestic partner and/or child(ren) for coverage, you will receive a packet in the mail asking you to verify your dependent's relationship to you and his/her eligibility for coverage. The documentation must be received by **EmployeeAccess Dependent Verification specialists** no later than 31 calendar days after the date you enroll your spouse/domestic partner and/or child(ren).

You may submit your documents electronically or by U.S. Mail using the postage-paid envelope included in your packet.

If the documentation is not provided by the deadline, your spouse/domestic partner and/or child's(ren's) enrollment will be cancelled as of that deadline. You may appeal the denial of coverage only if you can show that you complied with the verification requirements. In addition, you will not be able to enroll the spouse/domestic partner and/or child(ren) until the next year's Benefits Annual Enrollment unless a qualifying event or HIPAA special enrollment event occurs during the year that entitles you to change your existing coverage by enrolling another individual.

If you need assistance with the verification process or have questions, contact an **EmployeeAccess Dependent Verification specialist** at **1-855-617-0662**, Monday through Friday, from 8 a.m. to 8 p.m. or on Saturday from 9 a.m. to 2 p.m. Eastern time.

Documentation Examples

The verification process is designed to protect your privacy. Employees have the option to return documentation in a postage-paid envelope or via fax. You are requested to delete the first five digits of any Social Security number appearing on your documentation, and to delete any financial information. Once **EmployeeAccess Dependent Verification specialists** verify the eligibility of your spouse/domestic partner and/or child(ren), the documents provided will be destroyed.

Examples of required documents for eligibility verification include a copy of:

- Your marriage certificate.
- The individual's birth or adoption certificate.
- A Domestic Partner Affidavit signed by you and your partner. To obtain an Affidavit, visit **MyADTHR.com > Health & Group Benefits** or call **EmployeeAccess Dependent Verification specialists** at **1-855-617-0662**.

If you have trouble providing the required documentation, notify an **EmployeeAccess Dependent Verification specialist** at **1-855-617-0662** to explain your circumstances. Representatives can discuss possible alternative acceptable documents and are ready to assist throughout this process.

- A school tuition receipt showing full-time enrollment for the current semester to verify student status for dependent child(ren) over age 19. (This is required only for coverages **other than** Medical and Prescription Drug coverage.)
- The most recent tax return to verify dependency for dependent child(ren) over age 19. (This is required only for coverages other than Medical and Prescription Drug coverage.)

Tax Treatment of Benefits

Generally speaking, the Internal Revenue Code allows the Plan to provide you and your dependents with health and welfare benefits on a tax-free basis. This tax-free treatment extends to benefits provided to your "tax dependents" under the federal income tax code. However, because the federal government does not recognize domestic partnerships, some of your dependents may not be considered "tax dependents"—and therefore will not qualify for tax-free coverage under the Plan.

Generally speaking, a "tax dependent" is an individual who meets the requirements described in Section 152 of the Internal Revenue Code and who can be claimed as a tax dependent on your income tax return. Contact your tax adviser if you are unsure about whether a domestic partner qualifies as a tax dependent.

Same-Sex Spouses

Due to guidance from the U.S. Department of the Treasury and Internal Revenue Service (IRS), same-sex couples (legally married in jurisdictions that recognize their marriages) will be treated as married for federal tax purposes, regardless of whether the couple lives in a jurisdiction/state that recognizes same-sex marriage. This means that the fair market value of the ADT-provided portion of the coverage provided under the Plan that is attributable to your same-sex spouse and the child(ren) of your same-sex spouse is **not** considered taxable income to you (this is referred to as "imputed income") and ADT will no longer gross-up your salary for the value of this health care coverage. However, state tax treatment may differ.

For details, please consult your tax or financial adviser.

Domestic Partners

The IRS generally recognizes only legally married spouses as dependents, and, as a result, benefits provided to domestic partners are treated differently than those provided to a spouse for income tax purposes. For example, certain tax-favored benefits such as Medical Plan, Dental Plan, and Vision Plan coverage cannot be provided to a domestic partner on a tax-free basis and Flexible Spending Accounts (FSAs) and Health Savings Accounts are not available to reimburse expenses incurred by a domestic partners or the child(ren) of a domestic partner unless the domestic partner and his or her child(ren) (if applicable) are also tax dependents. (That means they must be individuals who can be claimed as your dependents for federal income tax purposes.) Therefore, benefits offered to domestic partners and child(ren) of domestic partners will generally be offered on an after-tax basis.

In addition, the fair market value of the ADT-provided portion of the coverage that is attributable to your domestic partner and the child(ren) of your domestic partner is considered taxable income to you (this is referred to as “imputed income”). Imputed income is taxed as if you received cash in an amount equal to the value of the coverage. For details, please consult your tax or financial adviser.

Your Child(ren) and Your Spouse’s/Domestic Partner’s Child(ren)

For Medical and Prescription Drug coverage, there is no taxation of the benefit value for your child if your child meets the eligibility definition under the Plan and is younger than age 26.

As described previously for coverages other than Medical and Prescription Drug, eligible dependent child(ren) include your (or your spouse’s/domestic partner’s) child(ren) for whom you’re entitled to claim a federal income tax exemption. Except as required under a Qualified Medical Child Support Order (QMCSO), this generally includes child(ren) who:

- Have not reached age 23 and not married;
- Are full-time students for purposes of Dental and Vision;
- Rely on you for over one-half of their support; and
- Have the same principal place of residence as you for more than six months of the year (unless the child is temporarily away at school).

If your domestic partner’s child(ren) do not qualify as tax dependent(s), the value of their benefits may be considered as taxable income to you (referred to as “imputed income”). For details, please consult your tax or financial adviser.

Enrollment

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Enrollment

When You May Enroll

You may enroll in the ADT Health and Welfare Benefits Plan (the "Plan"):

- When you are first eligible;
- During Benefits Annual Enrollment; or
- After certain qualifying events, such as marriage, divorce, or birth of a child, or HIPAA special enrollment events (if the event is reported within 31 calendar days).

Initial Enrollment

Waiting Period

- Direct Connect employees are eligible for benefits 91 calendar days after their hire date.
- All other employees are eligible for benefits 31 calendar days after their hire date.

Deadline for Enrolling

- Direct Connect employees should enroll within 60 calendar days of becoming employed in a class of employees who are otherwise eligible for coverage once the applicable waiting period has been satisfied to ensure that ID cards and other materials are received by the eligibility date.
- All other employees must enroll within 30 calendar days of becoming employed in a class of employees who are otherwise eligible for coverage once the applicable waiting period has been satisfied.

If you have questions about whether you are eligible or which waiting period applies to your situation, please call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Please note: If you don't enroll in the ADT health plans (Medical, Dental, and Vision) as well as the Flexible Spending Account (FSA) and Dependent Care Account (DCA) during the 31 calendar days after you first become eligible, you generally can't enroll until the next Benefits Annual Enrollment. However, you may experience a qualifying event or HIPAA special enrollment event that will allow you to change these pre-tax benefits.

Different rules apply to after-tax benefits, such as Long-Term Disability and Supplemental Life Insurance. You may enroll in or make changes to the after-tax benefits offered by ADT at any time during the year. You do not need to wait until a Benefits Annual Enrollment or until you have a qualifying status change or HIPAA special enrollment event. However, you may have to provide Evidence of Insurability (EOI) if you enroll after you first become eligible. See the **Disability** and **Life and AD&D** sections of this SPD for information on EOI.

When Coverage Begins

Provided you enroll no later than 30 calendar days (90 calendar days for Direct Connect) after you first become eligible, coverage for yourself and your eligible dependents generally begins on the latest of:

- The first day following 30 calendar days (or 90 calendar days for Direct Connect) of continuous employment;
- The date you or your dependent (as applicable) becomes eligible under the Plan (if acceptable documentation verifying dependent eligibility has been provided within 31 calendar days of the date of enrollment);
- The date you provide satisfactory Evidence of Insurability (EOI), if required for Supplemental Life Insurance. **Please note:** You must be in active service in order for Supplemental Life Insurance coverage to take effect; and
- The first day following satisfactory completion of your probationary period, if applicable.

Effective dates for certain benefits may vary depending on the plan. For more information about the effective date for specific benefits, see each section in this SPD describing a specific plan. You also can call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** or contact the insurer for the plan in question. If your coverage goes into effect retroactively, any pre-tax contributions for retroactive coverage may be taken from you pay on an after-tax basis. Alternatively, this retroactive coverage could be paid for by ADT.

Generally, your pre-tax benefit elections remain in effect until December 31 of the year in which you enroll, unless you make a change due to a qualifying event, such as marriage, divorce, or the birth of a child, or you qualify for a special enrollment period. See the **Life Events** section of this SPD for more information.

Benefits Annual Enrollment

From time to time, your benefit needs may change. That's why, in addition to enrolling when you first become eligible, you have the opportunity to make certain changes to your benefits once each year during the Benefits Annual Enrollment period, which will be held prior to the beginning of the plan year.

During the Benefits Annual Enrollment period, you may choose to keep your current benefit elections, change your elections, or change whom you cover.

When Coverage Begins

Changes you make to your ADT health and group benefits coverage during a Benefits Annual Enrollment period are effective on January 1 of the following year.

Generally, your pre-tax benefit elections remain in effect until December 31 of the year in which you enroll, unless you make a change due to a qualifying event, such as marriage, divorce, or the birth of a child, or you qualify for a special enrollment period. See the **Life Events** section of this SPD for more information.

How to Enroll

You can enroll by one of two ways:

- Visit the Enrollment Center online at **MyADTHR.com > Health & Group Benefits**; or
- Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

Coverage Levels

When you enroll for coverage under the ADT health plans, you must choose a "level" of coverage. The coverage levels you may choose are:

- Individual;
- Employee+1; or
- Family.

You may also waive coverage.

Your eligible family members can only be enrolled in the same plans in which you are enrolled.

If you enroll in the Medical, Dental, and Vision Plans, you may enroll any or all of your eligible family members, as long as they are not already covered as an employee under the Plan or as an eligible family member by your spouse/domestic partner who is also enrolled in the Plan.

Under the Supplemental Life Insurance Plan, you may enroll your spouse/domestic partner or dependent child(ren) only if you elect coverage for yourself.

Under Personal and Family Accidental Death and Dismemberment (P&F AD&D) Insurance, you may cover your family in addition to yourself. You may not cover only your spouse/domestic partner or only your dependent child(ren) under this P&F AD&D Insurance Plan.

If Your Spouse/Domestic Partner Is Employed by ADT

If both you and your spouse/domestic partner are eligible ADT employees, you can enroll in one of the following ways:

- Enroll only one of you as an ADT employee and the other as a spouse/domestic partner of an ADT employee. You cannot be covered as both an employee **and** a spouse/domestic partner under the Medical Plan. For example, you cannot select individual health coverage for yourself and also be a dependent under your spouse's/domestic partner's ADT Medical Plan. However, for Life and AD&D Insurance, an employee can be covered as both an employee and as a spouse/domestic partner.
- Enroll each of you in individual employee coverage.

Please note: In addition, if you have eligible child(ren), only one spouse/domestic partner can enroll eligible child(ren) for coverage under the Medical Plan. For example, you may cover your child(ren) for medical coverage and your spouse/domestic partner may cover them for dental coverage—or one of you may cover your child(ren) for both medical and dental coverage. However, **both** you and your spouse/domestic partner would not be able to cover your child(ren) for medical coverage. However, for Life and AD&D Insurance, both you and your spouse can cover your dependent child(ren).

If You Don't Enroll

When First Eligible

If you don't enroll for Plan coverage when you're first eligible, you'll automatically default to "waive coverage" for all benefits except the following:

- Long-Term Disability (50% level), for which you and the Company share in costs; and
- Benefits for which the Company fully pays:
  - Basic Term Life Insurance;
  - AD&D Insurance;
  - Business Travel Accident Insurance; and
  - Short-Term Disability.

Additionally, neither you nor your dependents will have coverage for the remainder of the calendar year. To change this coverage, you must wait until the next Benefits Annual Enrollment period, unless you experience a qualifying status change or other applicable change event. See "Qualifying Status Changes" later in this section for more information.

During Benefits Annual Enrollment

If you are eligible to enroll during Benefits Annual Enrollment and you were covered under the Plan in the previous year, you must actively waive coverage in most plans if you don't want to be covered in the subsequent year.

For Medical Plan coverage, your default coverage in the subsequent year will be the same as your coverage the previous year. You will default to your prior year coverage in the Dental Plan unless you were in the Dental DMO and that Dental Plan option is no longer offered in your location. In that case, you will be enrolled in the Standard Dental Plan for subsequent year dental coverage unless you actively enroll. For more information about whether the Dental DMO option will be offered in your location, see the **Dental** section of this SPD.

There is no default participation in the Health Savings Account, Flexible Spending Account and Dependent Care Account Plans. To participate, you must actively enroll during the Benefits Annual Enrollment period.

ADT retains the right to change the enrollment defaults for any given year. Watch for details in each year's annual enrollment materials.

You will default to your prior year coverage for Long-Term Disability, P&F AD&D Insurance, and Supplemental Life Insurance.

Paying for Coverage

Cost of Coverage

In most cases, you and ADT share in the cost of your coverage, with ADT paying the majority of the cost. You pay your share of the cost through pre-tax and after-tax payroll deductions each pay period. Pre-tax payroll deductions are made through the ADT Cafeteria Plan. The cost of your coverage is based on a number of factors, including which benefits you elect and whether you elect to cover eligible family members. Employee contributions for the Medical, Dental and Vision Plans are set annually. **Please note:** Failure to pay your share of the cost for your coverage—for example, while you are on an unpaid leave of absence—may have an impact on your coverage.

Pre-Tax Contributions

Payroll deductions for your share of the cost of your Medical, Dental, and Vision Plan coverage as well as for contributions to the FSA and DCA are made on a pre-tax basis, except where coverage is provided for a domestic partner who is not a tax dependent. Payroll deductions for a domestic partner will be taxable income to you. For more information on the taxation of domestic partner benefits see the **Eligibility** section of this SPD. One of the advantages of pre-tax deductions is that any amount you pay toward the cost of these benefits is paid before taxes are withheld. This means that you do not pay federal, Social Security and in many states, state and local income tax on your contributions.

Since your pre-tax contributions are not subject to Social Security tax, these contributions are not counted toward your Social Security earnings. This means that your future Social Security benefit may be reduced. For details and information on whether pre-tax contributions are advantageous for you, please contact your tax or financial adviser. See “Paying for Benefits Pre-Tax vs. After-Tax” in the **Overview** section of this SPD for more information.

After-Tax Contributions

Payroll deductions for your share of the cost of your Long-Term Disability, P&F AD&D Insurance, Supplemental Life Insurance, and other voluntary benefit coverages and Medical, Dental and Vision Plan coverage for a non-tax dependent domestic partner are made on an after-tax basis. Amounts you contribute on an after-tax basis are subject to federal and state income and employment taxes, just like the rest of your pay. These amounts will be taken into account when computing your federal Social Security benefit and for purposes of your pay-related benefits.

Deductions are withheld as soon as administratively possible after you become eligible, enroll, and are approved for coverage.

Generally, when you pay for coverage with after-tax dollars, the benefits you (or your beneficiary) receive are not subject to federal taxes. In a few cases, however, state taxes may apply. You should consult with your tax adviser to determine how these benefits apply to your specific tax situation.

Changing Your Coverage during the Year (Pre-Tax Benefits)

Generally, you cannot make changes to your pre-tax benefits until the next Benefits Annual Enrollment period, unless you experience certain "qualifying events." Different rules apply to your after-tax benefits. See "Changing Your Coverage during the Year (After-Tax Benefits)" later in this section for details.

Qualifying events allow you to make changes to your pre-tax benefits outside the Benefits Annual Enrollment period. These events include qualifying status changes, cost and coverage events, special enrollment events, and other qualifying events.

Qualifying Status Changes

Qualifying status changes that allow you to change pre-tax elections include the following:

- Birth, adoption, or placement for adoption of a dependent child;
- A Qualified Medical Child Support Order (QMCSO) that requires you to cover a dependent child or dependent child(ren);
- Marriage, divorce, legal separation, or annulment;
- Start or termination of a domestic partnership;
- Death of a spouse or dependent child;
- Dependent child ceases to be a dependent as defined by the Plan;
- Change in student status of a dependent child (enrollment or disenrollment); **Please note:** This is only a qualifying event for the Dental, Vision, and FSA Plans (not the Medical Plan);
- Significant cost or coverage change in your dependent's coverage due to a change in your dependent's residence;
- Changes in employment status for you or your spouse, including:
  - Beginning or ending of employment;
  - Switching from full-time to part-time status or vice versa; and
  - Commencing an unpaid leave of absence.
- A significant cost or coverage change in your spouse's coverage because of your spouse's employment (FSA changes, however, are not allowed for this reason);
- The dropping or adding of coverage by your spouse during his/her employer's annual enrollment for a plan whose plan year does not follow a calendar year;
- Medicare eligibility for you or your spouse if it impacts eligibility for coverage under this Plan;

- Changes in work schedule, including:
  - Increased or decreased hours;
  - Strike or lockout; and
  - Beginning or returning from an unpaid leave of absence by you, your spouse, or a dependent;
- Changes in residence or work site for you, your spouse, or a dependent, which results in eligibility or a loss of eligibility; and
- Changes in residence or work site for you, your spouse, or a dependent, which result in severe restrictions on availability of network providers.

Please note: To change your benefit elections because of a qualifying status change, you will be required to show proof verifying that these events have occurred (for example, a copy of a marriage or birth certificate, divorce decree, etc.). These rules apply to elections you make for your Medical, Dental, and Vision Plan coverage and your FSA. See the **Life Events** section of this SPD for more specific information on qualifying events.

Notifying ADT of Your Qualifying Status Change

To make a change to your pre-tax benefits, you must go online at **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. In general, all changes must be made no later than 31 calendar days after your qualifying status change, special enrollment event, cost or coverage change, or other qualifying event, but in some circumstances a longer period of time may apply. See the **Life Events** section of this SPD for more information. You will be required to provide documentation to verify the qualifying event.

In general, if you do not request a change during this 31-calendar-day period, you must wait until the next Benefits Annual Enrollment period to make any changes to your pre-tax benefits.

Consistency Requirements

The changes you make to your pre-tax benefits must be "due to and consistent with" your qualifying status change. This means that your qualifying status change and corresponding benefits coverage change must meet both of the following requirements:

- **Effect on Eligibility:** Except for the DCA, the qualifying status change must affect eligibility for coverage under the ADT plan or under a plan sponsored by your spouse's (or other dependent's) employer. For this purpose, the event is considered a qualifying status change if, as a result of the event:
  - You become eligible (or ineligible) for coverage; or
  - There is an increase or decrease in the number of your dependents who may benefit from coverage under the plans.

  For the DCA, the qualifying status change must affect the amount of dependent day care expenses eligible for reimbursement. For example, if your child reaches age 13, dependent day care expenses are no longer eligible for reimbursement.

- **Effect on Election Change:** The election change must correspond with the qualifying status change. For example, if your dependent loses eligibility for coverage under the terms of the Plan, you may cancel Medical, Dental, and Vision Plan coverage only for that dependent. You cannot cancel or expand coverage for yourself or other dependents.

Coverage and Cost Events

In some instances, you can make changes to your benefits coverage for other reasons, such as mid-year events affecting your plan cost or coverage, as described below.

Coverage Events

Health Care Coverage

If ADT adds or eliminates a plan option in the middle of the plan year, or if an ADT-sponsored benefit is significantly limited or ends, you and your eligible dependents can elect different coverage according to Internal Revenue Service (IRS) regulations.

For example, if there is an overall reduction under a plan option, participants enrolled in that option may elect coverage under another option providing similar coverage (if the option with similar coverage permits). Furthermore, if ADT adds another plan option mid-year, participants may be permitted to drop their existing coverage and enroll in the new option (if the new option permits). You and your eligible dependents may also enroll in the new option even if not previously enrolled for coverage at all (if the new option permits).

Additionally, you may make a corresponding mid-year election change if:

- An election change is permitted during another employer's annual enrollment period; or
- If applicable, during an enrollment period for another ADT-sponsored plan.

This rule applies to the health plans.

Lastly, if another employer's plan allows your spouse or other dependent to change his/her elections according to IRS regulations, you may make a corresponding mid-year election change to your coverage.

Dependent Care Account

If you must reduce or increase the number of hours of dependent day care, you may make a corresponding change to your Dependent Care Account (DCA) election. For example, if your child starts school, reducing the number of hours he/she is in the care of a dependent day care provider, you may decrease your DCA contribution.

Special Enrollment Events

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have special enrollment rights under certain circumstances. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents for health coverage in the future—provided that you request enrollment within 31 calendar days after your other coverage ends. Coverage becomes effective as of the 31st calendar day of employment (91st calendar day for Direct Connect).

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 31 calendar days from the date of the marriage, birth, adoption, or placement for adoption. If you miss the 31-calendar-day deadline, you must wait until the next Benefits Annual Enrollment period—or for another qualifying status change or another special enrollment event—to enroll. See the **Life Events** section of this SPD for more information. Coverage elected as a result of a special enrollment right due to a birth, adoption or placement for adoption will become effective as of the date of the event.

Additional HIPAA special enrollment rights were added by the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009. Special enrollment rights were extended to eligible employees or dependents who lose coverage under Medicaid or CHIP or who are available for government premium assistance under Medicaid or CHIP. This special enrollment period runs until 60 calendar days (not 31 calendar days) after the loss of coverage or determination of eligibility for premium assistance.

To meet IRS regulations and plan requirements, ADT reserves the right at any time to request written documentation of any dependent's eligibility for plan benefits and/or the effective date of the qualifying change in status.

Other Qualifying Events

Qualified Medical Child Support Order (QMCSO)

If a judgment, decree, or order (called a QMCSO) requires the Plan to provide health care coverage to your child(ren), then the plan administrator may automatically change your election under the Plan to provide coverage for that child. **(This includes enrolling you if you are not already enrolled in the Plan.)** In addition, you may make corresponding election changes as a result of such judgment, decree, or order, if you desire.

If the judgment, decree, or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan. To do so, you must provide proof to the plan administrator that the other person actually provides coverage for the child.

Medicare or Medicaid Entitlement

You may change an election for health coverage after the beginning of the plan year if you, your spouse, or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A, Part B, or Part D of Medicare, or under Medicaid. However, you are limited to:

- Reducing your health coverage only for the person who becomes entitled to Medicare or Medicaid; and
- Adding health coverage only for the person who loses eligibility for Medicare or Medicaid.

Different rules apply for terminated employees electing COBRA. See the **Continuing Coverage under COBRA** section of this SPD for more details.

Please note: Enrollment in Medicare may affect contributions to your Health Advantage Plan with associated Health Savings Account if you're enrolled in that option. See the **Medical** and **Prescription Drug** sections of this SPD for information.

Family and Medical Leave Act

You may drop health care coverage and stop participating in the FSA after the beginning of the plan year if you begin an unpaid leave of absence under the Family and Medical Leave Act (FMLA) or you may elect to make contributions during the leave on an after-tax basis. If you do not make contributions to the FSA during the leave, medical expenses incurred during the leave will not be eligible for reimbursement from the FSA. If you drop coverage or if you fail to make payments for benefit coverage during your FMLA leave, upon your return to active work, you have the right to be reinstated to the same elections you made prior to taking your FMLA leave or you may increase your elections to make up for contributions missed during the leave.

Leave of Absence Nine Months or Greater

If you have been on an approved Leave of Absence (LOA) for nine consecutive months (other than an approved Military Active Duty LOA), ADT reserves the right to terminate all benefit eligibility even if you have been making timely and accurate payments to continue your benefit coverage while on leave. If you lose benefit eligibility, you will receive notification of this action and you may have the right to continue health coverage under COBRA and be offered certain conversion rights for non-health coverages.

Please note: Depending on the policy, you may have certain rights that allow you to convert certain coverage to an individual policy or to port your coverage. See the **Life and AD&D** section of this SPD for additional details.

See the **Special Notices** section of this SPD for information on the Uniformed Services Employment and Reemployment Rights Act (USERRA) for information on military leaves.

When Your Pre-Tax Changes Become Effective

When you change your pre-tax benefit elections due to a qualifying event, the coverage change and any corresponding change in your contribution amount—for example, from Individual to Family coverage—are effective on the date of your qualifying event. If your coverage goes into effect retroactively, any pre-tax contributions for retroactive coverage may be taken from your pay on an after-tax basis. Alternatively, this retroactive coverage could be paid for by ADT.

Please note: IRS rules generally do **not** permit you to make a change of pre-tax benefits after the beginning of the plan year unless you experience a qualifying event involving an individual who obtains his/her benefits on a pre-tax basis (such as a spouse or a child who has not yet reached age 26 under the Medical Plan).

Domestic partners are usually not considered to be tax dependents. If you make a mid-year change because of an event involving your domestic partner (or child[ren] of your domestic partner), that change must generally be made on an **after-tax** basis—unless your domestic partner or his/her child(ren) can be claimed as your dependents for federal income tax purposes. (Exceptions may be made if your domestic partner makes an election change under his/her employer's plan according to IRS regulations.) For a discussion of the definition of a tax dependent, see IRS Publication 17, Your Federal Income Tax. The publication can be obtained by going to **irs.gov** and typing "Publication17" in the search box.

Changing Your Coverage during the Year (After-Tax Benefits)

You may enroll in or make changes to the after-tax Long-Term Disability and Life and AD&D Insurance Plans offered by ADT at any time during the year. You are not required to wait until Benefits Annual Enrollment or until you experience a qualifying event. However, you may have to provide EOI if you enroll past a given time period after you are first eligible or if you increase your current coverage.

Please note: Additional special rules apply to Supplemental Life Insurance.

To enroll in or make a change to your Long-Term Disability or Life and AD&D Insurance Plans, visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Allowable Changes to the After-Tax Benefits

Long-Term Disability

You may enroll in or make changes to Long-Term Disability (LTD) Insurance at any time. As a new hire, you will be automatically enrolled in LTD coverage at the 50% benefit level unless you choose to waive the coverage. You may increase your coverage to the 60% benefit level within 31 calendar days of first becoming eligible without having to provide Evidence of Insurability (EOI).

If you wish to enroll in the LTD Plan or increase your coverage level (e.g., move from 50% benefit to 60% benefit) after this initial enrollment period, you must provide EOI and the insurance company must approve this proof of good health before coverage is effective. If denied, you will not have the coverage level you have requested under the LTD Plan. Note that Evidence of Insurability (EOI) requirements also apply to any changes due to qualifying events. You may, however, decrease or drop LTD Plan coverage at any time; but if you drop coverage and would like to re-enroll later, you may be required to satisfy EOI requirements. EOI applications are generally initiated online while you are making your enrollment elections if EOI is required.

Personal and Family AD&D Insurance

You may enroll in or make changes to the Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance Plan at any time. EOI is not required for the P&F AD&D Insurance Plan.

Supplemental Life

You may decrease or discontinue your Supplemental Life Insurance at any time.

You may enroll or increase coverage levels without providing EOI if:

- You enroll within 31 calendar days of the date you first become eligible. **Please note:** New hires can elect up to three times base annual salary without providing EOI. Any amounts over this guaranteed issue amount will require EOI.
- You enroll a new dependent within 31 calendar days of acquiring the new dependent (up to the plan's guaranteed issue amounts).

You must complete an EOI application—and insurance company approval is required—for all other enrollments and/or increases in coverage. EOI applications are generally initiated online while you are making your enrollment elections if EOI is required. Your application for coverage (or the increase in coverage) could be denied if the insurer does not approve the EOI application.

When Your After-Tax Changes Become Effective

When you change your Supplemental Life Insurance because of marriage, domestic partnership, or birth or adoption of a new dependent child(ren), any corresponding changes in your contribution level or amount are usually effective as of the date of the qualifying event.

If EOI is required for Long-Term Disability or Supplemental Life Insurance, coverage takes effect on the date the plan's insurer approves your application and EOI or eligibility effective date, whichever is greater.

You **must** be in active service on the date your coverage under the Long-Term Disability and/or Supplemental Life Insurance Plans is scheduled to begin. If you are not in active service on this date, your Long-Term Disability and/or Supplemental Life Insurance coverage begins on the date that you return to active employment for one full day.

When Coverage Ends

When Coverage Ends for You

Plan coverage for you and your covered family members ends on the last day of the month in which the earliest of the following occurs:

- Your employment ends.
- You experience a temporary layoff or certain leaves of absence.
- You stop active work because the company suspends operations or your regular work hours are reduced to less than 20 hours per week.

Coverage may also end if:

- You experience a change in employee status, such as going from full-time to part-time status or changing from a class of employees covered under the Plan to another class of employees covered under a different group health plan.
- A covered family member no longer meets dependent or other eligibility requirements.
- You fail to pay any required contribution for plan coverage including during an unpaid LOA.
- You have been on an LOA (other than a Military Active Duty LOA), whether paid or unpaid, for nine consecutive months.
- You or a covered family member misuses your health plan ID card(s) by permitting someone other than the covered family member to use the card.
- You knowingly furnish incorrect or incomplete information in any of the following types of situations:
  - About a person's general health condition;
  - While following managed care or pre-certification procedures; or
  - When providing any other information to the company or a claims administrator or insurance company.
- ADT terminates the Plan or a coverage option.
- ADT amends the Plan or a coverage option and you are no longer eligible for coverage as a result of the amendment.

When Coverage Ends for Your Spouse/Domestic Partner

Coverage for your covered spouse/domestic partner ends on the last day of the month in which he/she no longer qualifies for coverage under the plan or your coverage ends.

When Coverage Ends for Your Covered Eligible Child

Medical coverage for your eligible child ends on the last day of the month in which he/she turns age 26.

Other coverages for your unmarried dependent child end on the last day of the month in which your coverage ends or he/she:

- Turns age 19, unless he/she is a full-time student; or
- If a full-time student, the day he/she:
  - Turns age 23;
  - Graduates;
  - Voluntarily stops attending school full-time, and does not return to school full-time;
  - Attends school full-time for less than eight months in any 12-month period (unless he or she is attending full-time at the end of the 12 months);
  - Marries; or
  - No longer meets the Plan's definition of a dependent for any other reason.

You must notify the claims administrator and the Company of any change to your own or your covered dependents' status. Failure to notify the Company within 60 calendar days if you become legally separated or divorced or if your child is no longer qualified as eligible under the Plan could impact your spouse's and/or eligible child's eligibility to continue coverage under COBRA. Similarly, failure to notify the Company within 60 calendar days if you terminate your domestic partnership could impact your domestic partner's rights to the COBRA-like continuation benefits provided under the Plan.

Extending Your Coverage under COBRA

Under some circumstances, you and/or your spouse and eligible dependents may be able to extend health care coverage beyond the date your coverage would otherwise end through COBRA continuation coverage. Please see the **Continuing Coverage under COBRA** section of this SPD for more details.

Life Events

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Life Events

How Certain Life Events Affect Your Benefits

When your life changes, chances are your benefits will need to change too. If you get married, have or adopt a baby, relocate, become disabled, or otherwise experience a major life event, you should know how your benefits may be affected. This section describes what happens to your benefits under the ADT Health and Welfare Benefits Plan (the "Plan") when you experience certain life events.

Internal Revenue Service (IRS) rules permit mid-year benefit election changes following certain life events—called qualifying status changes—that affect your eligibility for benefits. If you experience a qualifying status change, you have 31 calendar days to make permissible benefit changes—otherwise, you'll need to wait until the next Benefits Annual Enrollment period. Depending on the event and the type of benefit, you may only be permitted to make changes to your elections if certain consistency requirements are satisfied. In general, the consistency requirements will be satisfied if a change in elections is on account of and corresponds with a change in status that affects eligibility for coverage under an employer-sponsored plan.

Review this section along with the specific sections describing each benefit to help you answer the question, "What's best for me?"

For information on how benefits are affected during a leave of absence, refer to the following:

- **Family and Medical Leave Act (FMLA):** See "FMLA" under the **Special Notices** section of this SPD.
- **Military Leaves:** See "USERRA" under the **Special Notices** section of this SPD.

Please note: If your regular work hours are reduced to less than 20 hours per week, you are no longer eligible for coverage in the Plan. In this case, coverage will end at the end of the month that your hours are reduced.

Also see the "When Coverage Begins," "Changing Your Coverage during the Year (Pre-Tax Benefits)," "Changing Your Coverage during the Year (After-Tax Benefits)" and "When Coverage Ends" under the **Enrollment** section of this SPD for information on how benefits are affected by life events.

If You Get Married or Begin a Domestic Partnership

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	You can add coverage for yourself, your spouse/domestic partner, and other eligible dependent(s), or you can drop ADT coverage if you are enrolling in your spouse's/domestic partner's benefits as long as you are still employed by ADT. You can also change your current coverage option. You generally have 31 calendar days to make adjustments to your benefit elections upon marriage or commencing a domestic partnership. If you're adding your spouse/domestic partner to your Medical coverage, you can qualify for additional Healthy Rewards incentives if your spouse/domestic partner completes the qualified activities.	To enroll, drop, or make changes: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Supplemental Life Insurance **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	You can enroll in or increase your Supplemental Life Insurance or P&F AD&D Insurance as long as you are still employed by ADT. You can cover your new spouse/domestic partner and his/her eligible child(ren), if any. Changes can be made at any time. **For yourself—**If you enroll within 31 calendar days of the qualifying event, you can elect a one-level increase over the previous year (provided the amount is less than three times your base annual salary or under $1 million) without providing Evidence of Insurability (EOI). EOI is required if you elect: ▪ An increase of no coverage to any coverage; ▪ An increase over one level (if you want to change from one to three times base annual salary, you will receive two times base annual salary while election is processed for approval);	To increase your insurance coverage: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. To update your beneficiary designations: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Supplemental Life Insurance (cont'd) **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	▪ Four or more times base annual salary; ▪ Over $1 million; or ▪ An increase of any kind after 31 calendar days of the qualifying event. Update your beneficiary designation for Life and AD&D Insurance to ensure that death benefits go to the person you want to receive them if you should die. **For your dependents—**If you enroll in Supplemental Life Insurance for yourself within 31 calendar days of the qualifying event, you can elect a one-level increase (one level = $10,000) for your dependent over the previous coverage (provided the amount is $30,000 or less) without providing EOI as long as you are still employed by ADT. EOI is required if you elect: ▪ An increase of no coverage to $20,000; ▪ An increase over one level (if you want to change from $10,000 to $30,000, you will receive $20,000 while election is processed for approval); ▪ Over $30,000; or ▪ An increase of any kind after 31 calendar days of the qualifying event.	
Flexible Spending Account (FSA) **Dependent Care Account (DCA)**	In general, you can adjust your contributions to your FSA within 31 calendar days as long as you are still employed by ADT. You may want to open an FSA and/or DCA if you expect to have more expenses with your new dependent(s). If your new spouse is contributing to a spending account, you may need to adjust your contributions. For example, DCAs have contribution limits for married couples.	To adjust your spending account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Long-Term Disability (LTD)	You can enroll in LTD coverage if you're not already enrolled as long as you are still employed by ADT. You may enroll at any time, but after 31 calendar days of first becoming eligible you will need to provide EOI.	To enroll in LTD coverage: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Documentation Requirements

You may be asked to provide documentation to ADT to validate the change in status event.

Adding Dependents and Eligible Child(ren)

You will be asked to provide documentation to verify the eligibility of your spouse/domestic partner and the dependent child(ren) you wish to enroll for Medical and Dental coverage. **Please note:** The documentation for dependent child(ren) may vary depending on the plans in which they are being enrolled. Your spouse/domestic partner and eligible child(ren) must be enrolled in the same option in which you are enrolled. Please refer to the **Eligibility** section of this SPD for details about required documentation for verifying dependent eligibility.

Beginning a Domestic Partnership

To put your domestic partnership on file with ADT, you will need to call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. After you enroll your dependent(s), you will receive a packet in the mail asking you to verify your relationship by providing a Domestic Partner Affidavit and other documentation. Any benefit changes generally must be made within 31 calendar days of the date you report your domestic partnership (or such other period as designated by the plan administrator). If you marry your domestic partner who is currently enrolled for benefits, you will need to call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to report the event and to update your domestic partner's relationship code to Spouse. You will also need to provide a marriage certificate.

Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform** and follow the instructions to submit the Affidavit of Domestic Partnership or Affidavit of Termination of Domestic Partnership form. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

If You Get Divorced, Legally Separated, or End a Domestic Partnership

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	You can drop coverage for your former spouse/ domestic partner and his/her dependent(s), who are no longer eligible for coverage under the Plan as of the date of divorce, legal separation, or receipt of domestic partner termination affidavit as long as you are still employed by ADT. You can enroll in coverage if you were covered under your spouse's/domestic partner's plan and are losing that coverage. **Please note:** A court order may specify who has the responsibility to provide benefits for any child(ren). You generally have 31 calendar days to make adjustments to your benefit elections.	To enroll, drop, or make changes: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Supplemental Life Insurance **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	You can drop coverage for your former spouse/ domestic partner and his/her dependent(s), who are no longer eligible for coverage under the Plan as of the date of divorce or legal separation as long as you are still employed by ADT. You can enroll in or change your Supplemental Life Insurance or P&F AD&D Insurance. Changes can be made at any time. **For yourself—**If you enroll within 31 calendar days of the qualifying event, you can elect a one-level increase over the previous year (provided the amount is less than three times your base annual salary or under $1 million) without providing Evidence of Insurability (EOI). EOI is required if you elect: ▪ An increase of no coverage to any coverage;	To enroll, drop, or make changes: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. To update your beneficiary designations: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to speak with a representative.

Benefit	How Coverage Is Affected	How to Change Coverage
Supplemental Life Insurance (cont'd) **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	▪ An increase over one level (if you want to change from one to three times base annual salary, you will receive two times base annual salary while election is processed for approval); ▪ Four or more times base annual salary; ▪ Over $1 million; or ▪ An increase of any kind after 31 calendar days of the qualifying event. Update your beneficiary designation for Life and AD&D Insurance to ensure that death benefits go to the person you want to receive them if you should die. **For your dependents—**If you enroll in Supplemental Life Insurance for yourself within 31 calendar days of the qualifying event, you can elect a one-level increase for your dependent (one level = $10,000) over the previous coverage (provided the amount is $30,000 or less) without providing EOI. EOI is required if you elect: ▪ An increase of no coverage to $20,000; ▪ An increase over one level (if you want to change from $10,000 to $30,000, you will receive $20,000 while election is processed for approval); ▪ Over $30,000; or ▪ An increase of any kind after 31 calendar days of the qualifying event.	
Flexible Spending Account (FSA) **Dependent Care Account (DCA)**	In general, you can enroll, change your contributions, or stop your contributions within 31 calendar days as long as you are still employed by ADT. You may want to open an FSA and/or DCA or increase your contributions after your divorce or termination of domestic partnership if you were covered under your spouse's plan. Or, you may need to stop or reduce contributions if you no longer provide coverage for your former spouse/domestic partner or dependents.	To enroll in, change, or stop contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ **Call EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Long-Term Disability (LTD)	You can enroll in Long-Term Disability coverage if you're not already enrolled as long as you are still employed by ADT. You may enroll at any time, but after 31 calendar days of first becoming eligible you will need to provide EOI.	To enroll in LTD coverage: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ **Call EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Court-Ordered Coverage

If a court orders you to continue coverage for your former spouse, the court order does not entitle the former spouse to remain covered by the Plan as your dependent. ADT coverage may continue through COBRA for up to 36 months following divorce, by payment of the full cost of the coverage plus an administrative fee. The court order may require you to pay the COBRA premiums for your former spouse's coverage. For additional information, please call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** or see the **Continuing Coverage under COBRA** section of this SPD.

A court order may require you to commence or maintain ADT coverage for your child(ren). If so, the Plan will comply with the order as long as your child(ren) are otherwise eligible. A court order requiring continued medical coverage for child(ren) should be submitted to the Plan to determine if it is a Qualified Medical Child Support Order (QMCSO). The court order can be submitted to:

ADT LLC
Attn: Legal Department
RE: QMSCO / Subpoena
1501 Yamato Road
Boca Raton, FL 33431

COBRA Coverage

You or your former spouse/domestic partner must notify ADT if he/she is losing health coverage as a result of the divorce or end of a domestic partnership and wishes to continue coverage through COBRA. ADT must be notified within 60 calendar days of the event, or COBRA coverage will not be available. Failure to provide notice or elect coverage within the required time frames means COBRA coverage will not be available.

See the **Continuing Coverage under COBRA** section of this SPD for more information.

Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Ending a Domestic Partnership

It is your duty to advise ADT of any changes in your domestic partnership within 31 calendar days of the change. If you end a domestic partnership, you must complete and submit an Affidavit of Termination of Domestic Partnership form. The date in the affidavit determines the date of your qualifying status change, entitling you to make mid-year changes to your benefits.

Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform** to access the Affidavit of Termination of Domestic Partnership form. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

If You Give Birth or Adopt a Child

Before your baby arrives, you can help prepare yourself by:

- Reviewing ADT's resources and programs for information about pregnancy and childbirth, including information on additional support for high-risk pregnancies. This information is available at no cost to you. For more information visit **MyADTHR.com > Wellness > Baby Yourself Program**.
- Making arrangements for time off work.
  - Female employees giving birth qualify for benefits under the Short-Term Disability Plan for childbirth and the following recovery period.
  - If Short-Term Disability Plan benefits have expired or are not available, mothers and fathers may use paid vacation time or take an unpaid leave of absence under the Family and Medical Leave Act to care for the new child.
  - For more information, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Disability Management Services**.
- Deciding whether your benefits or those of your spouse/domestic partner are better for your new child. You generally have 31 calendar days (or such other period as selected by the plan administrator) from the date of the birth or adoption to make adjustments to your benefit elections for your new child.
- Arranging for day care, if needed. ADT's Employee Assistance & Work/Life Program (EAP) can help you find dependent day care in your area. For more information, call **1-855-4ADT-EAP (1-855-423-8327)**.

Also, if you're adopting a child, don't forget that ADT's Adoption Assistance Program is available to you. See the **Additional Benefits** section of this SPD for information.

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	You can add coverage for yourself, your spouse/ domestic partner, and your eligible dependent(s), or change your current ADT coverage option generally within 31 calendar days of the birth or adoption as long as you are still employed by ADT. Your new child must be enrolled in the same medical and dental plan options as you. **Please note:** Coverage for a new child will **not** occur automatically. **You must enroll your new child even if you already elected Family coverage**. If you're adding your spouse/domestic partner to your medical coverage, you can qualify for additional Healthy Rewards incentives if your spouse/domestic partner completes the qualified activities.	To enroll your child: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Supplemental Life Insurance **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	You can enroll or increase your Supplemental Life Insurance or P&F AD&D Insurance as long as you are still employed by ADT. You can cover your spouse/domestic partner and your new child under Supplemental Life Insurance (but only if you have such coverage for yourself) and P&F AD&D Insurance. Changes can be made at any time. **For yourself—**If you enroll within 31 calendar days of the qualifying event, you can elect a one-level increase over the previous year (provided the amount is less than three times your base annual salary or under $1 million) without providing Evidence of Insurability (EOI). EOI is required if you elect: ▪ An increase of no coverage to any coverage; ▪ An increase over one level (if you want to change from one to three times base annual salary, you will receive two times base annual salary while election is processed for approval); ▪ Four or more times base annual salary;	To enroll in or increase your Supplement Life Insurance or P&F AD&D Insurance: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. To update your beneficiary designations: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to speak with a representative.

Benefit	How Coverage Is Affected	How to Change Coverage
Supplemental Life Insurance (cont'd) **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	▪ Over $1 million; or ▪ An increase of any kind after 31 calendar days of the qualifying event. Update your beneficiary designation for Life and AD&D Insurance to ensure that death benefits go to the person you want to receive them if you should die. **For your dependents—**If you enroll in Supplemental Life Insurance for yourself within 31 calendar days of the qualifying event, you can elect a one-level increase for your dependent (one level = $10,000) over the previous coverage (provided the amount is $30,000 or less) without providing EOI as long as you are still employed by ADT. EOI is required if you elect: ▪ An increase of no coverage to $20,000; ▪ An increase over one level (if you want to change from $10,000 to $30,000, you will receive $20,000 while election is processed for approval); ▪ Over $30,000; or ▪ An increase of any kind after 31 calendar days of the qualifying event.	
Flexible Spending Account (FSA) **Dependent Care Account (DCA)**	Consider changing your existing contribution level, or beginning contributions to the FSA and DCA to help pay for the additional expenses you will be incurring. You generally have 31 calendar days after the date of birth or adoption to change your contribution or enroll in an FSA/DCA as long as you are still employed by ADT. If you enroll in either the FSA or DCA following a qualified life status event such as birth or adoption, the amounts you contribute are only available to reimburse charges incurred on or after the date of the event, not before.	To enroll in the FSA/DCA or to change your contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Long-Term Disability (LTD)	You can enroll in Long-Term Disability coverage if you're not already enrolled as long as you are still employed by ADT. You may enroll at any time, but after 31 calendar days of first becoming eligible you will need to provide EOI.	To enroll in LTD coverage: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Also, remember that the ADT Employee Assistance & Work/Life Program (EAP) is available to you by calling **1-855-4ADT-EAP (1-855-423-8327)**. The EAP offers resources that can assist you with:

- Setting realistic expectations for the first few weeks.
- Adjusting to day care.
- Understanding sibling relationships.
- Achieving a work/life balance.

If Your Spouse/Domestic Partner Works for ADT

If one spouse/domestic partner is enrolled in benefits as a Company employee, he/she can also enroll a child(ren) as a dependent with the same coverage. If each spouse/domestic partner is enrolled as a Company employee, either one may cover the child(ren) as a dependent. **Please note:** For Life and AD&D Insurance, both you and your spouse/domestic partner can maintain coverage for your dependent child(ren).

Adding Dependents and Eligible Child(ren)

You will be asked to provide documentation to verify the eligibility of your spouse/domestic partner and the dependent child(ren) you wish to enroll for Medical and Dental coverage. **Please note:** The documentation for dependent child(ren) may vary depending on the plans in which they are being enrolled. For certain benefit options, your spouse/domestic partner and eligible child(ren) must be enrolled in the same option in which you are enrolled. Refer to the **Eligibility** section of this SPD for details about required documentation for verifying dependent eligibility.

If You Need Short-Term Disability (STD) or Take an Unpaid Leave of Absence

Report your illness or injury of three consecutive calendar days or longer within seven calendar days of the start of your short-term disability absence. Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Disability Management Services** and speak with the disability administrator's intake department as soon as possible. The disability/leave administrator will oversee and coordinate your claims and work with you, your doctor, and other medical professionals. Disability benefits or salary continuation may be available for absences shorter than 180 calendar days in duration.

In any case in which the necessity for taking a leave is foreseeable based on an expected birth or placement or a planned medical treatment, you should give the Company at least 30 calendar days' advance written notice of intent to take a Family and Medical Leave. When you are unable, for a legitimate reason, to give 30 calendar days' advance written notice to the Company, you should give as much notice as possible under the circumstances and generally must comply with the Company's normal call-in procedures.

Please note: The Short-Term Disability Plan is an income replacement plan and is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). See the **Disability** section of this SPD for more details.

Contact the disability/leave administrator through **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Disability Management Services** as well as your local human resources representative if you plan to take an unpaid leave of absence.

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	If you take an unpaid leave of absence or are on short-term disability: ▪ Coverage continues through the end of the ninth month following the date your leave began, provided you make timely and accurate payments to continue your benefit coverage and are still employed by ADT. ▪ You will be eligible to continue coverage under COBRA when you have been off work for nine months. **Please note:** As discussed further in the **Coordination of Benefits** section of this SPD, it's important to enroll in Medicare Parts A and B as soon as possible if you qualify.	To continue your coverage through COBRA: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Life and AD&D Insurance **Supplemental Life Insurance** **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	Your Basic Term Life Insurance, Supplemental Life Insurance, and P&F AD&D Insurance coverage continues provided you pay for coverage and are still employed by ADT. See the **Life and AD&D** section of this SPD for information on conversion or portability options.	No changes are allowed.

Benefit	How Coverage Is Affected	How to Change Coverage
Flexible Spending Account (FSA) **Dependent Care Account (DCA)**	Your FSA will continue during the year you become disabled or take an unpaid leave as long as you are an employee and you continue to make contributions to the FSA. Once you stop making contributions to the FSA, only eligible expenses incurred prior to the date you ceased contributions will be reimbursable. Coverage under the DCA will end because you can only be reimbursed from your DCA for expenses that allow you to work. Only dependent care expenses incurred before the date you commence a leave of absence can be paid from your DCA. Your FSA can continue to reimburse health expenses during the year you become disabled, until you are no longer an employee. If you have money left in your FSA when your employment terminates, you can continue your participation until the end of the year through COBRA.	To change your FSA/DCA contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Long-Term Disability (LTD)	Group coverage may take effect when short-term disability ends. Coverage continues through the end of the ninth month following the date your leave began, provided you make timely and accurate payments to continue your benefit coverage and are still employed by ADT.	No changes are allowed.

If You Become Disabled and Are Eligible for Long-Term Disability (LTD) Plan Benefits

If you are receiving benefits under the ADT Short-Term Disability Plan and are enrolled in the LTD Plan, the Short-Term disability/leave administrator will review your claim periodically to determine if your claim should transition to the LTD Plan for review and determination.

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	If you elected LTD coverage: ▪ Coverage continues through the end of the ninth month following the date you became eligible for disability benefits, provided you make timely and accurate payments to continue your benefit coverage and are still employed by ADT. ▪ You will be eligible to continue coverage under COBRA when coverage ends. **Please note:** As discussed further in the **Coordination of Benefits** section of this SPD, it's important to enroll in Medicare Parts A and B as soon as possible if you qualify. Medicare benefits are generally available after 29 months of disability, if you are approved for Social Security disability benefits, and coverage provided to a disabled employee under the Plan will pay secondary to Medicare regardless of whether you actually elect Medicare.	To continue your coverage through COBRA: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Life and AD&D Insurance **Supplemental Life Insurance** **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	Your Basic Term Life, Supplemental Life, and P&F AD&D Insurance coverage continues through the end of the ninth month you became eligible for disability benefits, provided you make timely and accurate payments to continue your benefit coverage and are still employed by ADT. See the **Life and AD&D** section of this SPD for information on conversion or portability options.	No changes are allowed.

Benefit	How Coverage Is Affected	How to Change Coverage
Flexible Spending Account (FSA) **Dependent Care Account (DCA)**	Your FSA will continue during the year you become disabled as long as you are an employee and you continue to make contributions to the FSA. Once you stop making contributions to the FSA, only eligible expenses incurred prior to the date you ceased contributions will be reimbursable. Coverage under the DCA will end because you can only be reimbursed from your DCA for expenses that allow you to work. Only dependent care expenses incurred before the date you commence a leave of absence can be paid from your DCA. Your FSA can continue to reimburse health expenses during the year you become disabled, until you are no longer an employee. If you have money left in your FSA when your employment terminates, you can continue your participation until the end of the year through COBRA.	To change your FSA/DCA contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Long-Term Disability (LTD)	Group coverage continues through the end of the ninth month you became eligible to collect disability benefits, provided you make timely and accurate payments to continue your benefit coverage and are still employed by ADT. Benefits may be payable to you if you elected LTD coverage.	No changes are allowed.

Learn about Your Options and Next Steps

Upon a disability, you may have various income resources available to you. You may be eligible for:

- Short-Term Disability Plan payments.
- Long-Term Disability Plan benefits.
- Workers' Compensation (if your disability is work-related).
- Social Security Disability Insurance.
- Unused vacation days.

You can contact the Social Security Administration for information about Social Security Disability Insurance. Visit **ssa.gov** or contact your local Social Security office.

Contact Health Advocate by calling **EmployeeAccess** at **1-888-833-1839** and selecting **Health and Group Benefits** followed by **Health Advocate** to get support for medical insurance claims and billing issues and other resources that may be available to help you with health issues related to your disability.

Also, remember that the ADT Employee Assistance & Work/Life Program (EAP) is available if you or your family members need help coping with the challenges and stresses of your disability. Contact the EAP by calling **1-855-4ADT-EAP (1-855-423-8327)**.

Family and Medical Leave

Disability leave is considered a leave under the Family and Medical Leave Act (FMLA) as of the first day of disability. FMLA leave runs concurrently with any disability leave taken. Family and Medical Leave can be taken for other reasons besides a personal disability, including the care for a child or family member.

If Your Spouse/Domestic Partner Loses Employment or Changes Employment and Loses Eligibility for Benefits Coverage

Please note: For this purpose, "losing employment" could be loss of a job, beginning a leave of absence, or going from full-time to part-time status, whether voluntarily or involuntarily.

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	You can add coverage for yourself, your spouse/ domestic partner, and other eligible dependents who lost coverage under your spouse's/domestic partner's coverage. You generally have 31 calendar days to make adjustments to your benefit elections. If you're adding your spouse/domestic partner to your medical coverage, you can qualify for additional Healthy Rewards incentives if your spouse/domestic partner completes the qualified activities.	To enroll, drop, or make changes: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Supplemental Life Insurance **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	You can enroll in or increase your Supplemental Life Insurance or P&F AD&D Insurance. You can cover your spouse/domestic partner and his/her child(ren), if any. Changes can be made at any time. **For yourself—**If you enroll within 31 calendar days of the qualifying event, you can elect a one-level increase over the previous year (provided the amount is less than three times your base annual salary or under $1 million) without providing Evidence of Insurability (EOI). EOI is required if you elect: ▪ An increase of no coverage to any coverage;	To enroll in or increase your insurance coverage: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Supplemental Life Insurance (cont'd) **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	▪ An increase over one level (if you want to change from one to three times base annual salary, you will receive two times base annual salary while election is processed for approval); ▪ Four or more times base annual salary; ▪ Over $1 million; or ▪ An increase of any kind after 31 calendar days of the qualifying event. Update your beneficiary designation for Life and AD&D Insurance to ensure that death benefits go to the person you want to receive them if you should die. **For your dependents—**If you enroll in Supplemental Life Insurance for yourself within 31 calendar days of the qualifying event, you can elect a one-level increase for your dependent (one level = $10,000) over the previous coverage (provided the amount is $30,000 or less) without providing EOI. EOI is required if you elect: ▪ An increase of no coverage to $20,000; ▪ An increase over one level (if you want to change from $10,000 to $30,000, you will receive $20,000 while election is processed for approval); ▪ Over $30,000; or ▪ An increase of any kind after 31 calendar days of the qualifying event.	To update your beneficiary designations: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to speak with a representative.
Flexible Spending Account (FSA)	If you and your spouse/domestic partner lose health coverage (Medical, Dental, or Vision), you can enroll or increase your contributions. **Please note:** If you are enrolling for the first time during the calendar year, or are increasing your contribution amount due to your qualifying status change, your new contribution amount will only be available to pay for eligible expenses you incur after the effective date of your status change. If your spouse's/domestic partner's status change occurs late in the year, keep in mind that enrollments or contribution increases for the current calendar year are not available on or after December 1. However, you may be eligible to enroll or increase your contributions for the following calendar year.	To enroll or increase contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Dependent Care Account (DCA)	You can enroll, increase, stop, or decrease your contributions depending on the facts. **Please note:** Changes related to a domestic partner's status change are only available if your domestic partner qualifies as your tax dependent. If your spouse's/domestic partner's status change occurs late in the year, keep in mind that contribution changes for the current calendar year are not available on or after December 1. However, you may be eligible to stop or decrease your contributions for the following calendar year.	To enroll, increase, stop, or decrease contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Long-Term Disability (LTD)	You can enroll in Long-Term Disability coverage if you're not already enrolled. You may enroll at any time, but after 31 calendar days of first becoming eligible you will need to provide EOI. This coverage is not available to spouses/domestic partners.	Not applicable.

Also, remember that your participation in the ADT Employee Assistance & Work/Life Program (EAP) continues normally, and the EAP offers resources that can assist you when you experience a life event. Contact the EAP by calling **1-855-4ADT-EAP (1-855-423-8327)**.

If Your Spouse/Domestic Partner Gains Employment or Changes Employment and Gains Eligibility for Benefits Coverage

Please note: For this purpose, "gaining employment" could be getting a job, returning from a leave of absence, or going from part-time to full-time status.

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	You can drop coverage for yourself, your spouse/domestic partner, or any other eligible dependents who gain coverage under your spouse's/domestic partner's coverage. You generally have 31 calendar days to make adjustments to your benefit elections.	To drop coverage: ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Supplemental Life Insurance **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	You can drop or decrease Supplemental Life Insurance or P&F AD&D Insurance for yourself, your spouse/domestic partner and his/her child(ren), if any. Changes can be made at any time. Update your beneficiary designation for Life and AD&D Insurance to ensure that death benefits go to the person you want to receive them if you should die.	To drop or decrease your insurance coverage: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. To update your beneficiary designations: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to speak with a representative.
Flexible Spending Account (FSA)	If you and your spouse/domestic partner gain eligibility for health coverage (Medical, Dental, or Vision) under your spouse's/domestic partner's or dependent's plan, you can stop or decrease your contributions.	To enroll or increase contributions: ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**
Dependent Care Account (DCA)	You can enroll, increase, stop or decrease your contributions depending on the facts. **Please note:** Changes related to a domestic partner's status change are only available if your domestic partner qualifies as your tax dependent. If your spouse's/domestic partner's status change occurs late in the year, keep in mind that contribution changes for the current calendar year are not available on or after December 1. However, you may be eligible to stop or decrease your contributions for the following calendar year.	To enroll, increase, stop, or decrease your contributions: ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Long-Term Disability (LTD)	You can enroll in Long-Term Disability coverage if you're not already enrolled. You may enroll at any time, but after 31 calendar days of first becoming eligible you will need to provide EOI. This coverage is not available to spouses/domestic partners.	Not applicable.

Also, remember that your participation in the ADT Employee Assistance & Work/Life Program (EAP) continues normally, and the EAP offers resources that can assist you when you experience a life event. Contact the EAP by calling **1-855-4ADT-EAP (1-855-423-8327)**.

If You Relocate

Call **EmployeeAccess** at **1-888-833-1839** as well as your local human resources representative to report your new location. If you are covered under the Plan and you relocate, you may be able to make changes to your health plan options.

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	You can switch doctors if you relocate to a new area. There is no deadline for making this change. You can enroll in a new option if you relocate to or from Hawaii or Puerto Rico. You generally have 31 calendar days to from the date of the move to enroll. If you move into or out of a location serviced by a Dental Health Maintenance Organization (DHMO), you can change your dental option to or from the DHMO.	To change doctors: ▪ Visit **MyADTHR.com > Health & Group Benefits > Medical Plans**. To enroll or make changes: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Supplemental Life Insurance **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	You can enroll in Supplemental Life coverage if you're not already enrolled. You may enroll at any time, but after 31 calendar days of first becoming eligible you will need to provide EOI.	No changes are allowed.
Flexible Spending Account (FSA)	This is not a qualifying status change for FSAs.	No changes are allowed.

Benefit	How Coverage Is Affected	How to Change Coverage
Dependent Care Account (DCA)	If you can no longer access your current dependent care provider, you can enroll, change your contributions, or stop contributing. If you are enrolling for the first time during the calendar year, your contribution will only be available for eligible expenses you incur after the effective date of your status change.	To enroll or change your contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Long-Term Disability (LTD)	You can enroll in Long-Term Disability coverage if you're not already enrolled. You may enroll at any time, but after 31 calendar days of first becoming eligible you will need to provide EOI.	Not applicable.

Also, remember that your participation in the ADT Employee Assistance & Work/Life Program (EAP) continues normally, and the EAP offers resources that can assist you when you experience a life event. Contact the EAP by calling **1-855-4ADT-EAP (1-855-423-8327)**.

If You Terminate Employment or Retire

If you're leaving under a severance or workforce reduction program, special considerations may apply.

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	If you terminate employment: ▪ Coverage ends for you and your dependents on the last day of the month your termination occurs. ▪ You will be eligible to continue coverage under COBRA when coverage ends. Generally, COBRA coverage for you and your covered dependent(s) or eligible child(ren) can continue for up to 18 months beyond your termination date. Dental benefits may continue longer for certain dental services if treatment has already begun before your employment ends. Return your COBRA forms within 60 calendar days of receiving them if you want to continue health coverage through COBRA.	To continue your coverage through COBRA: ▪ Call **Conexis** at **1-877-722-2667**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839 and select Health and Group Benefits**.
Life and AD&D Insurance **Supplemental Life Insurance** **Personal and Family Accidental Death & Dismemberment (P&FAD&D) Insurance**	The Life Insurance vendor will be sent your employment termination information no later than 31 calendar days after your termination date. The Life Insurance vendor will contact you with information to convert or port Life and AD&D Insurance coverage for yourself and your dependents to individual policies. You will need to make payments directly to the insurance company. You do not have to provide Evidence of Insurability (EOI) if you convert or port during the 31-calendar-day period. If you request an increase in Supplemental Life Insurance coverage, you will need to provide EOI. **Please note:** If you chose to submit EOI for any applicable Life Insurance that you elect to port, you may be eligible for more favorable rates. See the **Life and AD&D** section of this SPD for more information on conversion or portability options.	To continue, convert, or port your Life and AD&D Insurance, call **The Hartford** at **1-888-563-1124**. Call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance**.
Flexible Spending Account (FSA)	If you terminate employment: ▪ Contributions stop on the last day of the month your termination occurs. ▪ You will be eligible to continue participation under COBRA when coverage ends. You can only file for reimbursement from your FSA for expenses incurred through your termination date. However, if you have a balance in your FSA, you may continue participation in the FSA through the end of the year through COBRA continuation, by paying your FSA contributions on an after-tax basis. This will allow you to use your remaining balance to reimburse expenses after your termination date, through the end of the year. Return your COBRA forms within 60 calendar days of receiving them if you want to continue FSA coverage through COBRA.	To continue your coverage through COBRA: ▪ Call **Conexis** at **1-877-722-2667**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Dependent Care Account (DCA)	Only dependent care expenses that allow you to work can be reimbursed from the DCA. After your termination from employment, if necessary to allow you to work, you can continue to file claims for reimbursement from your DCA for expenses incurred through the end of the year.	No changes are allowed.
Long-Term Disability (LTD)	Coverage ends on your termination date unless you are receiving LTD payments at the time of your termination. See the **Disability** section of this SPD for details.	Not applicable.

Rejoining the Company

If you are reemployed by ADT, your eligibility to resume benefits will be different depending on the length of your break in service. Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** for details.

If You or a Dependent Is Terminally Ill

In the event of your or your dependent's terminal illness, you can prepare by:

- Submitting a claim for Family and Medical Leave benefits if you need to take time off to care for your dependent or family member, if you are eligible. Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Disability Management Services**.
- Contacting The Hartford (through **EmployeeAccess** at **1-888-833-1839**) for assistance understanding your or your dependent's Accelerated Benefit options.
- Contacting Health Advocate (through **EmployeeAccess** at **1-888-833-1839**) for assistance understanding your or your dependent's condition and treatment options, obtaining a second opinion, applying for Social Security Disability Insurance (SSDI) benefits if not completed with the Long-Term Disability insurance company, securing community-based resources, and/or understanding more about Advance Directives.
- Contacting the ADT Employee Assistance & Work/Life Program (EAP) by calling **1-855-4ADT-EAP (1-855-423-8327)** for counseling and help for you and your family during this difficult time; note, EAP can also provide limited legal assistance for associated needs.
- Reviewing your or your dependent's Will and Advance Directives to ensure they are up to date and reflect current wishes.
- Providing a copy of your or your dependent's personal health record and Advance Directives to all health care providers.
- Planning for a discussion with your or your dependent's health care provider about palliative care services in advance so you understand the benefits of having expert care when you most need it. Health Advocate (through **EmployeeAccess** at **1-888-833-1839**) can assist you in preparing for this discussion.

Your benefits are affected as follows:

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	▪ Coverage continues through the end of the ninth month following the date you became eligible for disability benefits, provided you make timely and accurate payments to continue your benefit coverage. ▪ You will be eligible to continue coverage under COBRA when coverage ends. **Please note:** It's important to enroll in Medicare Parts A and B as soon as possible if you qualify. Medicare benefits are generally available after 29 months of disability, if you are approved for Social Security disability benefits. If you did not elect LTD coverage and take an unpaid leave, see "If You Need Short-Term Disability (STD) or Take an Unpaid Leave of Absence" earlier in this section.	To continue your coverage through COBRA: ▪ Call **Conexis** at **1-877-722-2667**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	You can select/adjust your contributions to your Health Savings Account at any time if elected the Health Advantage Plan as long as you are still employed by ADT.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Life and AD&D Insurance **Supplemental Life Insurance** **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	You can update your or your dependent's beneficiary designation for Life and AD&D Insurance to ensure that death benefits go to the person you intend. You should consider applying for an Accelerated Benefit from your Basic and Supplemental Life Insurance (if purchased). You can receive up to 75% of your benefit in advance, to a combined (Basic and Supplemental) maximum of $250,000. Speak with a qualified tax or financial adviser before receiving payment of Life Insurance or retirement benefits.	To update your beneficiary designations: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to speak with a representative. To apply for an Accelerated Benefit, call **The Hartford** at **1-888-563-1124**. Call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance**.

Benefit	How Coverage Is Affected	How to Change Coverage
Flexible Spending Account (FSA) **Dependent Care Account (DCA)**	This is not a qualifying status change for FSAs or DCAs.	No changes are allowed.
Long-Term Disability (LTD)	You can submit a claim for disability benefits (benefits for long-term disability are available only if you have purchased this coverage) when you are no longer able to work. This coverage is not available to spouses/domestic partners.	To submit a claim, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Disability Management Services**.

If You or a Dependent Dies

In the event of your or your dependent's death, the survivors should notify your manager or immediate supervisor (if you die) and call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** as soon as possible, to advise them of the death. Complete and return all forms in the benefit package they send. Survivors can call **EmployeeAccess** for assistance.

Your benefits are affected as follows:

Benefit	How Coverage Is Affected	How to Change Coverage
Medical **Prescription Drug** **Dental** **Vision**	Coverage continues through the end of the month of the employee's death for covered dependents. Your dependents can continue coverage through COBRA. If your dependent dies, remember to cancel dependent coverage under the health plans.	To continue dependent coverage through COBRA or to cancel a dependent's coverage: ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Health Savings Account	Coverage continues through the end of the month of the employee's death. If your dependent dies, remember you can adjust your contributions to your Health Savings Account at any time if necessary.	To adjust your Health Savings Account contributions: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Benefit	How Coverage Is Affected	How to Change Coverage
Life and AD&D Insurance **Supplemental Life Insurance** **Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	**If you die—**Your coverage ends on the date of your death. Survivors can call **EmployeeAccess** to begin receiving survivor benefits. If you purchased Supplemental Life Insurance for your dependents, they can convert coverage to an individual insurance policy by contacting the Benefits Service Team through **EmployeeAccess**. The life insurance vendor will send a packet to start the conversion process. **If your dependent dies—**Cancel dependent coverage and update your beneficiary designation if your dependent was named as your beneficiary. Remember to file a claim for benefits if you purchased Supplemental Life Insurance for your dependent. If the death was due to an accident, file a claim for accident benefits if your dependent was covered by P&F AD&D Insurance. **Please note:** Consider consulting with a qualified tax or financial adviser before receiving payment of Life Insurance or retirement benefits.	To begin receiving survivor benefits, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. For questions on converting coverage to an individual policy, call **The Hartford** at **1-888-563-1124**. To cancel a dependent's coverage: ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. To update your beneficiary designations: ▪ Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**; or ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to speak with a representative.
Flexible Spending Account (FSA) **Dependent Care Account (DCA)**	Coverage continues through the end of the month of the employee's death. Your dependents can continue FSA participation through COBRA. If your dependent dies, you can adjust your contribution to the FSA and DCA if necessary. You have 31 calendar days to make adjustments to your benefit elections.	To continue dependent participation through COBRA or to change your FSA/DCA contributions: ▪ Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
Long-Term Disability (LTD)	Your coverage ends on the date of your death. If you were receiving a disability benefit, payments will cease. If you have dependents, a survivor benefit may be available.	Not applicable.

Medical

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Medical Benefits at a Glance

If you enroll in medical coverage under the ADT Health and Welfare Benefits Plan, you have two medical options to choose from:

- The Preferred Provider Organization (PPO) Plan.
- The Health Advantage Plan with associated Health Savings Account.

When you enroll in the PPO or Health Advantage Plan with associated Health Savings Account (referred to herein as the "plans"), you automatically are covered by the Prescription Drug Plan (described in a separate section of this SPD).

> If you live in Hawaii or Puerto Rico, you participate in the HMSA (Hawaii) or Triple-S Salud (Puerto Rico) programs (described in later sections of this SPD), instead of the PPO Plan or Health Advantage Plan with associated Health Savings Account options.

When you enroll, you choose a plan option: PPO or Health Advantage Plan with associated Health Savings Account. You also choose a coverage level: Individual, Employee+1, or Family. **Please note:** If you enroll in ADT medical coverage, you and your spouse/domestic partner on the plan will be eligible for the Healthy Rewards Cash Reward Incentive.

Overview of the Medical Options

The PPO and Health Advantage Plan with associated Health Savings Account options are similar in many ways, but there are some important differences between the options.

How the PPO Works

The PPO pays the major portion of most medical expenses. You also share in costs through deductibles, copays, and coinsurance. The PPO works like this:

- You can choose any provider you wish. However, when you use in-network providers, the plan pays a higher portion of most charges, and your out-of-pocket costs are lower. In-network providers have agreed to charge lower prenegotiated rates for services and supplies provided under the PPO. These rates are called "allowable amounts."
- The PPO pays 100% of eligible preventive care expenses. You don't need to meet the deductible before these expenses are paid.
- For most in-network office visits with doctors and other health care professionals as well as emergency room facilities, you pay a copay (a flat-dollar amount), and the PPO pays 100% of remaining charges. No deductible is required before these expenses are paid.
- For all other eligible expenses, you must meet the annual deductible before the PPO starts to pay benefits. Each person must meet the individual deductible; however, when combined expenses for all family members equal the family deductible, no further deductibles will be required for the remainder of the calendar year. There are different deductibles for in-network or out-of-network providers and they do not cross accumulate. This means the expenses you incur for in-network benefits only accumulate towards your in-network deductible. The expenses you incur for out-of-network benefits only accumulate towards your out-of-network deductible.

- Once you satisfy the deductible, the PPO pays a percentage of covered charges and you pay the remaining amount. This cost-sharing is called coinsurance.
  - When you use in-network providers, the PPO pays 80% of eligible charges and you pay the remaining 20%. For more information, see "Finding In-Network Providers" later in this section.
  - When you use out-of-network providers, the PPO pays 50% of eligible charges, up to the allowable amount. You pay the remaining 50% plus any charges that exceed the allowable amount.

You can find a list of in-network doctors, specialists, hospitals, and other providers online at the claims administrator's website, **http://provider.bcbs.com**. You also can call BCBS's toll-free number listed on your medical ID card.

- If your deductibles and coinsurance reach the out-of-pocket maximum during a calendar year, the PPO pays 100% of eligible covered charges for the rest of the calendar year. There are separate in-network and out-of-network out-of-pocket maximums which do not cross accumulate. This means the expenses you incur for in-network benefits only accumulate towards your in-network out-of-pocket maximum. The expenses you incur for out-of-network benefits only accumulate towards your out-of-network out-of-pocket maximum.
- You can enroll in the Flexible Spending Account and contribute up to $2,500 each calendar year for tax-free reimbursement of any expenses you pay during the year:
  - That count toward the annual deductible;
  - For your portion of coinsurance;
  - For out-of-network eligible expenses that exceed allowable amounts; or
  - For other non-covered eligible health care expenses.
- For certain covered services, pre-certification may be required.

How the Health Advantage Plan with associated Health Savings Account Works

The Health Advantage Plan combines traditional PPO coverage with an associated Health Savings Account. The Health Advantage Plan portion is sometimes called a "high deductible health plan." In exchange for lower premiums to pay for your coverage, you take more responsibility for the cost of services you do receive—but only if and when you need them.

The Health Advantage Plan with associated Health Savings Account pays the major portion of most medical expenses. You also share in costs through deductibles and coinsurance. (There are no copays under the Health Advantage Plan with associated Health Savings Account.) The Health Advantage Plan with associated Health Savings Account works like this:

This option has two components—the Health Advantage Plan with associated Health Savings Account. The health savings account must be coupled with a high deductible health plan, such as the Health Advantage Plan, by law.

- When you enroll in the Health Advantage Plan with associated Health Savings Account, a health savings account is established in your name. ADT makes tax-free contributions to your health savings account. You can also contribute to your health savings account on a tax-free basis. All contributions to the health savings account are made through the ADT cafeteria plan. You can use your account to pay your deductibles or other current or eligible future health care expenses.
- You can choose any provider you wish. However, when you use in-network providers, the plan pays a higher portion of most charges, and your out-of-pocket costs are lower. In-network providers have agreed to charge lower prenegotiated rates for services and supplies provided under the Health Advantage Plan with associated Health Savings Account. These rates are called "allowable amounts."
- The Health Advantage Plan with associated Health Savings Account pays 100% of eligible preventive care expenses. You don't need to meet the deductible before these expenses are paid.
- For all other eligible expenses including prescriptions under the Prescription Drug Plan, you must meet the annual deductible before the Health Advantage Plan with associated Health Savings Account starts to pay benefits. The deductible you pay depends on whether you choose Individual coverage or Employee+1 or Family coverage. It's also based on whether you use in-network or out-of-network providers.
- Once you satisfy the deductible, the Health Advantage Plan with associated Health Savings Account pays a percentage of covered charges and you pay the remaining amount. This cost-sharing is called coinsurance.
  - When you use in-network providers, the Health Advantage Plan with associated Health Savings Account pays 90% of eligible charges and you pay the remaining 10%.
  - When you use out-of-network providers, the Health Advantage Plan with associated Health Savings Account pays 60% of eligible charges (up to the allowable amount). You pay the remaining 40% plus any amount that exceeds the allowable amount.

  You can find a list of in-network doctors, specialists, hospitals, and other providers online at the claims administrator's website, **http://provider.bcbs.com**. You also can call Blue Cross Blue Shield's toll-free number listed on your medical ID card.
- If your deductibles and coinsurance reach the out-of-pocket maximum during a calendar year, the Health Advantage Plan with associated Health Savings Account pays 100% of eligible covered charges for the rest of the calendar year.
- You can request reimbursement from your health savings account for any expenses you pay:
  - That count toward the annual deductible;
  - For your portion of coinsurance;
  - For out-of-network eligible expenses that exceed allowable amounts; or
  - For other non-covered eligible health care expenses (both current or in the future).
- For certain covered services, pre-certification may be required.
- You will not be able to make contributions to the health savings account if you participate in the Flexible Spending Account or in any other non-high deductible health plan coverage, including non-high deductible health plan coverage offered by your spouse's employer.

No Preexisting Conditions Limits or Lifetime Maximums

There are no preexisting conditions limitations under the PPO or Health Advantage Plan with associated Health Savings Account. Likewise, there is no lifetime maximum for benefits under either plan option (although there are limits imposed on certain health benefits provided under the plans).

Comparison of PPO and Health Advantage Plan with associated Health Savings Account

The chart that follows compares key features of the PPO and Health Advantage Plan with associated Health Savings Account.

	PPO Plan		Health Advantage Plan with associated Health Savings Account	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan and Claims Administration	Blue Cross Blue Shield (BCBS)			
BCBS Provider Network	Offers an extensive network of doctors, hospitals, outpatient facilities, and other health care providers throughout the U.S. Network doctors and hospitals have agreed to prenegotiated rates for services provided to ADT employees and covered family members.			
Preventive Care	Covered at 100% from in-network providers (regular rates from out-of-network providers apply).			
Covered Expenses	Both plans cover the same medical expenses, but with different deductibles, coinsurance, copays, and maximums. (The only exception is special PPO coverage for treatment at Centers of Excellence; this special coverage is not provided under the Health Advantage Plan with associated Health Savings Account.)			
Choice of Doctors	You can choose any doctor you wish. However, your out-of-pocket costs are lower when you use in-network doctors.			
Preexisting Conditions	No limits or reductions in coverage for preexisting conditions.			
Lifetime Maximums	No lifetime maximums (although certain health services have limits).			
Prescription Drug Eligibility	You automatically receive prescription drug coverage (described in a separate section) when you enroll.			

	PPO Plan		Health Advantage Plan with associated Health Savings Account	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar-Year Deductible If you elect: ▪ Individual coverage	$750	$1,500	$1,500	$3,000
▪ Employee+1 or Family coverage	$1,500	$3,000	$3,000	$6,000
▪ How it works: – When required	Each calendar year for all covered medical expenses except in-network preventive care, prescription drugs, in-network doctors, and in-network emergency room visits.		Each calendar year for all covered medical and prescription drug expenses except in-network preventive care.	
– Cross-over between deductibles	Only in-network charges count toward the in-network deductible and only out-of-network charges count toward the out-of-network deductible.		In-network charges count toward both the in-network and out-of-network deductible and out-of-network charges count toward both the in-network and out-of-network deductible.	
Health Savings Account Contributions ▪ Individual coverage	Not applicable		ADT contributions: $500 Your contributions: Up to $2,800	
▪ Employee+1 or Family coverage	Not applicable		ADT contributions: $1,000 Your contributions: Up to $5,550	
▪ Catch-up (if turning 55 or over in 2014)	Not applicable		Your contributions: Up to $1,000	
Copays and Coinsurance	**Plan pays:**	**Plan pays:**	**Plan pays:**	**Plan pays:**
▪ Primary care doctor's office visits	100% after $30 copay	50% coinsurance after deductible	90% coinsurance after deductible	60% coinsurance after deductible
▪ Specialist doctor's office visits	100% after $60 copay	50% coinsurance after deductible	90% coinsurance after deductible	60% coinsurance after deductible

	PPO Plan		Health Advantage Plan with associated Health Savings Account	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency Room Visits (Facility)				
▪ For true emergencies (health issues that must be treated within 24 hours of onset to avoid serious consequences (e.g., chest pain)	100% after $200 copay (waived if admitted to hospital); no deductible	100% after $200 copay (waived if admitted to hospital); no deductible	90% after deductible	90% after deductible
▪ If medical emergency criteria is not met (e.g., strep throat)	50% after $200 copay per visit	50% after $200 copay	60% after deductible	60% after deductible
▪ All other charges	80% coinsurance after deductible	50% coinsurance after deductible	90% coinsurance after deductible	60% coinsurance after deductible
Out-of-Pocket Maximum				
▪ Individual coverage	$6,000	$12,000	$3,000	$6,000
▪ Employee+1 or Family coverage	$12,000	$24,000	$6,000	$12,000
▪ How it works				
– What it means	The out-of-pocket maximum is the most you pay in eligible covered expenses each year before the plans pay 100% of eligible charges.			
– Cross-over between out-of-pocket maximums	In-network charges count only toward the in-network out-of-pocket maximum and out-of-network charges count only toward the out-of-network out-of-pocket maximum.		In-network charges count toward both the in-network and out-of-network out-of-pocket maximum and out-of-network charges count toward both the in-network and out-of-network out-of-pocket maximum.	

Preventive Care

Both the PPO and the Health Advantage Plan with associated Health Savings Account cover 100% of in-network preventive care as defined by the plans, with no deductible. In addition, certain prescriptions purchased at in-network pharmacies are considered preventive and also provided without a copy or deductible. See the **Prescription Drug** section of this SPD for more information.

Allowable Amounts

When you use out-of-network providers, the plans cover charges only up to the allowable amount for a service or supply. You are responsible for any charges that exceed the allowable amount. The allowable amount is established by the insurance carrier. It typically is the amount that has been negotiated with in-network providers for the services they provided through the network.

Here are two examples to show how this works, for a minor surgical procedure and for a routine physical. The examples compare what the plans would pay, and what you would pay, if you use in-network or out-of-network providers. Both examples assume that the regular charges are $1,000, but the prenegotiated fees (and hence, the allowable amounts) are $500. They also assume any deductibles have been met.

Eligible Charge	PPO		Health Advantage Plan with associated Health Savings Account	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Surgery	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Surgery Example Regular charge $1,000; benefits based on $500 allowable amount/ prenegotiated fee	**Plan pays $400** (80% of $500) **You pay $100** (20% of $500)	**Plan pays $250** (50% of $500) **You pay $750** (50% of $500 + remaining $500)	**Plan pays $450** (90% of $500); **You pay $50** (10% of $500)	**Plan pays $300** (60% of $500); **You pay $700** (40% of $500 + remaining $500)
Routine Physical	100%; no deductible	50% after deductible	100%; no deductible	60% after deductible
Routine Physical Example Regular charge $1,000; benefits based on $500 allowable amount/ prenegotiated fee	**Plan pays $500** (100% of $500) **You pay $0**	**Plan pays $250** (50% of $500) **You pay $750** (50% of $500 + remaining $500)	**Plan pays $500** (100% of $500) **You pay $0**	**Plan pays $300** (60% of $500); **You pay $700** (40% of $500 + remaining $500)

As you can see from the examples, the amount you pay is significantly less when you use in-network providers.

Deductible

The deductible is an amount you pay for eligible medical expenses each calendar year before the plans pay benefits. Your deductible depends on the medical option you choose (PPO or Health Advantage Plan with associated Health Savings Account) and whether you use in-network or out-of-network providers. See the chart under “Comparison of PPO and Health Advantage Plan with Associated Health Savings Account” earlier in this section for details on deductible amounts.

- If you choose Individual coverage, you must meet the individual deductible before the plan pays most expenses.
- If you choose Employee+1 or Family coverage and elect the:
  - PPO Plan—the deductible is met for any one person when he/she meets the individual deductible. The deductible is met for all family members when combined expenses from all family members equal the Employee+1 or Family coverage deductible.

- Health Advantage Plan with associated Health Savings Account—the deductible is met when combined expenses for you and all other family members equal the Employee+1 or Family coverage deductible. (In other words, when you have Employee+1, or Family coverage, benefits do not start for one person if he/she reaches the individual deductible).

The deductible does **not** apply to:

- In-network preventive care under the PPO or Health Advantage Plan with associated Health Savings Account; or
- Any charges subject to a copay under the PPO.

Different deductibles apply if you use in-network vs. out-of-network providers. If you use **both** in-network and out-of-network providers during a calendar year:

- For the PPO: Only in-network charges count toward the in-network deductible and only out-of-network charges count toward the out-of-network deductible.
- For the Health Advantage Plan with associated Health Savings Account: In-network charges count toward both the in-network and out-of-network deductible and out-of-network charges count toward both the in-network and out-of-network deductible.

The following charges do not count toward satisfying the deductible:

- Amounts exceeding allowable amounts.
- Expenses for medical services or supplies not covered by the plans.
- Amounts paid from your health savings account for expenses not covered by the Health Advantage Plan with associated Health Savings Account (such as dental and vision expenses).
- Any amounts you pay under the Vision or Dental Plans.
- Any amounts you pay under the Prescription Drug Plan (for the PPO only).

Copays (PPO Only)

If you enroll in the PPO, you pay a copay for certain in-network services, such as doctor's office visits and emergency room care, and the plan pays the rest of the charge. When a copay applies, it must be paid each time you receive the services (for example, for each doctor appointment). Copays do not count toward the deductible but will count toward the out-of-pocket maximum.

The copay for a doctor's office visit is based on whether the doctor is considered a Primary Care Physician (PCP) or a specialist.

- PCPs for adults include general practitioners, family practitioners, and internists (and obstetrician/gynecologists for certain services such as annual well-woman exams). PCPs for child(ren) can be pediatricians, family practitioners, general practitioners, or internists.
- The PCP copay also applies to allergy shots, physical therapy, speech therapy, occupational therapy, mental health care, and urgent care.
- The specialist care copay applies to specialist doctor visits, such as cardiologists or surgeons.

Essential Health Benefits

The Affordable Care Act (ACA) requires large self-funded group health plans to identify the comprehensive package of items and services, known as Essential Health Benefits. There are no annual limits or lifetime maximums for Essential Health Benefits. Essential Health Benefits are based on state-specific benchmark plans. For purposes of this Plan, Florida is the benchmark state that is used.

Essential Health Benefits include the following general categories:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health disorder and substance abuse services (including behavioral health treatment).
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services.
- Chronic disease management.
- Pediatric services, including oral and vision care.

Out-of-Pocket Maximum

The out-of-pocket maximum provides a level of protection in the event you have high medical expenses during a calendar year. It is the maximum amount you pay for eligible expenses before the plan begins to pay 100% of covered charges.

Your out-of-pocket maximum depends on the medical option you choose (PPO or Health Advantage Plan with associated Health Savings Account) and whether you use in-network or out-of-network providers. See the chart under “Comparison of PPO and Health Advantage Plan with Associated Health Savings Account” earlier in this section for details on out-of-pocket maximum amounts.

- If you choose **Individual coverage**, you must meet the individual out-of-pocket maximum before the plan pays covered expenses at 100%.
- If you choose **Employee+1 or Family coverage** and elect the:
  - PPO Plan—the out-of-pocket maximum is met for any one person when he/she meets the individual out-of-pocket maximum. The out-of-pocket maximum is met for all family members when combined expenses from all family members equal the Employee+1 or Family coverage out-of-pocket maximum.

- Health Advantage Plan with associated Health Savings Account—the out-of-pocket maximum is met when combined expenses for you and all other family members reach the employee+1 or family out-of-pocket maximum. (In other words, when you have Employee+1 or Family coverage benefits, 100% coverage does not start for one person if he/she reaches the individual out-of-pocket maximum).

Your coinsurance for eligible expenses counts toward the out-of-pocket maximum. The following expenses do **not** count toward the out-of-pocket maximum:

- Any amounts you pay to out-of-network providers that exceed allowable amounts.
- Any amounts you pay for medical services or supplies that are not covered by the plans.
- Any amounts you pay under the Vision or Dental Plans.
- Any amounts you pay under the Prescription Drug Plan (for the PPO only).
- Any amounts you pay for bariatric surgery.

Different out-of-pocket maximums apply if you use in-network vs. out-of-network providers. If you use **both** in-network and out-of-network providers during a calendar year:

- For the PPO: Only in-network charges count toward the in-network out-of-pocket maximum and only out-of-network charges count toward the out-of-network out-of-pocket maximum.
- For the Health Advantage Plan with associated Health Savings Account: In-network charges count toward both the in-network and out-of-network deductible and out-of-network charges count toward both the in-network and out-of-network deductible.

Health Savings Account and Flexible Spending Account

If you enroll in the Health Advantage Plan, a health savings account will be established in your name. You cannot enroll in the Flexible Spending Account for health care expenses for periods when you are a Health Advantage Plan with associated Health Savings Account participant. ADT will contribute to your health savings account and you may contribute as well as long as you are enrolled in the Health Advantage Plan with associated Health Savings Account and do not participate in any other non-high deductible health plan. Contributions are not subject to federal income tax or most state taxes. You decide how to spend the money. If you choose to spend it on deductibles, coinsurance amounts, charges over allowable amounts, or other qualified health expenses (such as prescription drugs, dental, and vision), the money is not taxed when paid out. You also may decide to leave the money in the health savings account where it can earn interest tax-free, similar to an Individual Retirement Account (IRA). Any portion of your health savings account balance that exceeds $2,000 can be invested in a variety of mutual funds. Your health savings account belongs to you, even if your Health Advantage Plan with associated Health Savings Account participation ends or you terminate employment with ADT. Also, any unused money at the end of each year stays in your health savings account and continues to roll over from year to year. For more details, please see “Health Savings Account Overview” later in this section. You can also find additional information in the **Spending Accounts** section of this SPD.

If you enroll in the PPO, you can also participate in the Flexible Spending Account for health care expenses. You cannot contribute to a health savings account while you are a PPO participant. Under the Flexible Spending Account, you can make before-tax contributions and receive tax-free reimbursement for any copays, coinsurance, charges exceeding allowable amount limits, and other qualified health expenses (such as dental and vision). You must use any amounts you contribute to the Flexible Spending Account during a calendar year for reimbursement of expenses incurred during that same calendar year; otherwise, you will forfeit the contributions you made. For more information, please see the **Spending Accounts** section of this SPD.

Treatment of Mental Health Disorders and Substance Abuse

Treatment of mental health disorders and substance abuse is covered in the same way as any other medical service. Charges are subject to the same deductibles, coinsurance, and copays (for the PPO) as other eligible expenses.

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

How Charges Are Covered under the PPO Plan and Health Advantage Plan with associated Health Savings Account

The chart below summarizes the benefits paid by the PPO and Health Advantage Plan with associated Health Savings Account options for different categories of eligible charges. It also shows whether you are required to pay a deductible or copay before benefits start. Keep in mind that out-of-network charges are subject to allowable amount limits, and that you are responsible for any charges over those limits. For more details on what's covered, see "Detailed Summary of Covered Charges" later in this section.

	PPO		Health Advantage Plan with associated Health Savings Account	
Eligible Services and Supplies	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Doctor Care				
Allergy Injections Related to Office Visits (allergy serum is covered separately and in addition to the office visit copay)	100% after $30 copay per visit.	50% after deductible	90% after deductible	60% after deductible
Biometric Screenings Includes blood pressure, cholesterol level, and other screenings, provided on-site (or at doctor's office)	100%; no deductible	50% after deductible	100%; no deductible	60% after deductible

Eligible Services and Supplies	PPO		Health Advantage Plan with associated Health Savings Account	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hearing ▪ Age 4 and under (out-of-network limited to one hearing exam per covered person every 24 months) ▪ Age 5 and over (one hearing exam per covered person every 24 months, in-network and out-of-network combined)	100%; no deductible 100% after $30 copay	100% after $30 copay (maximum benefit of $100) 100% after $30 copay (maximum benefit of $100)	100%; no deductible 90% after deductible	60% after deductible (maximum benefit of $100) 60% after deductible (maximum benefit of $100)
Hearing Aids (once every 3 years; $1,500 maximum per ear)	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Hospital Visits, Maternity Care, and Surgery (inpatient and outpatient; pre-certification may be required)	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Immunizations (as appropriate for age and frequency limitations)	100%; no deductible or copay	50% after deductible	100%; no deductible	60% after deductible
Office Visits ▪ Primary Care Physician (PCP) ▪ Specialist physician	100% after $30 copay per visit 100% after $60 copay per visit	50% after deductible 50% after deductible	90% after deductible 90% after deductible	60% after deductible 60% after deductible
Routine Physical Exams and Preventive Care Procedures (one routine physical exam per covered person per calendar year and associated preventive screenings)	100%; no deductible or copay	50% after deductible	100% of eligible charges; no deductible	60% after deductible
Treatment of Eye Diseases or Injuries	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Vision Exams	Not covered under Medical Plan, but covered under Vision Plan (if elected)		Not covered under Medical Plan, but covered under Vision Plan (if elected)	
Well-Child Care (to age 18 and immunizations according to each plan's guidelines; includes covered vaccinations when part of the standard well-child exam)	100%; no deductible or copay	50% after deductible	100%; no deductible	60% after deductible
Well-Men Exam (one per covered person per calendar year (includes prostate screening [PSA], as appropriate for age, and certain vaccinations when part of the standard well-man exam)	100%; no deductible or copay	50% after deductible	100%; no deductible	60% after deductible

Eligible Services and Supplies	PPO		Health Advantage Plan with associated Health Savings Account	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Well-Woman Exam (one per covered person per calendar year (includes preconception and pre-natal care, pap smears and mammograms as appropriate for age, and certain vaccinations when part of the standard well-woman exam)	100%; no deductible or copay	50% after deductible	100%; no deductible	60% after deductible
X-Rays and Laboratory Exams (pre-certification may be required)				
▪ If performed as part of preventive care office visit	100%; no deductible or copay	50% after deductible	100%; no deductible	60% after deductible
▪ If performed as part of office visit for illness or injury	100% after $30 copay per visit	50% after deductible	90% after deductible	60% after deductible
▪ If not performed as part of office visit	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Hospital or Other Facility				
Emergency Room Visits (Facility)				
▪ For true emergencies (health issues that must be treated within 24 hours of onset to avoid serious consequences–e.g., chest pain)	100% after $200 copay (waived if admitted to hospital); no deductible	100% after $200 copay (waived if admitted to hospital); no deductible	90% after deductible	90% after deductible
▪ If medical emergency criteria is not met (e.g., strep throat)	50% after $200 copay per visit	50% after $200 copay	60% after deductible	60% after deductible
Inpatient Hospital Care (includes semiprivate room and board, intensive care and ancillary charges; pre-certification required)	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Routine Newborn Care	100%; no deductible	50% after deductible; maximum 7 calendar days	100%; no deductible	60% after deductible; maximum 7 calendar days
Other Care, Services, Equipment, and Supplies				
Chiropractic Care (30 visits per visit per member per calendar year for in-network and out-of-network care combined)	100% after $30 copay per visit	50% after deductible	90% after deductible	60% after deductible
Convalescent Skilled Nursing Facility Care (maximum of 100 calendar days per calendar year, in-network and out-of-network combined; prior hospital care not required; pre-certification required)	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Durable Medical Equipment, Prostheses (pre-certification required)	80% after deductible	50% after deductible	90% after deductible	60% after deductible

Eligible Services and Supplies	PPO		Health Advantage Plan with associated Health Savings Account	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Home Health Care (maximum of 100 visits per calendar year for skilled nursing care, in-network and out-of-network combined; pre-certification required)	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Hospice Care (for patients with a diagnosis expected to result in death within 6 months or less; pre-certification required)	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Nutritional Counseling (effective April 1, 2014) (to help patients understand how food affects health and well-being; up to 8 30-minute sessions)	100%	100%	100%	100%
Physical and Occupational Therapy (outpatient; chiropractic visits not applicable; 90 visits per calendar year for in-network and out-of-network services combined)	100% after $30 copay per visit	50% after deductible	90% after deductible	60% after deductible
Private-Duty Nursing (maximum benefit of 70 [eight-hour] shifts per calendar year; pre-certification required)	80% after deductible	50% after deductible	90% after deductible	60% after deductible
Speech Therapy (outpatient; 90 visits per calendar year for in-network and out-of-network services combined)	100% after $30 copay per visit	50% after deductible	90% after deductible	60% after deductible

Detailed Summary of Covered Charges

The PPO and Health Advantage Plan with associated Health Savings Account options cover a wide range of medically necessary services and supplies. This section lists the eligible expenses under the medical options. To be covered, services and supplies must be medically necessary.

- Acupuncture performed by an M.D. for surgical anesthetic purposes.
- Allergy sera and biological sera.
- Alternative treatment for catastrophic illness or injury (**Please note:** Treatments that are considered to be experimental or investigational are **not** covered as alternative treatments).
- Ambulance transportation to and from the nearest hospital that can provide medically necessary care and treatment.
- Anesthetics and their administration.
- Artificial limbs, larynx, and eyes, including replacements that are medically necessary and not for cosmetic purposes only.

- Bariatric surgeries under certain circumstances. (Please see “Weight Management Programs” later in this section for more information.)
- Blood and blood plasma, unless the recipient uses his/her own stored blood or donated blood from a family member for which there is no charge.
- Bone marrow transplants, including certain donor searches, if the recipient is a covered plan member:
  - Preliminary computerized donor searches through national registries recognized by the claims administrator.
  - Screening and confirming tests for blood relatives.
  - Screening and confirming tests for a non-related potential donor, but only if the potential donor is identified through a National Marrow Donor Program or a similar program that is approved by the claims administrator in advance.
- Casts, splints, trusses, braces, and crutches, including replacements that are medically necessary.
- Chiropractic care, limited to 30 visits for each related illness or injury per covered person per calendar year for in-network and out-of-network care combined.
- Clinical trial services that would be covered under the plans if not provided as part of the clinical trial will be covered under the plans. As discussed below, all other costs of clinical trial are not covered under the terms of the plans.
- Convalescent nursing home, including room and board, normal daily services, supplies and non-professional services furnished by the nursing home for medical care while the plan member is a patient. To be eligible, the covered person must be under the continuous care of his/her doctor who:
  - Authorizes the nursing home stay is necessary:
    - To help the patient recover from the illness or injury that caused a hospital stay (or to help the patient recover from a related illness or injury); or
    - In place of a hospital stay.
  - Certifies that the covered person needs 24-hour-a-day nursing care.

  All convalescent nursing home stays are considered related unless the covered person fully recovered from the illness or injury that caused the prior stay or he/she returns to active employment between the stays.

- Cosmetic surgery to:
  - Correct the result of an accidental injury sustained within the previous 24 months;
  - Treat a condition, including a birth defect, that impairs the function of a body organ; or
  - Provide post-mastectomy services and reconstruct a breast after a mastectomy performed for the treatment of a disease.
- Dental services for:
  - The treatment or removal of a malignant tumor.
  - The treatment of accidental injury to natural teeth when the charges are for doctor’s services and X-ray exams within 12 months of the accident. Treatment includes the replacement of those teeth within that 12-month period.

Please note: For many dental problems, there may be more than one acceptable course of treatment. When two or more procedures are available for a particular dental problem, the plans cover the least expensive procedure that will produce a professionally satisfactory result, based on common dental practice.

If you have oral surgery for removal of impacted wisdom teeth and hospital confinement is required, eligible hospital charges will be paid up to allowable amounts, if applicable. Check your dental plan to see if the doctor's services and X-rays are covered under that plan.

- Doctor's services (including surgical procedures and mental health disorder and substance abuse services). **Please note**: Certain services have annual or lifetime benefit maximums, including physical, occupational and speech therapy, chiropractic treatment, and routine physical examinations.
- Donor transplant services and supplies required for a live donor as a result of a surgical transplant procedure, when the covered person is the recipient of the transplant. In the case of a covered person who is the recipient, the following requirements also apply:
  - The services and supplies must be furnished on account of the recipient's illness or injury; and
  - Eligible charges are limited (or "coordinated") to the extent that benefits for charges, services, and supplies are not provided by the donor's coverage under the PPO or Health Advantage Plan with associated Health Savings Account, covered by any other group or individual contract, or paid by any arrangement of coverage for individuals in another plan whether insured or uninsured.
- Durable medical equipment for the rental or purchase (as determined by the claims administrator and subject to review by the plan administrator) of a wheelchair, iron lung, hospital bed or equipment for the use of oxygen. This coverage includes repair and necessary maintenance that is not provided under a manufacturer's warranty or purchase agreement for equipment purchased with the claims administrator's approval. Disposable supplies are not covered.
- Fluoride trays and gel packs in connection with covered radiation therapy and chemotherapy.
- Glucometer and initial diabetic instruction.
- Hearing exams to determine the need for hearing aids or for the need to adjust them, once per covered person every 24 months.
- Hearing aids, once per covered person every three years, up to a $1,500 maximum per ear.
- Heart pacemaker, including replacements that are medically necessary.
- Home health care for part-time or intermittent home nursing care given or supervised by a registered nurse (RN). Care may be provided by a licensed practical nurse (LPN) if supervised by an RN or a doctor.

  Care must be furnished while the covered person is under a doctor's care and may not be for custodial purposes only. Services may include part-time or intermittent home health aide services for care of the covered person and nutritional counseling furnished or supervised by a registered dietician.

  Services must be prescribed in writing by the covered person's doctor as medically necessary:
  - For the care and treatment of the patient's injury or illness in his/her home; and
  - In place of an inpatient stay in a hospital or convalescent nursing home.

- Hospice care program services and supplies, furnished for a terminally ill covered person and his/her family. A terminally ill person is one whose life expectancy is six months or less, as certified by that person's doctor.

  Eligible services and supplies must be provided within seven months from the date the terminally ill covered person entered, or re-entered, the hospice. Eligible charges include:

  – Hospice room and board while the covered person is an inpatient in a hospice;
  – Other hospice services furnished by a hospice or a hospice team; and
  – Counseling services provided by members of a hospice team, including bereavement counseling.

  The hospice must operate as an integral part of a hospice care program and be directed by a doctor to help care for a terminally ill covered person. If the facility is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a hospice under the PPO or Health Advantage Plan with associated Health Savings Account.

  A hospice team is made up of professionals and volunteer workers who provide care to reduce pain or other symptoms of mental or physical distress, as well as to meet the special needs that arise out of stresses of terminal illness, dying, and bereavement. A hospice team must include the patient's doctor and a registered graduate nurse (RN), and may include one or more of the following: a social worker, a cleric/counselor, volunteers, a clinical psychologist, a physiotherapist, and an occupational therapist.

  Each service or supply provided by the hospice must be furnished under a hospice care program that meets standards set by the National Hospice Organization. In addition, each service or supply must be ordered by the doctor directing the hospice care program.

- Hospital room and board. Normal daily services and supplies furnished by a hospital, including:
  – A semiprivate room. The eligible charge limit for each day is the semiprivate room rate for that day. If the hospital has no semiprivate rooms, the limit is 90% of its lowest private room rate for that day. The eligible charge limit does not apply if the covered person is being isolated because of a communicable disease or if a private room is medically necessary for treatment of the covered person's condition.
  – All other supplies and nonprofessional services furnished by the hospital for medical care, unless specifically excluded under the PPO or Health Advantage Plan with associated Health Savings Account.
- Immunizations, when given or authorized by the covered person's doctor. Immunizations generally are limited to routine immunizations (as defined by the PPO or Health Advantage Plan with associated Health Savings Account) given to covered individuals. The plans also cover the following four vaccines: annual flu shots, human papillomavirus (HPV) vaccine, and boosters for tetanus and diphtheria.
  – The plans cover Gardasil (HPV recombinant vaccine) for the prevention of cervical cancer in girls and women 11 to 26 years of age and in girls 9 and 10 years old at the discretion of the covered person's doctor. This vaccine will be covered as part of the standard well-child or well-woman exam. If administered in a separate visit, an office visit copay will apply.
  – Tetanus and diphtheria boosters are covered every 10 years.

- Infertility treatment, provided for covered employees, spouses, and domestic partners only, including:
  - Basic services required to diagnose a possible underlying disorder and/or medical condition (covered at the same level as any other medical condition). Diagnostic services and primary treatments include:
    - Outpatient hysterosalpingogram and medically appropriate tubal recannulization;
    - Evaluation of ovulatory function and medically appropriate treatment with no more than three cycles of Clominphene Citrate (Clomid);
    - Semen analysis;
    - Laboratory evaluation, including FSH levels;
    - Ovulation induction with oral and injectable non-experimental prescription medications that are approved by the American Medical Association; and
    - Ovulation monitoring with ultrasound.
  - Advanced services for Assisted Reproductive Techniques (ART) and artificial insemination, including:
    - In vitro fertilization (IVF);
    - Gamete intrafallopian transfer (GIFT); and
    - Zygote intrafallopian transfer (ZIFT).

    The lifetime maximum for ART is $10,000, a combined maximum for all ADT medical options.
- Inhalation therapy (intermittent positive pressure breathing), under certain conditions. For more information, you can call the toll-free number for your claims administrator listed on your medical ID card.
- Injectants, other than prescribed insulin. (Insulin and certain injectants are covered under the Prescription Drug Plan.)
- Maternity services. The plans cover doctor, hospital, and other charges related to pregnancy in the same way as any other illness or injury. Coverage is provided for newborn and maternity stays for at least 48 hours for normal deliveries and 96 hours for caesarian deliveries, unless both mother and doctor agree that an earlier discharge is prudent.
- Oxygen.
- Physical, occupational, and speech therapy and cardiac rehabilitation:
  - Physical therapy administered by a qualified physical therapist.
  - Occupational therapy administered by a licensed occupational therapist.
  - Speech therapy administered by a qualified speech therapist that is intended to:
    - Restore speech after a loss or impairment of a demonstrated, previous ability to speak and is not caused by a mental, psychoneurotic, or personality disorder;
    - Develop or improve speech after surgery to correct a defect that both existed at birth and impaired, or would have impaired, the ability to speak; or
    - Develop or improve speech for hearing defects that existed at birth, impair the ability to speak, and cannot be corrected by a surgical procedure.

- Cardiac rehabilitation administered by a trained provider and/or facility accredited to perform cardiac rehabilitation.

There is a combined maximum of 90 visits per year for occupational and physical therapy and a separate 90-visit maximum for speech therapy. These limits apply to each covered person each calendar year.

- Post-mastectomy services, including:
  - All stages of reconstruction of the breast on which the mastectomy was performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses.
  - Treatment of physical complications of the mastectomy, including lymph edemas.

  Coverage is subject to the same deductible and coinsurance provisions that apply for any other surgical procedures under the plans.
- Prescription drugs under limited situations, such as:
  - Allergy sera and biological sera.
  - Those prescribed for use while you are an inpatient at a hospital or other facility.

  Most prescription drugs and medicines are covered under the Prescription Drug Plan instead of the PPO or Health Advantage Plan with associated Health Savings Account. See the **Prescription Drug** section of this SPD for more information. **Please note:** Some drugs, such as those used for cosmetic purposes, are not covered under the PPO, Health Advantage Plan with associated Health Savings Account, **or** the Prescription Drug Plan, even if your doctor approves or recommends them. If you have questions about coverage for a specific prescription drug, call the toll-free numbers for your medical and prescription drug claims administrators listed on your medical and prescription drug ID cards.

- Private-duty professional nursing by a registered graduate nurse. The maximum benefit for in-network and out-of-network coverage under the PPO Plan and Health Advantage Plan with associated Health Savings Account is 70 (eight-hour) shifts per calendar year. Services must be required for the intensive care of an acute illness or injury and:
  - The covered person cannot be in a hospital or another health care institution that provides nursing care; and
  - The care must not be furnished primarily as custodial care.
- Routine physical examinations, limited to one per calendar year.
- Surgical dressings.
- Tertiary care.
- Temporomandibular Joint Dysfunction (TMJ)—Phase I including the TMJ joint repositioning appliance (limited to one appliance every three years unless medical necessity is documented prior to payment), removable or fixed (which is designed to stabilize the jaw joint and muscles and not to permanently alter the teeth), up to six monthly office visits, every three years, if necessary, to adjust the appliance.
- Vision care, one exam per calendar year.

- Weight management programs, including prescription medications as described in the **Prescription Drug** section of this SPD, or surgical procedures if recommended by a doctor if certain criteria are met.
- Well-newborn care. The PPO and Health Advantage Plan with associated Health Savings Account cover services and supplies furnished by a hospital to a well newborn baby for routine nursery care. Coverage includes hospital room and board and other supplies and nonprofessional services furnished by the hospital for medical care.
- Wigs for the following conditions:
  - Burns—2nd degree full thickness and 3rd degree burns with resulting permanent alopecia.
  - Lupus.
  - Alopecia areata with near complete or complete cranial hair loss.
  - Alopecia universalis.
  - Fungal infections not responsive to an appropriate course of antifungal treatment resulting in near complete or complete cranial hair loss.
  - Chemotherapy.
  - Radiation therapy.
- Routine X-rays and lab exams ordered by the covered person's doctor.
- Treatment by X-ray, radium or any other radioactive substance, or by chemotherapy.

Centers of Excellence Program

For certain procedures covered under the plans, you or a covered family member may receive treatment at a Center for Excellence (also known as "tertiary care").

A Center of Excellence is a hospital or other health care facility that specializes in delivery of certain types of complex medical care—for example, organ transplants and coronary care. Because these Centers regularly deliver certain types of complex care, they generally have access to the most up-to-date technology and are able to provide high-quality care at a lower cost.

Either you or your doctor may request that you be treated at a Center of Excellence. To make the request, call the claims administrator at the toll-free number on your medical ID card. When you receive treatment at a Center of Excellence, you have several advantages, including:

- You do not have to meet any calendar-year deductible before services provided by the Center are covered (doesn't apply to the Health Advantage Plan with associated Health Savings Account);
- The amount the PPO pays for covered services increases to 100% (doesn't apply to the Health Advantage Plan with associated Health Savings Account); and
- Eligible expenses for travel to and from the Center for you and a companion are paid at 100%, up to the limits listed below (under both plans and after the deductible has been satisfied for the Health Advantage Plan with associated Health Savings Account).

Covered expenses for the travel companion also include reasonable hotel accommodations and services and supplies, provided these expenses are approved in advance by the claims administrator, and provided the travel companion:

- Lives at least 50 miles from the Center;
- Is accompanying the covered person to or from the Center; and
- Travels by motor vehicle or common carrier.

Eligible charge limits to the travel and accommodation expenses include:

- The limit for air travel is equal to the cost of a round-trip coach airfare. For stays of three weeks or more, the limit is equal to two round-trip coach airfares.
- The limit for transportation by motor vehicle (for example, car, truck, or van) is as established by the Internal Revenue Service (IRS) under Code Section 213. Total mileage cannot exceed the round-trip mileage to the Center, as determined by Rand McNally's guide, up to the maximum airfare allowed under the plans.
- The daily limit for hotel accommodations is the prevailing charge for a mid-range priced hotel, up to a maximum of $50 per room. Each stay is limited to 21 calendar days.
- For other charges (for example, meals), the daily limit is $25, to a maximum of $500. Reimbursements for meals are taxable by the IRS and ADT is required to report it as income to the member.

Catastrophic Illnesses and Injuries

If you or a covered family member is suffering from a catastrophic illness or injury, you may be eligible for alternative treatment under the plans. Catastrophic illnesses and injuries include, but are not limited to:

- Cancer.
- Head injury requiring an inpatient stay.
- Spinal cord injury.
- Severe burns over 20% or more of the body.
- Multiple injuries due to an accident.
- Premature birth.
- Cerebrovascular accident (stroke).
- A congenital defect that severely impairs bodily function.
- Brain damage due to an accident, cardiac arrest or resulting from a surgical procedure.
- Terminal illness, with a prognosis of death within six months.
- Acquired Immune Deficiency Syndrome (AIDS).
- Substance abuse.
- Mental, nervous, or psychoneurotic disorders.

Alternative treatments are services and supplies that are not otherwise eligible for coverage under the plans. These services and supplies are covered if the claims administrator determines they would be medically appropriate and cost-effective in meeting the long-term needs of the covered person.

Treatments that are considered to be experimental or investigational are **not** covered as alternative treatments.

When alternative treatment is ordered by your doctor, the claims administrator will discuss the treatment with both you and the doctor. If approved and you agree to the alternative treatment, you will receive this treatment in lieu of benefits otherwise payable under the plans for your condition.

Any coverage changes apply only to the supplies and services provided as part of the alternative treatment plan. These supplies and services must be approved in advance by the claims administrator.

The maximum benefit amount payable for alternative treatment is the amount that would have been payable if the alternative treatment was not used. Any benefits paid for alternative treatment will count toward any benefit maximums in force at the time the treatment is given or in the future.

For more information, you can call the toll-free number for your claims administrator listed on your medical ID card.

Weight Management Programs

Bariatric Surgery

Bariatric surgery includes several different surgical procedures that are used to treat obesity. For the plans to cover this type of surgery, the patient must be a participant and also must have a body mass index (BMI):

- Greater than 40 (morbidly obese); or
- Greater than 35 with one or more co-morbidities such as diabetes or hypertension, which have been documented in his/her medical record.

The plans will pay benefits for one bariatric surgery per lifetime. The surgery must be performed in-network. The plans will not provide coverage for the costs related to experimental bariatric surgeries or procedures.

Surgical candidates must meet all of the following criteria as documented in, and supported by, his/her medical records:

- The obesity problem must have a duration of more than five years;
- The patient must be over age 18;
- The patient must complete six months of a supervised weight loss program during the two-year period before the surgery, at least three months of which are consecutive; and
- The patient must complete an appropriate pre-surgical psychological evaluation.

Benefits for bariatric surgery and related medical, hospital, diagnostic, and radiological services are not available when services are rendered by an out-of-network provider.

It is your responsibility to apply and provide proof that you are complying with your surgeon's prescribed and supervised post-surgical care plan.

Benefits and plan limits will be based on the terms of the PPO or Health Advantage Plan with associated Health Savings Account at the time the surgery is performed. The plans' out-of-pocket maximum benefits do **not** apply to this payment. However, for the Health Advantage Plan with associated Health Savings Account, the out-of-pocket maximum is reduced by the bariatric surgery expense.

Behavior Change Programs

Enrollment in the Medical Plan provides access to Weight Management Behavior Change programs including Health Coaching and Nutritional Counseling. See the **Wellness** section of this SPD for more details on Health Coaching and charges table in this section for more details on the Nutritional Counseling.

Charges that Are Not Covered

While the Health Advantage Plan with associated Health Savings Account and the PPO provide coverage for many services, there are some services that are not covered under either of the plans, even if your doctor approves or recommends them.

Expenses that are not covered by the plans include but are not limited to:

- Charges above allowable amounts, which typically means the charge or portion of a charge for services or supplies that:
  - Exceeds the rates negotiated with in-network providers;
  - Exceeds the usual charge made by the provider for the service or supply when there is no health coverage; or
  - Is above usual charges in the area for a like service or supply, as determined by the claims administrator of your medical option.
- Blood charges for blood or blood plasma that is replaced by or for the covered person.
- Cosmetic surgery performed mainly to change a covered person's appearance, including surgery that is intended to treat a mental, psychoneurotic, or personality disorder by changing appearance.

  Cosmetic surgery **is** covered under the plans when it is performed to:
  - Correct the result of an accidental injury that occurred within the previous 24 months;
  - Treat a condition, including a birth defect, that impairs the function of a body organ; or
  - Provide post-mastectomy services and reconstruct a breast after a mastectomy performed for the treatment of a disease.
- Any charge in connection with an injury arising out of the attempt of, commission of, or participation in the commission of, a crime.

- Charges for services in connection with custodial care.
- Dental services, including any charges for doctor's services or X-ray exams involving:
  - One or more teeth;
  - The tissue or structure around teeth; or
  - The alveolar process or the gums.

    This exclusion applies even if the condition requiring any of these services involves a part of the body other than the mouth, such as the treatment for or related to TMJ. This includes Phase II according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances), or a combination of these treatments

    See the **Dental** section of this SPD for an explanation of how that plan pays benefits for dental services.
- Charges for services or supplies that are educational, experimental, or investigational in nature. This includes, but is not limited to:
  - The services provided as part of a clinical trial that would not otherwise be a covered benefit if not provided as part of a clinical trial. As discussed above, benefits provided as part of a clinical trial that would be covered by the plans if not provided as part of a clinical trial, will be covered by the plans.
  - All treatment protocols based upon or similar to those used in clinical trials;
  - Any drugs approved by the Food and Drug Administration (FDA) under its Treatment Investigational New Drug regulation; and
  - FDA-approved drugs for unrecognized treatment indications.

    If a drug, service, or supply is not rated by the FDA and/or American Medical Association, the plans will rely on the prevailing medical opinion regarding the educational, experimental, investigational, or medical standards status of the drug, service, or supply. In making this determination, the plans will use commissioned studies, opinions, or references of the medical associations or federal government agencies that have the authority to approve medical testing of the drug, service, or supply.
- Charges for disposable medical supplies (for example, gloves, masks, other disposable apparel, swabs, sponges, and syringes). Insulin syringes are covered under the Prescription Drug Plan.
- Charges for a service or supply furnished by your employer.
- Charges for or in connection with eyeglasses or lenses of any type, except initial replacement for the loss of a natural lens.
- Eye surgery, such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring).
- Charges for a service or supply furnished by you, a member of your household, or a family member, including your spouse, your domestic partner, or a child, brother, sister or parent of yourself, your spouse, or your domestic partner.

- Charges for routine foot care including, but not limited to: the treatment of corns, calluses, clavus, tyloma or tylomata, plantar keratosis, hyperkeratosis and keratotic lesions, keratoderma or tylosis, bunions (except capsular or bone surgery thereof), or nails (except surgery for ingrown nails); the reduction of nails, including the trimming of nails.
  - Foot care is considered non-routine and covered only in the following circumstances when medically necessary:
    - The non-professional performance of the service would be hazardous for the member because of an underlying condition or disease (such as diabetes, arteriosclerosis, peripheral neuropathies, and chronic thrombophlebitis);
    - Routine foot care is performed as a necessary and integral part of an otherwise covered service (e.g., treatment of warts, or debriding of a nail to expose a subungual ulcer); or
    - Debridement of mycotic nails is undertaken when the mycosis/dystrophy of the toenail is causing secondary infection and/or pain, which results or would result in marked limitation of ambulation and require the professional skills of a provider.
- Charges for infertility treatment for dependent child(ren).
- Charges for services or supplies furnished or provided under a government plan, including those:
  - Furnished in whole or in part by or for the United States government or any other government, unless required by law; and
  - Provided or paid for, in whole or in part, by any law or government plan under which the patient is or could be covered. (This does not apply to a state plan under Medicaid or to any law or plan whose benefits, by law, are greater than those of any private insurance program or other non-governmental program.)
- Charges for services and supplies that are not medically necessary, as determined by the claims administrator and subject to review by the plan administrator.
- Charges for services and supplies that are not specifically covered under the PPO or Health Advantage Plan with associated Health Savings Account.
- Charges for services or items for personal comfort, convenience, and safety.
- Charges in connection with surgical procedures to reverse a voluntary sterilization procedure.
- Charges in connection with surgical procedures for sex changes.
- Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed.
- Travel expenses for a covered person or travel companion, except as noted under “Centers of Excellence Program” earlier in this section.
- Charges for any illness or injury due to war or any act of war while covered under the PPO or Health Advantage Plan with associated Health Savings Account.
- Work-related injuries or illness arising out of the course of any work for wage or profit (whether or not with the company) or work covered by any Workers’ Compensation law, occupational disease, or similar law.

For more information on what is and is not covered under the plans, contact the claims administrator at the toll-free number listed on your medical ID card.

Pre-Certification Requirements

With both medical options, there are certain services that require pre-certification before you receive care. In some cases, care must be approved while or even after you receive it. See below for details.

Pre-Certification for Inpatient Care

When you or a covered family member is admitted to a hospital, skilled nursing facility, rehabilitation facility, residential treatment facility, or hospice, or has inpatient surgery, you **must** follow the plans' pre-certification procedures outlined in this section. When you call to pre-certify, the claims administrator reviews the services for "medical necessity" and to ensure that you receive quality care within the proper setting and at the appropriate cost. Note, pre-certification is not required for maternity admissions.

In some cases, your doctor may handle pre-certification for you. However, it is always **your** responsibility, not your doctor's, to make sure all the pre-certification requirements are followed.

Please note: Following the pre-certification process does not guarantee payment of benefits. Coverage is always subject to other plan requirements, such as benefit limits or exclusions, payment of premiums, and eligibility at the time that care and services are provided.

Failure to pre-certify your care could result in a $500 penalty, a reduction in benefits, or in some cases, an actual loss of benefits.

If any pre-certification is denied, you may appeal the denial.

Non-Emergency Admissions

For non-emergency admissions to a hospital, you, your doctor, or your covered family member must contact the claims administrator at the toll-free number on your medical ID card at least seven calendar days **before** the hospital stay is scheduled to begin. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to contact the claims administrator. You must provide the claims administrator with all the information needed to determine if the service is medically necessary and to ensure care will be provided within the proper setting.

The claims administrator may ask you or your doctor for additional information. Any additional information must be provided no later than the end of the second business day after the claims administrator requests it. Your request is not considered complete until you provide all information required by the claims administrator.

Once the claims administrator reviews all the information, your doctor will receive authorization by telephone for the number of days approved for your hospital stay. Both you and your doctor will also receive written confirmation of the determination.

Emergency Admissions

If you or a covered family member is admitted to the hospital on an emergency basis, you must notify the claims administrator no later than 48 hours following the admission, or as soon as possible thereafter if there are extenuating circumstances (as determined by the plan administrator). This call may be made by you, a family member, your doctor, or the hospital.

In all cases, it is *your* responsibility to make sure the notification takes place.

Extension of Length of Hospital Stay

If your hospital stay is expected to continue beyond the number of days initially approved, you or your doctor must notify the claims administrator before this period expires. Once the claims administrator conducts a new determination of medical necessity, the claims administrator will notify your doctor as to how many more days, if any, have been approved.

You, your doctor, and the hospital will also receive written notification of this determination.

If your stay exceeds this number of days without additional authorization from the PPO or Health Advantage Plan with associated Health Savings Account, you will be responsible for the charges for any additional days.

If any pre-certification is denied, you may appeal the denial. See the **Claim Review and Appeal Processes** section of this SPD for information on filing an appeal.

Pre-Certification for Urgent and Emergency Care

You are **always** covered for urgent and emergency care, no matter where you are when you need care.

For urgent care, if you use an in-network facility, you will receive benefits at the in-network level. If you use an out-of-network facility, your benefits will be paid at the out-of-network level.

For emergency care, you should go immediately to the nearest emergency room.

The level of benefits received for emergency room treatment is determined by the medical necessity of the care received. True emergency care is considered in-network regardless of whether an in-network or out-of-network facility is used. However, if your visit to the emergency room is determined not to be for a life-threatening event, your benefits will be paid at the level paid for non-emergency out-of-network care.

Pre-Certification for Elective Outpatient Treatment

When you or a covered family member elects to receive certain elective outpatient services or procedures—including certain surgeries, diagnostic tests, or behavioral health care—you **must** follow the plan's pre-certification procedures outlined in this section. When you call to pre-certify, the claims administrator reviews the services for "medical necessity" and to ensure that you receive quality care within the proper setting and at the appropriate cost.

In some cases, your doctor may handle pre-certification for you. However, it is always **your** responsibility, not your doctor's, to make sure all the pre-certification requirements are followed.

Please note: Following the pre-certification process does not guarantee payment of benefits. Coverage is always subject to other plan requirements, such as benefit limits or exclusions, payment of premiums, and eligibility at the time that care and services are provided.

Failure to pre-certify your care could result in an actual loss of benefits for that care.

In order to pre-certify elective outpatient treatments, you, your doctor, or your covered family member must contact the claims administrator at the toll-free number on your medical ID card at least 14 calendar days **before** the treatment is scheduled to occur. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to contact the claims administrator. You must provide the claims administrator with all the information needed to determine if the service is medically necessary and to ensure care will be provided within the proper setting.

The claims administrator may ask you or your doctor for additional information. Any additional information must be provided no later than the end of the second business day after the claims administrator requests it. Your request is not considered complete until you provide all information required by the claims administrator.

Once the claims administrator reviews all the information, your doctor will receive authorization by telephone regarding the approval for your treatment. Both you and your doctor will also receive written confirmation of the determination. Your pre-certification approval remains valid for 60 calendar days as long as you remain enrolled in the PPO or Health Advantage Plan with associated Health Savings Account.

Please note: Given the rapid developments in medical technology and treatment protocols, contact the claims administrator for the most up-to-date list of elective outpatient treatments requiring pre-certification. The following lists the most common categories of affected care:

- Computerized Axial Tomography (CAT scan);
- Magnetic Resonance Imaging (MRI) or Magnetic Resonance Angiogram (MRA);
- Positron Emission Tomography (PET scan);
- Private-duty nursing care;
- Home uterine activity monitoring;
- Air ambulance transports;
- Partial hospitalization programs for mental health disorders and substance abuse;
- Intensive outpatient programs for mental health disorders and substance abuse;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Outpatient detoxification;

- Psychiatric home care services;
- Psychological testing;
- Blepharoplasty (eyelid surgery);
- Breast reconstruction or enlargement;
- Onco Type Dx breast cancer assay;
- Chemical peels;
- Gastroplasty/gastric bypass;
- Lipectomy (excess fat removal);
- Sclerotherapy (varicose or spider vein treatment);
- Panniculectomy (“tummy tuck”);
- Back disc or lumbar fusion surgery;
- Lumbar neurostimulators;
- Capsule endoscopy for GI tract imaging;
- Hyperbaric oxygen therapy;
- Negative pressure wound therapy;
- Osseointegrated implant;
- Osteochondral allograft (knee reconstruction);
- Stereotactic radiosurgery;
- Uvulopalatopharyngoplasty (throat tissue surgery);
- TMJ (temporomandibular joint) procedures;
- Cochlear devices or implantation;
- Botox injections;
- Autologous chondrocyte implantation (cartilage repair);
- Electronic or motorized wheelchairs and scooters;
- Limb prosthetics;
- Customized braces; and
- Oral appliances.

Filing Claims

The claims process you follow after receiving care depends on whether you use in-network providers or out-of-network (non-participating) providers.

In-Network Claims

When you receive in-network care, there are no claim forms to file. Simply show your medical ID card, and pay any amounts that may be required (for example, if you have PPO coverage, you may have to pay a copay when you receive services). Your in-network provider then bills the PPO or Health Advantage Plan with associated Health Savings Account directly for its share of the cost for your care. If the charges are subject to a deductible or coinsurance, you will then pay the remaining prenegotiated fee until the deductible has been satisfied or coinsurance percentage of the prenegotiated fee.

Out-of-Network Claims

When you receive out-of-network care, you may be required to pay for your care upfront and then file a claim for reimbursement. Here's what you need to do:

- Complete a claim form, available from **MyADTHR.com > Health & Group Benefits > Forms**. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
- Obtain an itemized bill from your provider on the appropriate letterhead that includes:
  - The patient's name, member ID number, and date of birth;
  - The date of service;
  - A description of the services provided;
  - A diagnosis or diagnosis code;
  - The provider's federal tax ID number; and
  - The amount you paid (if any).
- Send the claim form and bill to your claims administrator.

Claims should be submitted within 90 calendar days after the date care was received. In addition, all claims for each calendar year should be filed no later than 60 calendar days after the end of the calendar year. Generally, claims are processed and paid within 20 calendar days after your claims administrator receives all of the information that is needed to process the claim.

If it is not reasonably possible to submit your claim within these time frames, your claim will still be valid if it is furnished as soon as is reasonably possible. However, claims submitted more than one year after the date of service are not considered valid and will not be paid. Any benefit unpaid at the time of your death will be paid to your estate.

The claims administrator reserves the right to request a physical examination, at its own expense, as often as is reasonable while a claim is pending.

If a Claim Is Denied

If your claim is denied in whole or in part, you will receive a claim denial notice setting forth the reasons for the denial and explaining how to appeal the denial. You may then appeal the denial. See the **Claim Review and Appeal Processes** section of this SPD for information on the claim denial and how to file an appeal.

Contact Health Advocate by calling **EmployeeAccess** at **1-888-833-1839** and selecting **Health and Group Benefits** followed by **Health Advocate** to get support for medical insurance claims and billing issues and other resources that may be available to help you with health claims issues.

Coordination of Benefits if You Are Covered by another Plan

If you receive care that is also covered under another group health care plan, your benefits under the PPO or Health Advantage Plan with associated Health Savings Account may be coordinated with the other coverage. For more information, see the **Coordination of Benefits** section of this SPD.

Health Savings Account Overview

You can have a health savings account if you enroll in the Health Advantage Plan with associated Health Savings Account.

A health savings account is comprised of two components:

- High Deductible Health Plan (HDHP) – An HSA-compatible health insurance plan with a high annual deductible.
- Health Savings Account (HSA) – A tax-advantaged health savings account is a type of savings or checking account with a bank or financial institution. You typically withdraw funds by using a debit card for eligible health care expenses.

You can't establish the health savings account without enrolling in a HSA-compatible high deductible health plan first. For many people, HSAs offer a way to save money on their overall health care spend because of generally lower health insurance premiums, lower taxable income due to HSA contributions, and the ability to build savings for future medical needs.

You can find detailed information on the health savings account portion of the Health Advantage Plan with associated Health Savings Account in the **Spending Accounts** section of this SPD, including information on:

- How the health savings account works.
- Eligible dependents.
- HSAs and domestic partners.
- Eligible HSA expenses.
- Contribution limits.
- Paying expenses from your health savings account and how to use the HSA debit card.
- Using your health savings account for retirement.
- When your health savings account participation through ADT ends.

Additional Information You Should Know

Finding In-Network Providers

The PPO Plan and Health Advantage Plan with associated Health Savings Account both use the same Blue Cross Blue Shield (BCBS) network of health care providers who have agreed to provide services through the plans.

Here's how it works:

- You can find a list of in-network doctors, specialists, hospitals, and other providers online at the claims administrator's website, **http://provider.bcbs.com**. You also can call B's toll-free number listed on your medical ID card.
- After you enroll, you will receive a medical ID card, a separate prescription drug ID card, and a separate vision ID card (if enrolled in vision coverage). You should carry the cards with you and use them whenever you access care. Your ID card lists the information your health care provider will need when you receive care as well as the toll-free number you can call when you have questions about the plans.

Every effort is made to ensure that provider lists are up-to-date. However, it's important to note that the providers who participate in your plan's network may change over time. To ensure that you receive the highest level of benefits available under your plan, you may wish to contact your provider before receiving care to verify that he/she currently participates in your plan's network.

Dependents Living Away from Home

Dependent students who live away from home during the school year can use an in-network provider for services, if one is available in the area. If an in-network provider is used, services will be paid at the in-network level. If an out-of-network provider is used, services will be paid at the out-of-network level.

For information about other services provided for students by your network, call the toll-free number for your claims administrator listed on your medical ID card or online at **MyADTHR.com**, where you can search for a list of in-network doctors and hospitals in the area of the student's school or university.

Travel Vaccines

Travel vaccines will be covered like any other injection when rendered in the physician's office. This includes but is not necessarily limited to the following injections: malaria, hepatitis A, hepatitis B, lyme, rabies, typhoid, yellow fever, cholera, and Japanese B encephalitis; meningococcal polysaccharide/ conjugate vaccines.

Traveling Abroad

You take your health care benefits with you when you are abroad. Through the BlueCard Worldwide Program, you have access to medical assistance services, doctors and hospitals around the world. BlueCard Worldwide is an extension of the BCBS network, so coverage in this program is per the contract benefits under the Medical Plan. Some worldwide hospitals are PPO providers, and services received in those facilities are covered at the in-network level and subject to the hold-harmless protection for employees. Some worldwide physicians are participating providers, but not PPO. Meaning services received are covered at the in-network level, but the provider does have the right to balance bill the member.

For more information, see the **Additional Benefits** section of this SPD.

Traveling Between U.S. and Canada

Employees may require travel between the U.S. and Canada either for Company or leisure-related reasons. Your benefits will continue with you while abroad. The chart below summarizes how your coverage options compare as a U.S. employee both in the U.S. as well as a U.S. employee travelling to Canada.

	Coverage			
Employee Location	**Medical**	**Prescription Drug**	**Dental**	**Vision**
U.S. Coverage	PPO, Health Advantage Plan with Associated Health Savings Account (through BCBS)	Prescription Drug Plan (through CVS)	DMO, Standard (through Aetna)	Vision Plan (through EyeMed)
U.S. Employee Coverage in Canada*	BCBS BlueCard Worldwide No limit on duration of visit	Prescription Drug Plan (through CVS via claim form submission) No limit on duration of visit; claim form must be submitted within one year	DMO, Standard (through Aetna for emergencies only via claim form submission) No limit on duration of visit	Vision Plan (through EyeMed via out-of-network claim form submission) with same benefit frequency

*For Medical, Prescription Drug, and Dental, claims are determined as in-network or out-of-network depending on provider.

Prescription Drug

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Prescription Drug Benefits at a Glance

The Prescription Drug Plan is considered to be part of the PPO and Health Advantage Plan with associated Health Savings Account (defined below), even though it is has a different claims administrator (CVS Caremark). As a result, you are automatically covered by the Prescription Drug Plan when you enroll in the:

- Preferred Provider Organization (PPO) Plan option; or
- Health Advantage Plan with associated Health Savings Account option.

You have the same coverage level under the Prescription Drug Plan that you choose for your PPO or Health Advantage Plan with associated Health Savings Account coverage: Individual, Employee+1, or Family.

If you live in Hawaii or Puerto Rico, you participate in the HMSA (Hawaii) or Triple-S Salud (Puerto Rico) programs (see the **If You Reside in Puerto Rico–Triple-S Salud** and **If You Reside in Hawaii–Hawaii Medical Service Association (HMSA)** sections of this SPD.). Your prescription coverage is provided through those plans, instead of the Health Advantage Plan with associated Health Savings Account or PPO Plan options.

Overview of the Prescription Drug Plan

How Prescription Coverage Works under the PPO

The Prescription Drug Plan pays the major portion of most prescription drugs and medicines. You also share in costs through copays and coinsurance. The plan works like this:

- The amount you pay for a prescription depends on:
  - The type of medication—preventive, non-preventive, or Affordable Care Act (ACA) preventive;
  - Whether you and your doctor choose generic, preferred brand-name, or non-preferred brand-name drugs;
  - Whether you use in-network or out-of-network pharmacies; and
  - Whether you use the retail pharmacy program (for short-term use), or the mail-service or CVS Caremark Maintenance Choice programs (for maintenance or longer-term use of greater than 84 calendar days).
- You have first-dollar coverage for all of your prescriptions when you use in-network providers. You don't need to meet any in-network deductibles before the plan pays benefits. If you use out-of-network pharmacies, you must meet a $50 annual deductible before the plan pays benefits and file a claim form for benefits.
- When you fill a prescription, you pay either a copay (a flat dollar amount) or coinsurance (a percentage of the drug's cost). However, if the prescription drug is considered preventive care under the ACA ("ACA preventive drug") and you use an in-network pharmacy, you will not be required to pay any copay or coinsurance for your prescription.
- When you use in-network pharmacies, the plan pays a larger portion of costs, and you pay a smaller portion. The network is a group of pharmacies that have contracted with the claims administrator to provide prescriptions to covered persons.

- The Plan allows up to two 30-calendar-day supplies per medication to be filled at retail pharmacies. For longer-tem or maintenance medications, you should use the mail-service pharmacy program or the CVS Caremark Maintenance Choice program. You pay lower costs when you use these programs and can receive up to a 90-calendar-day supply for each prescription fill.
- You can request reimbursement from your Flexible Spending Account for any copays or coinsurance that you pay.

How Prescription Coverage Works under the Health Advantage Plan with associated Health Savings Account

Here's how you pay for prescriptions under the Health Advantage Plan with associated Health Savings Account:

- The amount you pay for a prescription depends on:
  - The type of medication—preventive, non-preventive, or ACA preventive;
  - Whether you and your doctor choose generic, preferred brand-name, or non-preferred brand-name drugs;
  - Whether you use in-network or out-of-network pharmacies; and
  - Whether you use the retail pharmacy program (for short-term use), or the mail-service or CVS Caremark Maintenance Choice programs (for maintenance or longer-term use of greater than 84 calendar days).
- You have first-dollar coverage for preventive care prescriptions that you purchase from in-network pharmacies; you don't need to meet a deductible before these medications are covered.
- For in-network preventive care prescriptions that do not qualify as an ACA preventive drug, you pay the same amount as you would for a non-preventive drug. For in-network preventive care prescriptions that qualify as an ACA preventive drug, coverage is provided with a copay or coinsurance, but no deductible. For information about whether a drug is a preventive drug or an ACA preventive drug, see "Eligible Expenses" later in this section or contact the plan administrator.
- For all other non-preventive care prescriptions, you must meet the annual Health Advantage Plan with associated Health Savings Account deductible before the Prescription Drug Plan begins to cover charges. See the **Medical** section of this SPD for more information about the deductible.
- When you fill a preventive care prescription for a drug that does not qualify as an ACA preventive drug or a non-preventive care prescription after the deductible has been satisfied, you pay either a copay (a flat dollar amount) or coinsurance (a percentage of the drug's cost).
- Any amounts you pay toward your prescription drug or medical deductible(s) and your copays and coinsurance expenses count toward reaching the out-of-pocket maximum(s) under the Health Advantage Plan with associated Health Savings Account.
- When you use in-network pharmacies, the plan pays a larger portion of costs, and you pay a smaller portion. The network is a group of pharmacies that have contracted with the claims administrator to provide prescriptions to covered persons.
- The Plan allows up to two 30-calendar-day supplies per medication filled at retail pharmacies. For longer-tem or maintenance medications, you should use the mail-service pharmacy program or the CVS Caremark Maintenance Choice program. You pay lower costs when you use these programs and can receive up to a 90-calendar-day supply for each prescription fill.

- You can request reimbursement from your health savings account for deductibles, copays, or coinsurance that you pay.

Prescription Drug Coverage under the PPO

	PPO Plan	
	In-Network	**Out-of-Network**
Claims Administration	CVS Caremark	
Covered Expenses	Both plans cover the same prescription drug expenses, but with different deductibles, coinsurance, and copays.	
Out-of-Pocket Maximum		
▪ Individual coverage	$6,000	$12,000
▪ Employee+1 or Family coverage	$12,000	$24,000
Prescription Drug Plan (Rx) deductible	Not applicable	$50
Medical Plan deductible		
▪ Individual coverage	Not applicable	Not applicable
▪ Employee+1 or Family coverage	Not applicable	Not applicable
Retail Program (up to 30-calendar-day supply; two maintenance fills)	**Plan Pays**	**Plan Pays**
Preventive Drugs that Do Not Qualify as ACA Preventive Drugs		
▪ Generic	100% after $5 copay	50% coinsurance after $50 deductible
▪ Preferred brand-name	100% after $40 copay	50% coinsurance after $50 deductible
▪ Non-preferred brand-name	50% coinsurance (your maximum coinsurance is $200 per fill)	50% coinsurance after $50 deductible
Preventive Drugs that Qualify as ACA Preventive Drugs		
▪ Generic	100%, no copay	50% coinsurance
▪ Preferred brand-name	100%, no copay	50% coinsurance
▪ Non-preferred brand-name	100%, no copay	50% coinsurance
Non-Preventive Drugs		
▪ Generic	100% after $5 copay	50% coinsurance
▪ Preferred brand-name	100% after $40 copay	50% coinsurance
▪ Non-preferred brand-name	50% coinsurance (your maximum coinsurance is $200 per fill)	50% coinsurance
Mail-Service or Maintenance Choice Program (84- to 90-calendar-day supply)	**Plan Pays**	**Plan Pays**
Preventive Drugs that Do Not Qualify as ACA Preventive Drugs		
▪ Generic	100% after $10 copay	Not covered
▪ Preferred brand-name	100% after $80 copay	Not covered
▪ Non-preferred brand-name	50% coinsurance (your maximum coinsurance is $200 per fill)	Not covered

	PPO Plan	
	In-Network	**Out-of-Network**
Preventive Drugs that Qualify as ACA Preventive Drugs		
▪ Generic	100%, no copay	Not covered
▪ Preferred brand-name	100%, no copay	Not covered
▪ Non-preferred brand-name	100%, no copay	Not covered
Non-Preventive Drugs		
▪ Generic	100% after $10 copay	Not covered
▪ Preferred brand-name	100% after $80 copay	Not covered
▪ Non-preferred brand-name	50% coinsurance (your maximum coinsurance is $200 per fill)	Not covered
Contraceptives (Retail, mail service, or Maintenance Choice programs)	100% (no deductible or copay)	100% (no deductible or copay)

*Your coinsurance applies to the out-of-pocket maximum under the Medical Plan.

Prescription Drug Coverage under the Health Advantage Plan with associated Health Savings Account

	Health Advantage Plan with associated Health Savings Account	
	In-Network	**Out-of-Network**
Claims Administration	CVS Caremark	
Covered Expenses	Both plans cover the same prescription drug expenses, but with different deductibles, coinsurance, and copays.	
Out-of-Pocket Maximum		
▪ Individual coverage	$3,000	$6,000
▪ Employee+1 or Family coverage	$6,000	$12,000
Prescription Drug Plan (Rx) deductible	Combined with Medical	Combined with Medical
Medical Plan deductible		
▪ Individual coverage	$1,500 which applies to non-preventive care prescriptions	$3,000
▪ Employee+1 or Family coverage	$3,000 which applies to non-preventive care prescriptions	$6,000
Retail Program (up to 30-calendar-day supply; two maintenance fills)	**Plan Pays**	**Plan Pays**
Preventive Drugs that Do Not Qualify as ACA Preventive Drugs		
▪ Generic	100%, after $5 copay; no deductible	50% coinsurance after deductible
▪ Preferred brand-name	100%, after $40 copay; no deductible	50% coinsurance after deductible
▪ Non-preferred brand-name	50% coinsurance after deductible (your maximum coinsurance is $200 per fill)	50% coinsurance after deductible

	Health Advantage Plan with associated Health Savings Account	
	In-Network	**Out-of-Network**
Preventive Drugs that Qualify as ACA Preventive Drugs		
▪ Generic	100%, no copay	50% coinsurance after deductible
▪ Preferred brand-name	100%, no copay	50% coinsurance after deductible
▪ Non-preferred brand-name	100%, no copay	50% coinsurance after deductible
Non-Preventive Drugs		
▪ Generic	90% coinsurance after deductible	50% coinsurance after deductible
▪ Preferred brand-name	90% coinsurance after deductible	50% coinsurance after deductible
▪ Non-preferred brand-name	50% coinsurance after deductible (your maximum coinsurance is $200 per fill)	50% coinsurance after deductible
Mail-Service or Maintenance Choice Program (84- to 90-calendar-day supply)	**Plan Pays**	**Plan Pays**
Preventive Drugs that Do Not Qualify as ACA Preventive Drugs		
▪ Generic	100% after $10 copay; no deductible	Not covered
▪ Preferred brand-name	100% after $80 copay; no deductible	Not covered
▪ Non-preferred brand-name	50% coinsurance after deductible (your maximum coinsurance is $200 per fill)	Not covered
Preventive Drugs that Qualify as ACA Preventive Drugs		
▪ Generic	100%, no copay	Not covered
▪ Preferred brand-name	100%, no copay	Not covered
▪ Non-preferred brand-name	100%, no copay	Not covered
Non-Preventive Drugs		
▪ Generic	90% coinsurance after deductible	Not covered
▪ Preferred brand-name	90% coinsurance after deductible	Not covered
▪ Non-preferred brand-name	50% coinsurance after deductible (your maximum coinsurance is $200 per fill)	Not covered
Contraceptives (Retail, mail service, or Maintenance Choice programs)	100% (no deductible or copay)	100% (no deductible or copay)

*Your coinsurance applies to the out-of-pocket maximum under the Medical Plan.

Please note: Under the Affordable Care Act (ACA) of 2010, as amended, certain preventive health drugs referred to herein as ACA preventive drugs do not require cost-sharing. You will not pay a copay or coinsurance for these prescription drugs.

How the Prescription Drug Plan Works

Three Tiers of Drugs

There are three levels of coverage for prescription drugs purchased under the plan:

- A **generic drug** is one that has the same chemical make-up and active ingredients as a brand-name drug, but is usually much less expensive than its brand-name counterpart.
- A **preferred brand-name drug** is one that is selected for the preferred brand-name drug list based on effectiveness, limited side effects and price.
- A **non-preferred brand-name drug** is one that is not on the preferred brand-name drug list because the cost is generally higher and it is no more effective than available preferred brand-name drugs.

The list of preferred brand-name drugs changes periodically. A list of preferred brand-name drugs is available online at **MyADTHR.com > Health & Group Benefits > Prescriptions > Performance Drug List**. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Prescription Drugs.**

How You Can Purchase Your Prescriptions

There are several ways you can purchase prescribed medications under the Prescription Drug Plan:

- Through the retail pharmacy program (maintenance medications are limited to two fills of 30 calendar days or less);
- Through the mail-service pharmacy program (for longer-term or maintenance medications with convenient at-home delivery);
- Through the CVS Caremark Maintenance Choice Program (for longer-term or maintenance medications purchased at neighborhood CVS pharmacies); and
- Through the specialty medication pharmacy program (for certain specialty medications delivered to your home or your doctor's office).

The programs are explained in detail below. When you enroll, you will receive the necessary documentation to use these programs, including a prescription drug ID card, a list of in-network retail pharmacies in your area, a mail-service pharmacy Participant Profile form (which should be completed when you order your first prescription through the mail service program), and a claim form (which should be needed if you use an out-of-network retail pharmacy).

For medications you will be taking on a long-term basis, ask your doctor for two prescriptions—one you can use right away at an in-network retail pharmacy for up to a 30-calendar-day supply and a second prescription to use with the mail-service pharmacy program for up to a 90-calendar-day supply.

Retail Pharmacy Program for Short-Term Prescriptions

With the retail pharmacy program, you can fill short-term (up to a 30-calendar-day supply) and emergency prescriptions at in-network or out-of-network pharmacies.

You can receive a maximum of two fills (the original prescription and one refill) under the retail pharmacy program for maintenance medication. After two fills, you must purchase that medication through the mail-service or CVS Caremark Maintenance Choice programs to continue receiving benefits.

> You can receive two fills under the retail pharmacy program for maintenance medication. After two fills, you must obtain your maintenance prescriptions through the mail-service or CVS Caremark Maintenance Choice programs. No further benefits will be paid under the retail pharmacy program for that medication.

In-Network Pharmacies

The claims administrator for the Prescription Drug Plan offers an extensive network of retail pharmacies from which to choose, including most national chains. In most cases, you will have convenient access to an in-network pharmacy and will not need to use an out-of-network pharmacy.

To locate in-network pharmacies:

- Use the ADT provider website at **MyADTHR.com > Health & Group Benefits > Prescriptions**; or
- Call the claims administrator for the Prescription Drug Plan at the phone number on the back of your prescription drug ID card.

When you use in-network pharmacies, you pay lower costs than when you use out-of-network pharmacies. In addition, you don't need to submit claims. The pharmacy handles all claims; you simply pay your portion of costs when you pick up your prescription.

Out-of-Network Pharmacies

If you choose to use a pharmacy that does not participate in the Prescription Drug Plan, you must pay the full cost of your prescription at the pharmacy and then submit a claim form for reimbursement.

You will receive a claim form with your enrollment materials. You also can obtain one by calling the toll-free number on the back of your prescription drug ID card.

If you pay the full cost of the prescription price at an in- or out-of-network pharmacy (or while traveling outside the United States), you will need to file a paper claim form with the original prescription receipt(s) to CVS Caremark. If it is a covered prescription per the Plan, CVS Caremark will reimburse you, based on the contracted rate with ADT, up to a 30-calendar-day supply per prescription. Your claim form must be submitted within 365 calendar days from the date of service to receive reimbursement.

Mail-Service or Maintenance Choice Program for Long-Term Prescriptions

You can receive two fills under the retail pharmacy program for maintenance medication (the original prescription plus one refill). After two fills, you must obtain your maintenance prescriptions through the mail-service or CVS Caremark Maintenance Choice programs to continue receiving benefits.

> When you need to take medication for longer than 60 calendar days (two 30-calendar-day fills), you should use the mail-service or CVS Caremark Maintenance Choice programs. No benefits are paid for more than two fills of maintenance medication under the retail pharmacy program.

The mail-service or CVS Caremark Maintenance Choice programs are especially convenient and cost-effective for anyone with ongoing or long-term prescriptions, such as prescriptions for high blood pressure or other chronic conditions (see the box to the right). You can use these programs for any medications that you need to take for durations longer than 60 calendar days (two 30-calendar-day fills).

Remember that you **must** use either the mail-service pharmacy or the CVS Caremark Maintenance Choice program to receive benefits for more than 60 calendar days of maintenance medication. **No plan benefits will be paid for more than two 30-calendar-day fills of maintenance medication under the retail pharmacy program.**

Maintenance Drugs

Maintenance drugs are prescription drugs used for the treatment of chronic medical conditions, including but not limited to:

- Cancer.
- Chronic obstructive pulmonary disease.
- Clotting disorders.
- Congestive heart failure.
- Coronary artery disease (angina).
- Diabetes.
- Depression.
- Glaucoma.
- Hypertension (high blood pressure).
- Hyperlipidemia (high cholesterol).
- Thyroid disease.
- Seizure disorders.

Mail-Service Pharmacy Program

You should consider the mail-service pharmacy program if you prefer to receive your prescriptions through the mail, or if you do not have convenient access to a CVS pharmacy in your area.

To use the mail-service pharmacy, you will need to complete the mail-service pharmacy Participant Profile form before you fill your first prescription. Instructions are on the form. After completing the form, attach your prescription and your payment and mail it to the mail-service pharmacy at the address indicated on the form. Your prescription will arrive approximately 10 – 14 calendar days after the mail-service pharmacy receives your form.

If you need help calculating the cost of your prescription, your coinsurance, or your deductible requirement, visit **caremark.com** or call the number on your prescription drug ID card for assistance. You can pay for your mail-service prescriptions by personal check, credit card, or your health savings account or FSA Debit Card. Please don't send cash through the mail.

When you order refills, be sure to leave enough time for the mail-service pharmacy to receive your refill request, and to fill and mail the prescription to you. Please note, however, that your prescription cannot be refilled until at least 60% of the previous prescription has been used.

CVS Caremark Maintenance Choice Program

You should consider the Maintenance Choice program if you have convenient access to a CVS pharmacy in your area. Some people prefer to have their maintenance prescriptions filled at their pharmacy, rather than through the mail.

You can sign up for the Maintenance Choice program online at **caremark.com** or by calling the Customer Care number listed on your prescription drug ID card. CVS Caremark will contact your doctor to get a new prescription for a 90-calendar-day supply of your medication(s).

Prescription Drug ID Cards
You will receive a prescription drug ID card to show at retail pharmacies when you fill your prescriptions. You will also receive an ExtraCare Health Card, which can be used at CVS pharmacies to receive 20% off the purchase price of CVS store brand health-related items. These include products you may frequently buy, such as ibuprofen, allergy relief items, nasal decongestants, and more. If you already have an ExtraCare Rewards Card through CVS, your new card can replace it to provide you with additional discounts. You can transfer your ExtraCare Rewards Card by calling **1-888-543-5938**.

Specialty Medication Pharmacy Program

The Prescription Drug Plan also provides coverage for specialty medications. These medications typically have high costs and often are administered through an injection. Since many pharmacies do not routinely carry these medications, they are dispensed out of CVS Caremark specialty pharmacies and shipped directly to you or your physician. Through the CVS Caremark Specialty Guideline Management (SGM) program, these drugs are also subject to review (such as to confirm they are being taken for an approved diagnosis) and must be filled through the CVS Caremark specialty pharmacy. If you have questions, you can contact the CVS Caremark specialty pharmacy at **1-800-237-2767**.

Eligible Expenses

How Eligible Expenses Are Determined

In general, the Prescription Drug Plan covers medications that are deemed medically necessary and considered to be commonly accepted practice to treat given medical conditions. Due to the evolving nature of prescription drug therapy and ongoing advancements in medications available, you should contact the plan's claims administrator listed on your prescription drug ID card for more information on what is covered under the plan.

Some prescriptions may require prior authorization before being dispensed. Your pharmacist will handle this process for you. For additional information on prior authorization, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Prescription Drugs**. You also can call the phone number for the plan's claims administrator listed on your prescription drug ID card. See "Prescription Weight Loss Medications" later in this section for more information on approval criteria for these medications.

As new drugs are approved by the Food and Drug Administration (FDA), pharmacy experts for the plan's claims administrator evaluate the effectiveness, risks, and costs associated with the drugs. Recommendations regarding coverage are then reviewed by ADT for decisions on coverage under the plan.

Drugs for Preventive and Non-Preventive Care

Preventive Drugs that Do Not Qualify as ACA Preventive Drugs

For most preventive medications that do not qualify as preventive care under the ACA, you pay either a set copay or a percentage of the drug's cost (coinsurance), depending on the type of drug dispensed (generic, preferred brand-name or non-preferred brand-name) and where you fill it (in-network or out-of-network pharmacy). See the "Prescription Drug Coverage Under the PPO" and "Prescription Drug Coverage Under the Health Advantage Plan with Associated Health Savings Account" sub-sections earlier in this section for details on how benefits are paid.

For participants in the Health Advantage Plan with associated Health Savings Account, the plan's deductible does not apply to preventive drugs purchased in-network. You pay the prescription drug deductible for non-preventive care drugs and preventive drugs purchased out-of-network through the retail pharmacy program.

Preventive drugs are those that are taken by a person with risk factors for a disease to prevent the occurrence of the disease, such as the treatment of high cholesterol with cholesterol-lowering medication to prevent heart disease. Preventive drugs also include drugs that prevent the recurrence of a disease from which a person has recovered, such as treating a recovered stroke victim with ACE inhibitors to prevent another stroke. In addition, drugs taken in connection with certain preventive care programs are included, such as weight loss and smoking cessation programs.

You can find a complete list of the drugs considered preventive for purposes of the Health Advantage Plan with associated Health Savings Account at **MyADTHR.com > Health & Group Benefits > Prescriptions > Performance Drug List**. This list is updated periodically.

Preventive Drugs that Qualify as ACA Preventive Drugs

Under the ACA, certain recommended preventive drugs ("ACA preventive drugs") are required to be covered without cost-sharing and before the deductible has been satisfied. The PPO and Health Advantage Plan with associated Health Savings Account cover the following preventive medications—both prescription and over-the-counter (OTC)—with no cost-sharing (no deductible, copay, or coinsurance). To receive these medications at no cost-sharing, you must have an authorized prescription for the product—even for products sold over the counter (OTC)—and it must be dispensed by a participating mail or retail pharmacy.

The U.S. Preventive Services Task Force makes recommendations on what drugs and services qualify as preventive. The listing below is based on their recommendations. The list may change from time to time.

- Aspirin—An OTC product for men age 45 to 79 and women age 55 to 79 for cardiovascular protection.
- Colonoscopy Screening Preparation—Some OTC and some prescription products for men and women age 50 to 75 for bowel preparation for colonoscopy screening.
- Folic Acid—OTC doses of 400 to 800 mcg/day for women who are pregnant or who are planning to become pregnant.
- Fluoride—A prescription product for child(ren) to prevent dental cavities.
- Generic or brand-name contraceptives for women, including those sold over the counter, with an authorized prescription.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Any charge related to the administration of a vaccine in a doctor's office is covered under the terms of the medical plans.
- Iron supplements—An OTC product to treat/prevent anemia.
- Smoking cessation products—Some OTC and some prescription products.

- Women's preventive health services do not require cost-sharing. You will not pay a copay or coinsurance or have to satisfy a deductible for oral contraceptives and other contraception devices obtained with a written prescription from a licensed practitioner.

Non-Preventive Drugs

For non-preventive medications, you pay either a set copay or a percentage of the drug's cost (coinsurance) depending on the type of drug dispensed (generic, preferred brand-name, or non-preferred brand-name) and where you fill your prescription (in-network or out-of-network pharmacy). See the "Prescription Drug Coverage Under the PPO" and "Prescription Drug Coverage Under the Health Advantage Plan with Associated Health Savings Account" sub-sections earlier in this section for details on how benefits are paid.

For participants in the Health Advantage Plan with associated Health Savings Account, non-preventive drugs are subject to the Health Advantage Plan with associated Health Savings Account deductible. You pay the full cost of all non-preventive prescription drugs until you meet your annual Health Advantage Plan with associated Health Savings Account deductible. You can choose to reimburse yourself from your health savings account for your out-of-pocket prescription costs. See the "Prescription Drug Coverage Under the PPO" and "Prescription Drug Coverage Under the Health Advantage Plan with Associated Health Savings Account" sub-sections earlier in this section for details on how benefits are paid.

Prescription Weight Loss Medications

Weight loss medications are covered under the standard terms and conditions of the Prescription Drug Plan for plan participants who meet the following criteria:

- Body mass index ≥ 30; or
- Body mass index > 27 with one or more of the following obesity-related risk factors:
  - Hypertension (systolic blood pressure > 140mm Hg or diastolic blood pressure > 90mm Hg on more than one occasion).
  - Dyslipidemia:
    - LDL Cholesterol ≥ 160 mg/dl;
    - HDL Cholesterol < 35 mg/dl; or
    - Triglycerides ≥ 400 mg/dl.
  - Coronary heart disease.
  - Type 2 diabetes mellitus.
  - Sleep apnea.

Weight loss medications are subject to Prescription Drug Plan prior authorization procedures that include physician verification that the covered person meets the medical criteria.

The covered person must also follow a medical weight loss program, including diet and exercise, in conjunction with the weight loss medications, as documented in the medical record. ADT also offers a variety of Wellness Programs to support healthy lifestyle choices. These include telephonic and online health coaching, nutritional counseling, a Wellness Portal, and other programs. See the **Wellness Programs** section of this SPD for more details.

For more information on these services, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Prescription Drugs**. You also can call the toll-free number for your claims administrator listed on your medical ID card.

Ineligible Expenses

The Prescription Drug Plan provides coverage for a majority of prescription drugs. It's important to note that a limited number of prescription drugs are not available through the Prescription Drug Plan—such as allergens—may be covered under the PPO or Health Advantage Plan with associated Health Savings Account.

Some drugs are not covered, even if your doctor approves or recommends them. These include, but are not limited to:

- Anti-obesity agents, such as Meridia® and Zenical®—even if a physician recommends such medications—except as described under "Prescription Weight Loss Medications" earlier in this section.
- Contraceptive devices (male and female) and topicals that do not require a written prescription from a licensed practitioner to purchase.
- Drugs that do not require a prescription, with the exception of non-prescription insulin and certain other medications. Contact the plan's claims administrator for more information about these exceptions.
- Products used for cosmetic purposes.
- Prescription drugs that are not medically necessary.

Keep in mind that some prescription drugs, such as allergy sera and biological sera and drugs prescribed for use while you are an inpatient at a hospital or other facility, are covered under the PPO or Health Advantage Plan with associated Health Savings Account instead of under the Prescription Drug Plan. This is also true for some durable medical equipment that may be prescribed by your physician and is not covered under the Prescription Drug Plan.

It's important to note that some drugs, such as those used for cosmetic purposes, are not covered under the PPO, the Health Advantage Plan with associated Health Savings Account, **or** the Prescription Drug Plan, even if your doctor approves or recommends them.

You are encouraged to call the claims administrators for the PPO or Health Advantage Plan with associated Health Savings Account or the Prescription Drug Plan whenever you have questions about coverage for a prescription drug. Toll-free numbers are listed on your medical and prescription drug ID cards.

Filing a Claim for Prescription Drugs

If the claims administrator determines that a prescription is not eligible to be filled by the plan, or if you disagree with the way the claims administrator fills a prescription, you may appeal the denial.

The claims process you follow after receiving care depends on whether you use in-network providers or out-of-network (non-participating) providers.

You can also contact Health Advocate by calling **EmployeeAccess** at **1-888-833-1839** and selecting **Health and Group Benefits** followed by **Health Advocate** to get support for medical insurance claims and billing issues and other resources that may be available to help you with pharmacy-related claims issues.

In-Network Claims

You don't need to file claims when you purchase your prescriptions at in-network retail pharmacies or through the mail-service program. Simply show your medical ID card at an in-network retail pharmacy or complete your prescription order form for the mail-service pharmacy. Pay any amounts you owe for copays or coinsurance (or the deductible under the Health Advantage Plan with associated Health Savings Account). The in-network pharmacy then bills the plan directly for its share of the prescription cost.

Out-of-Network Claims

If you buy your prescriptions from an out-of-network pharmacy, you will have to pay the full cost when you pick up your prescription. You'll then need to file a claim. Here's what you need to do:

- Complete a claim form, included in your package when you became a participant. Additional claim forms are available from **caremark.com**. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Prescription Drugs**.
- Obtain an itemized bill from the pharmacy.
- Send the claim form and bill to the claims administrator at the address shown on the claim form.

Please note: If you pay the full cost of the prescription price at an in- or out-of-network pharmacy (or while traveling outside the United States), you will need to file a paper claim form with the original prescription receipt(s) to CVS Caremark. If it is a covered prescription per the Plan, CVS Caremark will reimburse you, based on the contracted rate with ADT, up to a 30-calendar-day supply per prescription. Your claim form must be submitted within 365 calendar days from the date of service to receive reimbursement.

If a Claim Is Denied

If your claim is denied in whole or in part, you will receive a claim denial with information about why the claim was denied and how to file an appeal. You may then file an appeal of the denial. See the **Claim Review and Appeal Processes** section of this SPD for information in the claim denial and on how to file an appeal.

Traveling Abroad

You take your health care benefits, including prescription drug coverage, with you when you are abroad.

For more information, see the **Additional Benefits** section of this SPD.

Traveling Between U.S. and Canada

Employees may require travel between the U.S. and Canada either for Company or leisure-related reasons. Your benefits will continue with you while abroad. The chart below summarizes how your coverage options compare as a U.S. employee both in the U.S. as well as a U.S. employee travelling to Canada.

Employee Location	Coverage			
	Medical	**Prescription Drug**	**Dental**	**Vision**
U.S. Coverage	PPO, Health Advantage Plan with Associated Health Savings Account (through BCBS)	Prescription Drug Plan (through CVS)	DMO, Standard (through Aetna)	Vision Plan (through EyeMed)
U.S. Employee Coverage in Canada*	BCBS BlueCard Worldwide No limit on duration of visit	Prescription Drug Plan (through CVS via claim form submission) No limit on duration of visit; claim form must be submitted within one year	DMO, Standard (through Aetna for emergencies only via claim form submission) No limit on duration of visit	Vision Plan (through EyeMed via out-of-network claim form submission) with same benefit frequency

*For Medical, Prescription Drug, and Dental, claims are determined as in-network or out-of-network depending on provider.

Wellness Programs

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Wellness Benefits at a Glance

The ADT Wellness Program is designed to assist you in learning about your health and to take steps to maintain good health or become healthier. ADT provides a variety of wellness resources to support all aspects of health, including physical, emotional, social, and financial health, leading to overall well-being.

Wellness benefits include many resources such as:

- 24-Hour Nurseline
- Health Advocate
- Employee Assistance & Work/Life Program
- Wellness Program and Services, including the following:
  - Biometric Screenings
  - Health Assessment
  - Health Coaching, Maternity or Member Management Program
  - Health Challenges and eConference Series
  - Online Education Series
  - Local Wellness Activities
- Wellness Portal
- Healthy Rewards Cash Reward Incentive

The 24-Hour Nurseline, Employee Assistance & Work/Life Program, Biometric Screenings, Health Assessment, Health Coaching, and eConference Series are provided under the Plan and are subject to the requirements of the Employee Retiree Income Security Act (ERISA). For more information about ERISA and how it applies to these programs, including information about the Consolidated Omnibus Budget Reconciliation Act (COBRA), claims procedures, and other general protections provided by ERISA, see the other applicable sections of this SPD.

The other programs and benefits described in this SPD are provided outside of the Plan and are not subject to the requirements of ERISA.

In addition, the availability of individual wellness benefits described in this section may vary in terms of whether they are available to you and/or your dependents. Please refer to the details of each program in this section to see which programs are available to you and your dependents.

24-Hour Nurseline

When you have health questions, you can get answers from experienced, specially trained registered nurses through Blue Cross Blue Shield's 24-Hour Nurseline.

To contact the 24-Hour Nurseline, call **1-800-896-2724**. When you call, the nurses can provide information on a wide variety of topics, including:

- Effective home treatment and prevention.
- When to call your physician.
- Making wise decisions about treatment.
- How to use prescription drugs effectively.

Nurses also can direct you to other resources.

You can get answers to health questions from Nurseline if you are an employee or dependent participating in the Medical Plan.

The 24-Hour Nurseline program is provided as part of the Medical Plan. Accordingly, for questions about eligibility, claims, and administration, please see the sections of the summary plan description applicable to the Medical Plan.

Health Advocate

The Health Advocate program is designed to help you and your family with health care and insurance-related issues and to resolve problems you may encounter in navigating the world of health care. To use your Health Advocate benefits call **1-877-776-6199** or go online to **healthadvocate.com/adt**. Calls are unlimited and service is available 24 hours a day, seven days a week.

ADT offers this program to you and your spouse/domestic partner, dependents, parents, and parents-in-law at no cost to you. You do not need to enroll in the program or be enrolled in the Medical Plan.

When you call Health Advocate, you will be connected with a Personal Health Advocate. Typically a Personal Health Advocate is a registered nurse supported by medical directors and benefits and claims specialists. Your Personal Health Advocate will work one-on-one with you to resolve your issue, no matter how long it takes. If necessary, your Personal Health Advocate is available for follow-up needs.

Your Personal Health Advocate can help you in the following ways:

- Find doctors, specialists, hospitals and treatment centers.
- Clarify insurance plan provisions.
- Untangle medical bills, uncover errors, negotiate medical fees.
- Assist in scheduling appointments.
- Help estimate costs for medical procedures.
- Locate eldercare and caregiver support resources.
- Research and explain conditions and treatment options.

- Identify external resources for services not covered by your health plan and assist with the transfer of medical records between providers.

Employee Assistance & Work/Life Program

Introduction

The Employee Assistance & Work/Life Program (EAP) provides confidential support and referral services at no cost to you. These services can help you balance the demands of work and life or address other personal issues.

> The EAP services are available to all ADT employees and their dependents. Dependents must be at least 13 years of age or have parental approval to contact the EAP.

Counseling and support services are available for you and everyone in your household. You can contact the EAP whether it's a simple question, a sudden emergency, or an ongoing problem. By calling the EAP's 24-hour toll-free number, you can connect to trained professionals to help you any hour of the day or night—and deal with problems early to prevent them from becoming more serious.

The EAP program is administered by ComPsych. You can contact ComPsych at **1-855-4ADT-EAP (1-855-423-8327)** or at **guidanceresources.com**. **Please note:** If you are based in Puerto Rico and enroll in Triple-S Salud, you also have access to the Quick Help Employee Access Assistance Program (EAP). However, we encourage you to use the ComPsych program since it offers greater benefits.

EAP Services

The EAP provides professional and confidential assistance in many areas, including:

- Stress, depression, and other mental health issues.
- Family and relationship concerns.
- Workplace conflicts.
- Parenting issues.
- Legal questions.
- Budgeting and financial worries.
- Child and elder care concerns.
- Alcohol, drug, or other substance abuse issues.

> To make the most use of your EAP benefit, it's a good idea to register at **guidanceresources.com > First-Time User**. When prompted to enter the Organization Web ID, enter ADTEAP.

EAP Online

The EAP also offers online interactive support and resources at **guidanceresources.com**. Through the EAP, you can find information and assistance with everyday challenges such as:

- Pregnancy and adoption, including pre-natal care, birthing options, breastfeeding, and domestic or international adoption resources.
- Child care and parenting, including care options, centers, in-home care, child safety, and other parenting resources.
- Education, including pre-K to college, financial aid, scholarships, and special needs programs.
- Adult care and aging, including short- and long-term care options, care-giving resources, and retirement.
- Health and wellness, including exercise programs, weight loss, nutrition, and safety.
- Daily needs, including relocation, pet care, financial and legal concerns, and home improvement.

There is no charge for you to use the EAP's online services.

EAP Counseling and Work-Life Consultation

You and your household members can contact the EAP 24 hours a day, seven days a week, by calling **1-855-4ADT-EAP (1-855-423-8327)**.

When you contact the EAP, you can speak with a professional counselor about your concerns. EAP counselors can help clarify your needs and offer suggestions to work toward a solution. These could include face-to-face counseling with an EAP counselor in your area. You and your dependent family members can each receive up to eight face-to-face visits per clinical issue per year.

There is no charge to you for consultations with an EAP counselor. However, if you require services beyond the scope of the EAP and you need to contact or be referred to other providers, charges for those services are determined by the professional providing the service. **Please note:** You are responsible for the cost of those services. These charges may or may not be eligible for coverage through the Medical Plan or another medical plan in which you participate.

Depending on your issue, you may also speak telephonically with a work-life specialist for:

- Consultation with an attorney on issues such as divorce and family law, debt and bankruptcy, real estate issues, and civil matters. If you require representation, you can receive a local referral for a free 30-minute in-person consultation with a 25% reduction in customary fees thereafter.
- Consultation with a professional financial counselor on issues such as getting out of debt, planning for retirement or college, estate planning, or tax questions.
- Consultation with a work-life specialist who will research referrals to resources in your community for services such as elder child and pet care, education, moving and relocation, and convenience services.

You may also use the EAP's online services to locate other resources on your own.

For More Information

Since there is no charge for online services or consultations under the EAP, you do not need to file claims for EAP benefits. However, if a claim is denied in whole or in part, you will receive a claim denial notice setting for the reasons for the denial and explaining how to appeal the denial. You may then appeal the denial. See the **Claim Review and Appeal Procedures** section of this SPD for information on the claim denial and how to file an appeal.

Wellness Program and Services

Many of the ADT Wellness Program components are administered by StayWell® Health Management, a third-party administrator. You, your spouse/domestic partner, and your dependents must meet the requirements of the individual programs to participate.

Biometric Screenings

Biometric screenings are a valuable tool for measuring the condition your body is in. Knowing your screening values is an essential first step to understanding your current medical condition and taking action toward a better, healthier lifestyle.

ADT offers two voluntary biometric screening options at no cost to you:

- On-site biometric screenings
- Health Care Provider Form (HCPF).

Employees and dependents age 18 or over who are enrolled in the Medical Plan can participate in the biometric screening.

On-Site Biometric Screenings

On-site biometric screenings are completely confidential and take approximately 15 to 25 minutes to complete. Fasting is recommended but not required.

At your biometric screening, you'll receive tests for the following:

- Height.
- Weight.
- Blood pressure.
- Total cholesterol
- High Density Lipoprotein (HDL).
- Glucose.

Biometric screenings are available at no cost at most larger ADT locations. If you work at a location that does not offer the screenings, you can see your doctor for the screening. See the **Medical** section of this SPD for more information on coverage and **Health Care Provider Form** to submit the screening.

To register for an on-site health screening, ADT employees can access the Wellness Portal at **MyADTHR > Wellness Portal > Healthy Rewards > Biometric Screening.** Spouses/domestic partners (and employees not on the network) can go to **ADTwellness.staywell.com > Healthy Rewards > Biometric Screening**. Although walk-ins may be accepted if slots are available, scheduled appointments will take priority.

Spouses/domestic partners enrolled in the Medical Plan can participate in an on-site biometric screening, but will need to pre-register for the screening, sign in with security, and be escorted by the employee to participate.

Health Care Provider Form (HCPF)

If you are unable to attend an on-site biometric screening, or if one is not being offered at your location, you can download a Health Care Provider Form (HCPF) between January 2 and November 30 at **MyADTHR > Wellness Portal > Healthy Rewards > Biometric Screening** or **ADTwellness.staywell.com > Healthy Rewards > Biometric Screening**. Once completed, you should fax the form to StayWell at **1-800-239-5731** before November 30.

By participating in the biometric screenings, you and your spouse or domestic partner on the Medical Plan may become eligible for certain Healthy Rewards cash rewards. For more information see "Healthy Rewards Cash Reward Incentive" later in this section.

Health Assessment

The Health Assessment is an important tool for determining your current health condition. It gives you a snapshot of what you're doing well and where you can make improvements. Your Health Assessment results can help you make important health decisions going forward.

The Health Assessment is a questionnaire about your health that takes 15 to 20 minutes to complete. The questions are simple and your answers are entirely confidential. If you complete an on-site health screening, or submit a completed HCPF your health values will be pre-populated within two to three weeks into this year's Health Assessment for your convenience. You can also input your biometric screening results directly into the Health Assessment.

ADT has partnered with StayWell Health Management, a third-party administrator, to provide Wellness Program services. All employees are eligible to participate in the Health Assessment. Dependents age 18 or over who are enrolled in the Medical Plan can also participate in the Health Assessment.

After you submit your Health Assessment, you'll receive instant personal results and an invitation to participate in follow-up programs that meet your unique health needs. Use your Health Assessment results to drive healthy changes to your current lifestyles.

By participating in the Health Assessment, you and your spouse or domestic partner may become eligible for certain Healthy Rewards cash rewards. For more information see "Healthy Rewards Cash Reward Incentive" later in this section.

Important Information Regarding Confidentiality

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, among other things, is designed to ensure the privacy of your health information. Under HIPAA, medical plans (such as ADT's Medical Plan) may use personal health information for payment and operation of the Medical Plan. However, there are limits on the circumstances under which the Medical Plan may disclose your health information.

ADT will not receive the specific results of your answers to the Health Assessment and/or biometric screening. StayWell may use and/or provide participation information to your employer or its contracted entities that administer your plan for incentive fulfillment purposes. StayWell may also use this information to provide you with other services on behalf of your employer. Your participation serves as your consent for StayWell to use and/or provide this information.

StayWell's Role

ADT has partnered with StayWell Health Management to administer the Wellness Program. StayWell also runs the logistics of the on-site biometric screenings. StayWell compiles de-identified (meaning all personal information has been removed), aggregate data reports for ADT. StayWell is subject to the privacy requirements of HIPAA for "business associates" and will take all action required by law to protect your protected health information.

For More Information

This is only a brief summary of HIPAA. As a participant in the Medical Plan, you'll review a "privacy notice" that more fully describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a copy of this notice at no cost, contact the Plan's Privacy Officer or go to **ADTwellness.staywell.com > My Account**.

Health Coaching, Maternity or Member Management Program

Once you have your Health Assessment results, you can decide on steps to take toward living your best life. Perhaps you're ready to quit smoking or to start an exercise program. Perhaps you are pregnant or have a chronic health condition and could use some advice. As described in the charts below, the Health Coaching, Maternity or Member Management Program will provide you with the support necessary to help you reach your goals. You'd be surprised at how motivating a partner can be in your health improvement plan.

Employees and dependents age 18 or over who are enrolled in the Medical Plan can participate in the Health Coaching program. The "Baby Yourself" maternity program and Member Management program are available to employees and dependents who are enrolled in the Medical Plan regardless of age.

Your Health Assessment results will help you to determine which programs best fit your lifestyle and health goals. You decide which programs are right for you and enroll as described below. Note that Health Coaching is available via two options: phone coaching or online coaching.

Health Coaching Topics (Phone)	
Back care Blood pressure Cholesterol Nutrition Physical activity Stress management Tobacco cessation Weight management	To participate in the Phone Coaching Program enroll at **MyADTHR > Wellness Portal > Healthy Rewards** or call **1-855-428-6328**.
Health Coaching Topics (Online)	
Easy Start Get in Shape Healthier Diet Healthy Aging Healthy Heart Healthy Kids Healthy Seniors Smoke Free Stress Relief Weight Loss	To participate in the Online Coaching Program, enroll at **MyADTHR > Wellness Portal > Healthy Rewards** or call **1-855-428-6328**.
Maternity Management Program Topics	
Pregnancy	A Member Management nurse may contact you through your Medical Plan carrier (Blue Cross Blue Shield) based on your claims data to help you during a pregnancy. Or you can participate in the Maternity Management Program by contacting the "Baby Yourself" maternity program at **1-800-222-4379**.
Member Management Program Topics	
Chronic Conditions	A Member Management nurse may contact you through your Medical Plan carrier (Blue Cross Blue Shield) based on your claims data to help you with a chronic condition such as asthma, cancer, diabetes, and hypertension. If you have questions, you may contact the Member Management Program at **1-888-841-5741**.

Health Coaching programs are offered via personalized phone or online coaching. If you choose to participate one-on-one with a health coach over the phone, he/she will give you helpful tips, encouragement, and ideas for success. If you prefer to work independently, you can enroll in an online program.

Completion of a phone-based coaching program is at least three sessions with a health coach and online coaching is six sessions and a post survey.

Health Challenges

By participating in a Health Challenge, you and your dependents may become eligible for certain Healthy Rewards cash rewards. Health Challenges are typically at least six weeks in length and require tracking and a post-survey for completion. Challenge topics include: physical activity, nutrition, stress management, etc.

All employees are eligible to participate in the Health Challenge. Dependents age 18 or over who are enrolled in the Medical Plan can also participate in the Health Challenge.

ADT will choose from a variety of challenges to offer per year.

eConference Series

The eConference Series is an eight-week buddy coaching program. It includes a variety of weekly presentations with a StayWell Health Coach with goal sharing and motivation from other participants. The program is held via conference call and webinar. Participants must complete at least six of the eight sessions to be considered for the Healthy Rewards cash rewards.

Employees and dependents age 18 or over who are enrolled in the Medical Plan can participate in the eConference Series.

Topics include:

- Stress management and resiliency
- Weight management

Registration for these eConference Series is through the Learning Management System (LMS) which can be found via **MyADTHR**. For more information visit **ADTwellness.staywell.com**.

Online Classrooms

To learn more about healthy behaviors you can incorporate into your routine, you can go to the Wellness Portal to complete four interactive courses that cover topics such as safety, stress management, healthy eating, and more.

All employees are eligible to participate in the Online Classrooms. Dependents age 18 or over who are enrolled in the Medical Plan can also participate in the Online Classrooms.

However, only you and your spouse/domestic partner on the Medical Plan may become eligible for certain Healthy Rewards cash

Online Classroom topics include:

- Stress Management 101
- Physical Activity 101
- Back Care Basics
- Tobacco Basics

By completing all of the four Online Classrooms, you and your spouse/domestic partner on the Medical Plan may become eligible for certain Healthy Rewards cash rewards.

Local Wellness Activities

To get healthy, you don't have to go at it alone. Wellness events are being held at many work site location. Events include:

- Exercise classes
- Lunch and learns
- On-site weight management programs with your co-workers
- Walking challenges

All ADT employees can participate in Local Wellness Activities; however dependents must be age 18 or over and enrolled in the Medical Plan. You can earn incentives only if you are an Medical Plan participant.

You can also earn reward dollars by participating in local activities such as physical activity at a local fitness center, group exercise/yoga studio classes, or charity walk/runs.

By connecting to **MyADTHR > Wellness Portal >Healthy Rewards** you can review the Local Activity list and the requirements to achieve activities, self-report your activities online, and track your rewards. You and your spouse/domestic partner are eligible for two rewards for completing Local Wellness Activities each year. Rewards are credited only to the person who is enrolled in the Medical Plan.

The Wellness Program is committed to helping you and your spouse/domestic partner achieve your best health. If you think you might be unable to participate in Local Wellness Activities, the other components of the Wellness Program described in this SPD are available to you. If you are concerned, contact StayWell at **1-855-428-6328** and they will be happy to work with you to provide alternatives and make sure you achieve your health goals and are eligible for all of your reward dollars.

Wellness Support Resources

Having a strong support system can help you stay focused on your goals. You can contact StayWell Health Management online at **MyADTHR > Wellness Portal**. You and your spouse/domestic partner can also visit **ADTwellness.staywell.com** or call the StayWell HelpLine at **1-855-428-6328** during these hours:

Monday through Thursday from 8 a.m.to 8 p.m. (Central time)
Friday from 8 a.m.to 6 p.m. (Central time)
Saturday from 8 a.m.to 1 p.m. (Central time)

You can also contact the Employee Assistance Program (EAP) or 24-Hour Nurseline if needed.

Wellness Portal

Many of the programs that are included in the Wellness Program are facilitated through a Wellness Portal administered by StayWell® Health Management, a third-party administrator. If you are logged on to the ADT network, you can access the site through **MyADTHR.com > Wellness Portal**. If you are not logged on to the ADT network, you can go directly to StayWell at **ADTwellness.staywell.com**.

The Wellness Portal contains the Health Assessment, biometric screening information and registration, the Health Care Provider Form, Health Coaching information, Health Challenge information, eConference Series, Healthy Rewards Cash Reward Incentive tracking, and other general health information. **Please note:** See "Wellness Benefits at a Glance" earlier in this section for information on the availability of these benefits for you and your dependents.

All employees have access to the Wellness Portal. Dependents age 18 or over who are enrolled in the Medical Plan should log in directly at **ADTwellness.staywell.com**. Wellness Program services and incentive tracking information will be specific to each individual.

This website also provides access to the latest health findings and information about a specific health topic.

Whatever your questions, the Wellness Portal is a valuable resource for health and wellness information.

Healthy Rewards Cash Reward Incentive

The Healthy Rewards Cash Reward Incentive program is designed to encourage you and your spouse/domestic partner covered by the Medical Plan to take steps to improve your health. When you complete qualified Wellness Activities, you receive Healthy Rewards cash rewards. These cash rewards can be used to help offset medical costs not otherwise covered by the Medical Plan (copays, coinsurance, deductibles) or in any way you wish. The program is administered by StayWell® Health Management, a third-party administrator. If you and your spouse/domestic partner are not covered by the Medical Plan, you will still be able to participate in some Wellness Activities and the Wellness Portal. However, Healthy Rewards cash rewards are only awarded to employees and their spouses/domestic partners who are enrolled in the Medical Plan.

The path to health really pays off. By participating in the Healthy Rewards program between January 1 and November 30, employees and spouses/domestic partners who are enrolled in the Medical Plan can save money throughout the year and get healthier in the process. You can earn up to $400 for individual coverage or up to $600 if both you and your covered spouse/domestic partner are enrolled in the Medical Plan and complete certain health activities throughout the year. All cash rewards paid under the program will be taxable compensation to you.

Please note: You can earn up to $400 in Healthy Rewards cash rewards if you have individual coverage under the ADT Medical Plan and you complete Healthy Rewards activities. You can also earn up to an additional $200, for a total of $600, if your covered spouse/domestic partner on the Medical Plan also completes Healthy Rewards activities. To qualify for the Healthy Rewards cash reward you must be currently enrolled in the Medical Plan, and employed at the time of payout.

Healthy Rewards cash rewards earned by you and your spouse/domestic partner are taxable and paid monthly in your paycheck for activities completed through the previous month. You can track your cash reward earnings between January 1 and November 30 at **MyADTHR.com > Healthy Rewards**.

If you are not enrolled in the Medical Plan, you can access and participate in many of the Wellness Activities; however, you will not receive the Healthy Rewards cash reward. If you are enrolling in medical coverage for the first time, cash rewards for your participation in any Healthy Rewards activities will be applied after you are enrolled. Residents of Hawaii who are enrolled in the HMSA (Blue Cross Blue Shield of Hawaii), can participate in the Healthy Rewards Cash Reward Incentive program and receive cash rewards; however, you may not have access to all qualified Wellness Activities.

The chart that follows lists the Healthy Rewards Cash Reward Incentive program activities:

Activity	Description	How To Complete Activity	Maximum Incentive Credit
Complete the Health Assessment.	Available on your PC, smartphone, or tablet, the Health Assessment provides you with a personal health score and individualized plan for improvement. It will also point you to Wellness Program services that may be of the most benefit to you.	Select the Health Assessment on the Wellness Portal or contact **1-855-428-6328** to request a paper copy. (ADT will not see your individual results.)	$125 per year for each ADT employee covered by the Medical Plan. $50 per year for each spouse/domestic partner covered by the Medical Plan.
Complete a Biometric Screening Form to Know Your Numbers.	These screenings can help you understand your current health and alert you to health risk factors you may not know about. A quick blood draw and a little bit of your time is all it takes to begin your journey to a healthier you.	Complete an on-site biometric screening or print the Health Care Provider form found on the Wellness Portal. (ADT will not see your individual results.)	$125 per year for each ADT employee covered by the Medical Plan. $75 per year for each spouse/domestic partner covered by the Medical Plan.
Complete a Health Coaching, Maternity or Member Management Program.	Everyone could use a little support when it comes to managing weight, quitting smoking, stressing less, managing a chronic condition, or just learning to live healthier. Health Coaching is available via phone or online. Maternity and Member Management is available via phone. You'd be surprised at how motivating a partner can be in your health improvement plan!	Health Coaching: Enroll via the Wellness Portal or contact **1-855-428-6328**. Maternity Management: Contact the "Baby Yourself" maternity program at **1-800-222-4379** (Monday – Friday: 7 a.m. – 6 p.m. Central). Member Management: Contact the Member Management Program at **1-888-841-5741**.	$100 per completed program for ADT employees covered by the Medical Plan. Maximum of three programs per year. $50 per completed program for covered spouse/domestic partner covered by the Medical Plan. Maximum of three programs per year.

Activity	Description	How To Complete Activity	Maximum Incentive Credit
Complete a Health Challenge or eConference Series.	Participate in an ADT Health Challenge and work to get healthier alongside your coworkers. Participate in an ADT Health Challenge or eConference Series and work to get healthier together. Track your progress on the Wellness Portal.	Sign up for challenges on the Wellness Portal. Register for an eConference Series via the LMS Training Program through MyADTHR.	$50 per completed program for ADT employee covered by the Medical Plan. Maximum of three programs per year. $25 per completed program for spouse/domestic partner covered by the Medical Plan. Maximum of three programs per year.
Complete Online Classroom Series.	To learn more about healthy behaviors you can incorporate into your routine, go to the Wellness Portal to complete four interactive courses that cover topics such as safety, stress management, healthy eating, and more.	Online courses are also available on the Wellness Portal under the Program tab.	$50 per completed program for ADT employee covered by the Medical Plan. Maximum of one series per year. $25 per completed program for spouse/domestic partner covered by the Medical Plan. Maximum of one series per year.
Participate in local Wellness Activities.	To get healthy, you don't have to go at it alone. Check out if wellness events are being held at your work site location or participate in local activities such as physical activity at a local fitness center, group exercise/yoga studio, charity walk/runs, personal training sessions, on-site lunch and learn, or on-site weight management programs.	Review the Local Activity list on the Wellness Portal to see requirement to achieve activity and self-report activity online.	$50 per completed activity for ADT employee covered by the Medical Plan. Maximum of two activities per year. $25 per completed activity for spouse/domestic partner covered by the Medical Plan. Maximum of two activities per year.

You can find your completed activities, details regarding your credits, and the progress your spouse/domestic partner has achieved towards the maximum goal.

Many of your online Healthy Rewards Cash Reward Incentive program activities will be immediately displayed, whereas other activities, such as completing your biometric screening, will display as soon as administratively possible.

Dental

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Dental Benefits at a Glance

ADT offers two Dental Plan options. The options available to you depend on where you live.

- The Standard Dental Plan (available at all locations).
- The Dental Maintenance Organization (DMO) Plan (available at many locations).

The Dental Plan is separate from the Medical Plan and Prescription Drug Program. As a result, you make separate enrollment decisions for this plan, and can make different coverage level decisions: Individual, Employee+1, or Family coverage.

Overview of the Dental Options

The Standard Dental Plan and DMO options are similar in many ways, but there are some important differences between the options. Both options provide three types of coverage for you and your family, and both cover orthodontic services (with different eligibility requirements).

Types of Coverage
▪ **Preventive and diagnostic care**, such as oral exams, X-rays and routine cleanings. ▪ **Basic care,** such as fillings, tooth extractions, root canals, and periodontal services. ▪ **Major care**, such as crowns, bridges, and dentures. ▪ **Orthodontia.**

The plans cover expenses differently, with different deductible, coinsurance, and copay rules. More importantly, the Standard Dental Plan lets you use any dentist that you want, while the DMO covers in-network dentists only.

How the Standard Dental Plan Works

This option offers a network of dentists throughout the United States. You can see any dentist you wish, but when you visit an in-network dentist, you pay less for care. The plan works like this:

- You can choose any licensed dentist you wish. But you'll pay lower costs when you choose in-network providers.
- The plan pays 100% of eligible preventive care expenses. You don't need to meet the deductible before these expenses are paid.
- For eligible basic and major care expenses, you must meet an annual Dental Plan deductible before the plan starts to pay benefits. Once you satisfy the deductible, the plan pays a percentage of covered charges and you pay the remaining amount. This cost-sharing is called coinsurance. You can receive up to $1,500 in basic and major care expenses each year.
- The plan also covers orthodontia expenses for child(ren) up to age 19, up to a lifetime maximum of $1,500.

- The plan pays the same percentage of charges, whether you use in-network or out-of-network providers. However:
  - In-network dentists have agreed to charge lower costs for their services, so your portion of costs is lower when you use in-network providers. For more information, see the box to the right.
  - When you use out-of-network providers, the plan pays eligible charges, up to the reasonable and customary limit. You pay the remaining percentage of charges, plus any amount that exceeds the reasonable and customary limits.

In-network dentists have agreed to charge lower rates to ADT employees. You can find in-network dentists online at **MyADTHR.com** > **Health & Group Benefits > Dental Plans** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

How the Dental Maintenance Organization (DMO) Plan Works

The DMO Plan is available at many ADT locations. When you enroll, you'll receive information on whether this option is offered to employees in your zip code.

This option offers a lower-cost alternative to the Standard Dental Plan. If you elect this option, you must select an in-network dentist before you receive care, and you must use in-network dentists to receive plan benefits. **No benefits are paid if you use dentists that do not participate in the DMO network.** The plan works like this:

- You don't need to meet an annual deductible under the DMO.
- The plan pays the full cost of preventive care and basic services, and a percentage of charges for major services.
- The plan also covers orthodontia treatment for child(ren) and adults. The plan pays the full cost of eligible charges after you pay a $2,000 copay. Coverage is limited to 24 months of treatment plus 24 months of retention.
- You must use in-network providers to receive any benefits from the DMO Plan. For a list of in-network providers, visit **MyADTHR.com > Health & Group Benefits > Dental Plans**.

Comparison of Standard Dental Plan and DMO Plan

The chart that follows compares key features of the Standard Dental Plan and DMO Plan.

	Standard Dental Plan	DMO Plan
Claims Administrator	Aetna	
Provider Network	Available at all ADT locations	Available at many ADT locations
Calendar Year Deductible (must be met before benefits are paid unless otherwise noted)		
▪ Preventive and diagnostic care and orthodontia	No deductible	No deductible
▪ Basic and major care (combined)	$50 per covered person	No deductible
Copays and Coinsurance	**Plan Pays**	**Plan pays**
▪ Preventive and diagnostic care (oral exams, X-rays, and routine cleanings)	100%; no deductible	100%; no deductible
▪ Basic care (fillings, tooth extractions, root canals, and periodontal services)	80% after deductible	100%; no deductible*
▪ Major care (crowns, bridges and dentures)	50% after deductible	60%; no deductible
▪ Orthodontia		
– Treatment and retention	50%; no deductible	100% after $2,000 copay
– Covered persons	Child(ren) under age 19	Child(ren) and adults
▪ Temporomandibular Joint Disorder (TMJ) related appliances	50% after deductible	Not covered
Maximum Benefits		
▪ Cleanings	2 per year	No maximum
▪ Basic and major care	$1,500 per year	No maximum
▪ Orthodontia	$1,500 per lifetime	24 months of treatment; 24 months of retention

*Certain tooth extractions, root canals, and periodontal services may be considered major care.

If you enroll in the Health Advantage Plan with associated Health Savings Account, you can pay your share of dental costs with the tax-free money from your account. If you are not covered by the Health Advantage Plan with associated Health Savings Account and maintain a Flexible Spending Account for health care expenses, you can use your Flexible Spending Account to pay your share of dental expenses on a pre-tax basis.

How Charges Are Covered under the Standard Dental Plan

Using In-Network Providers

With the Standard Dental Plan, you may see any licensed provider you want for care. However, your out-of-pocket costs are lower when you use dentists who participate in the dental network. In addition, you don't need to file claims when you use in-network providers.

There are several advantages to using in-network dentists:

- You have access to one of the nation's largest dental networks, with participating dentists located in all 50 states and Puerto Rico.
- When you use in-network dentists, your out-of-pocket costs are lower because the plan has negotiated special rates with participating dentists.
- PPO dentists will:
  - File claims for you (See "Filing Claims under the Standard Dental Plan" later in this section for more Information);
  - Accept the plan's reimbursement rate (up to the annual maximum); and
  - Not bill you for additional charges (like charges above the Reasonable and Customary [R&C] charge for that service). You will be billed for any deductibles and coinsurance that apply.

To locate a participating dentist, visit **MyADTHR.com > Health & Group Benefits > Dental Plans** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Reasonable and Customary (R&C) Charges

If you go to a dentist who participates in the dental network, the plan will pay benefits based on the prenegotiated fees charged by the dentist. If you go to an out-of-network dentist, the plan will pay benefits based on the reasonable and customary (R&C) charge for the service. R&C charges refer to the amounts that are generally charged in your geographic area for those services. If your out-of-network dentist charges more than the R&C charge for a service or treatment, you must pay the amount that exceeds R&C.

To understand what charges you will have to pay for services, you may want to review the charges with out-of-network dentists **before** you receive treatment. In addition, you should also obtain a pre-determination of benefits from the Claims Administrator before starting any major or orthodontic services with in-network or out-of-network providers. A pre-determination lets you know how much the plan will pay, and what you will have to pay, before you receive dental services. See "Pre-Determination of Benefits" later in this section for more information.

Eligible Expenses under the Standard Dental Plan

How Expenses Are Covered

The Standard Dental Plan covers a wide variety of necessary dental services (as defined by the plan), up to the R&C charge for those services. To be covered under the plan, services you receive must be furnished while you are a participant in the plan.

When a particular dental problem can be treated by two or more procedures, the plan covers the amount equal to the R&C charge for the least expensive procedure that would produce a professionally satisfactory result based on common dental practice.

The maximum benefit for preventive and diagnostic, basic, and major services combined is $1,500 per year for each covered person. The lifetime orthodontia maximum is $1,500 per covered dependent child under age 19.

Here is a summary of the benefits the plan provides for covered services.

Services are considered to be necessary if they are:

- Ordered by a dentist or doctor;
- Recognized throughout the doctor's or dentist's profession as safe and effective;
- Required for the diagnosis or treatment of the particular condition;
- Employed appropriately in a manner and setting consistent with generally accepted dental standards; and
- Not educational, experimental, or investigational in nature.

Preventive and Diagnostic Services

Preventive and diagnostic services are covered at 100% of the R&C charge with no deductible. These services include:

- Application of sealants to permanent teeth for child(ren) under age 14 (one application per tooth).
- Routine bitewing X-rays, limited to two sets per year.
- Cleanings (prophylaxis) performed by a dentist or licensed dental hygienist, limited to two per year.
- Diagnostic X-rays and laboratory procedures.
- Routine examinations, limited to two per year.
- Fluoride treatments for child(ren) under age 19, limited to two per year.
- Full mouth or Panoramic X-rays, one set in any 36 consecutive month period.
- Space maintainers for missing primary teeth.
- Temporary treatment needed to ease dental pain.
- Vertical bitewings limited to one set in any 36-consecutive-month period.

Basic Services

Basic services are covered at 80% of R&C charges after your annual deductible has been met. These services include:

- General anesthesia for oral surgery, except when due to pre-orthodontic treatment.
- Consulting with your doctor or dentist when required, except when due to pre-orthodontic treatment.
- Emergency care and treatment of the jaw or natural teeth received within 72 hours after the first visit.
- Extractions, including surgical removal of impacted wisdom teeth.
- Fillings—amalgam, silicate, acrylic, and composite.
- Medicines or prescribed drugs for dental conditions which are dispensed by the dentist.
- Oral surgery performed by your dentist or doctor within six months of an accidental injury to your jaw or natural teeth (prosthetic devices are included). If you are covered under the Medical Plan, then this procedure will be covered under that plan.
- Periodontal therapy to stop any severe and recurring symptoms, including periodontal prophylaxis and occlusal adjustments.
- Relining or rebasing after six months from the date of placement of a denture, limited to one relining or rebasing in any 36-consecutive-month period.
- Repair of dentures or bridgework.
- Root canal therapy (endondotics).
- Surgery to prepare dental ridges for prosthetic appliances.

Major Services

Major services are covered at 50% of R&C charges after your annual deductible has been met. These services include:

- First placement of a bridge.
- First placement of partial or full dentures to replace teeth lost or removed while covered under the plan.
- Implants to replace teeth that were lost or removed while covered under the plan—but only to the extent a fixed bridge would have been covered.
- Inlays, onlays, crowns, and buildups for crowns when the tooth cannot be restored with a filling or when needed as a support for a bridge.
- Replacement of a bridge or denture when not serviceable, if:
  - At least five years have passed since the last placement; or
  - The existing denture cannot be used because of the first placement of an opposing full denture.
- TMJ-related appliances including X-rays specific for TMJ treatments and occlusal orthotic appliances, if necessary.

Any benefits paid for temporary crowns, bridges, or dentures will be subtracted from benefits paid for permanent crowns, bridges, or dentures. The total benefit paid for temporary dentures cannot exceed the maximum benefit payable for permanent dentures.

Orthodontic Services

Orthodontic services are covered at 50% of R&C charges with no deductible; limited to covered dependent child(ren) under age 19. These services include:

- Correction of malocclusion by wire appliances, braces, and other mechanical aids.
- Initial diagnostic procedures.

Benefits are payable if the braces are placed while the child is covered under the plan. Reimbursement is made for initial placement and monthly case fees. The lifetime orthodontia maximum per covered dependent child is $1,500.

Before receiving orthodontic services, remember to request a pre-determination of benefits from the plan.

If you start orthodontic treatment before dental plan coverage goes into effect, coverage for continuing treatment may be excluded.

Charges that Are Not Covered under the Standard Dental Plan

While the Standard Dental Plan provides coverage for a wide range of dental services, there are some services that are not covered, even if your dentist approves or recommends them. Here are some of the services that the plan does not cover:

- Accidental injury suffered while working for pay or profit. The plan will pay benefits for certain covered individuals who are not eligible for coverage under Workers' Compensation laws, any occupational disease law, or any similar legally mandated coverage.
- Charges incurred after coverage ends, even if services were started before the termination of coverage,
- Charges over the R&C charge, as determined by the claims administrator, subject to review by the plan administrator,
- Illness or accidental injury during the commission of a crime or participation in the commission of a crime,
- Cosmetic dentistry, except when:
  - Necessary because of a non-work-related accidental injury that occurred while you or your family member was covered by the plan.
  - Facings for crowns on molar teeth are needed because of an accidental injury.
  - Necessary because of a birth defect or sickness of one of your child(ren) who was born while you or your spouse had dependent coverage.
- Dietary planning, plaque control, or oral hygiene instruction.

- Any educational service or treatment. (A service or supply is considered educational if the primary purpose of the service or supply is to provide the covered person with any training in the activities of daily living.)
- Any experimental or investigational service or treatment. (An experimental or investigational treatment is one that is still under study. In addition, the service or treatment has not yet been recognized throughout the dental profession in the U.S. as safe and effective for diagnosis or treatment under the accepted standards of dental practice as determined by the Food and Drug Administration [FDA] and the American Dental Association [ADA].)
- Illness or accidental injury suffered in a fight in which the covered person is the aggressor.
- First placement of dentures or bridgework or implants to replace teeth lost or removed before coverage under this plan began.
- Fluoride treatments after age 18.
- Any dentures, crowns, inlays, onlays, bridgework, or other appliances or services mainly intended to increase vertical dimension.
- Charges for missed appointments or completion of claim forms.
- Charges for care that is not appropriate, not necessary, or not required.
- Charges you would not have to pay if you did not have coverage under the plan.
- Orthodontic services for individuals age 19 and over or charges for any course of treatment begun before the coverage effective date.
- Any restorations or treatment used mainly to keep periodontally involved teeth from moving or to restore occlusion.
- Treatment or services provided by you, a member of your household, or a family member, including your spouse, your domestic partner, or a child, brother, sister or parent of yourself, your spouse or your domestic partner.
- Replacement of dentures or bridgework if less than five years has passed since the last placement, except as specified under the plan.
- Replacement of a lost or stolen prosthetic device or appliance.
- Intentionally self-inflicted injury, whether inflicted while the covered person is sane or insane.
- Services for which you do not pay, including those provided by the government, a labor union, a trustee, a school, or any other group.
- Any charges for services not specifically covered under the plan.
- Any charges for a course of treatment begun before the coverage effective date.
- Illness or accidental injury resulting from an act of war, whether declared or undeclared, armed aggression, or military service.

Pre-Determination of Benefits

If your dentist recommends that you or a covered family member receives major or orthodontic services, or services totaling more than $200, you should request a pre-determination (sometimes called a pre-treatment estimate) of the benefits payable under the plan.

The pre-determination of benefits is intended to provide you and your dentist with an estimate of how services may be covered under the plan. Based on the pre-determination of benefits, you and your dentist may revise the treatment plan or prepare a payment schedule, if necessary.

To obtain a pre-determination, ask your dentist to submit a regular claim form to the claims administrator, indicating that it is for a pre-determination of benefits. In most cases, your request for a pre-determination of benefits will be processed in approximately three weeks.

Please note: For many dental problems, there may be more than one acceptable course of treatment. When two or more procedures are available for a particular dental problem, the plan covers the least expensive procedure that will produce a professionally satisfactory result, based on common dental practice.

Keep in mind that the pre-determination of benefits procedure does not guarantee coverage of, or payment for, a particular condition or treatment—even when recommended by your dentist. For example, if you cancelled your dental coverage during Benefits Annual Enrollment, dental services obtained after the cancellation effective date would not be covered, even if you had obtained a pre-determination of benefits.

Also remember that a pre-determination of benefits is not a recommendation about your treatment, only an advance determination of whether the treatment will be covered under the plan. Whether or not to receive treatment is always your decision.

Filing Claims under the Standard Dental Plan

Dentists participating in the network will file claims for you. In some cases, out-of-network dentists also will file claims directly with the claims administrator. If an out-of-network dentist will not file claims for you, you will need to pay for your services up front when you receive care, then file a claim form for reimbursement. Follow these steps to file a claim:

- Visit **aetna.com** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to obtain claim forms. All the information you need to file a claim is shown on the dental claim form, including the toll-free number for the claims administrator.
- Complete and sign the “Employee” sections of the form.
- Give the form to your dentist to complete and sign the “Dentist” sections of the form.
- Submit the completed form, together with your original dental bill(s), to the claims administrator at the address listed on the claim form.

Your bills for dental expenses must be on the dentist’s or doctor’s letterhead and include all information necessary to process the claim, including:

- Employee’s name and member ID number.
- Patient’s full name.
- Provider’s full name, address, and taxpayer ID number.
- Nature of the dental services.

- Date and type of treatment or services rendered.
- Itemized charges.

In most cases, your claim should be filed within 90 calendar days of the beginning of treatment or dental services. Claims must be submitted within one year of the date of service. Claims submitted more than one year after the date of service will not be paid.

Generally, the claims administrator will process the claim and make payment or issue a denial notice within 20 calendar days of receipt of the claim.

If a Claim Is Denied

If your claim is denied in whole or in part, you will receive a claim denial notice setting forth the reasons for the denial and explaining how to appeal the denial. You may then appeal the denial. See the **Claim Review and Appeal Processes** section of this SPD for information on the claim denial and how to file an appeal.

Coordination of Benefits if You Are Covered by another Plan

If you receive care that is also covered under another group dental or health care plan, your benefits under this plan may be coordinated with the other coverage. For more information, see the **Coordination of Benefits** section of this SPD.

How Charges Are Covered under the DMO Plan

The DMO Plan, available in many locations, is a low-cost option if you're willing to use in-network providers.

Key features of the DMO Plan include:

- There is no annual deductible to meet, and no claim forms to file.
- There are no copays required for preventive and basic services.
- Each family member chooses his/her own in-network dentist.
- Orthodontic services are covered for child(ren) as well as adults—with no lifetime maximum—after you satisfy a $2,000 copay.

Please remember: Under the DMO Plan, you **must** use an in-network dentist to receive coverage. Visit **MyADTHR.com > Health & Group Benefits > Dental Plans** for a list of in-network providers.

Using In-Network Providers

You must use in-network providers under the DMO—the plan does not cover out-of-network care. To receive benefits, you must select a Primary Care Dentist (PCD) who is a member of the DMO network.

If you're thinking of enrolling in this option, check to see if your dentist is in the network or if there's an in-network dentist in your area who is accepting new patients. If you do not see this option on your enrollment information, it is because you do not live in an area that has in-network dentists available. DMO network areas are updated annually; therefore, your eligibility for this option is subject to change.

Please note: Should you move and your new address is no longer in a DMO network area, you will be sent enrollment information and will have 31 calendar days to elect replacement dental coverage. If you fail to elect replacement dental coverage during that time, you will not be able to re-enroll in dental coverage until the next Benefits Annual Enrollment period.

Finding In-Network Providers

You will need to select a PCD before receiving care. Your PCD will manage your overall dental care and is your key to maximum coverage. Each covered family member can select his/her own PCD. To find a participating dentist is your area, visit **MyADTHR.com > Health & Group Benefits > Dental Plans**.

Your PCD keeps a roster of eligible patients that is updated monthly. Your name will appear on this roster when it is updated, the month after your selection. Call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** if your dentist needs to confirm your eligibility.

Specialty Referrals

Services performed by specialists are eligible for coverage only when prescribed by the PCD and authorized by the insurance carrier. If payment is based on a negotiated fee, then your copay will be based on the same negotiated fee. If payment is on another basis, then the copay will be based on the dentist's usual fee for service.

You can visit an orthodontist without first obtaining a referral from your PCD.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving/stabilizing) of a dental emergency, you are covered 24 hours a day, seven days a week. You should contact your PCD to receive treatment. If you are unable to contact your PCD, or you are more than 50 miles from your home address, you should contact Aetna for assistance with locating a dentist. If you receive treatment from a non-participating dentist more than 50 miles away from your home, then the emergency services will be covered up to a maximum of $100. You must submit a claim to the insurance carrier in order to receive benefits.

Eligible Expenses under the DMO Plan

How Expenses Are Covered

The DMO Plan covers a wide range of necessary dental services as defined by the plan. To be covered under the plan, services you receive must be furnished while you are a participant in the plan. When a particular dental problem can be treated by two or more procedures, the plan covers the least expensive procedure that would produce a professionally satisfactory result based on common dental practice.

Please note: There are certain state-specific requirements that may change or limit the provisions of the DMO coverage described in this Summary Plan Description. If you live in a state that has such requirements, those requirements will apply to your coverage and will be part of the Group Insurance Certificate issued by the insurance carrier. See the Claims Administrator Directory for how to access additional information from the insurance carrier regarding state-specific requirements.

Traveling Abroad

You take your health care benefits, including dental coverage, with you when you are abroad. The standard plan does allow benefits outside of the US. ADT employees have the same benefits as provided in the states. Most out of country providers will not file the claim. Therefore, you will need to get a detailed receipt of services rendered and file with a claim form (Aetna will reimburse the member).

With the DMO, members can only receive emergency care benefits. Once in the U.S., you will need to complete the treatment needed with your DMO provider.

For more information, see the **Additional Benefits** section of this SPD.

Traveling Between U.S. and Canada

Employees may require travel between the U.S. and Canada either for Company or leisure-related reasons. Your benefits will continue with you while abroad. The chart below summarizes how your coverage options compare as a U.S. employee both in the U.S. as well as a U.S. employee travelling to Canada.

Employee Location	Coverage			
	Medical	Prescription Drug	Dental	Vision
U.S. Coverage	PPO, Health Advantage Plan with Associated Health Savings Account (through BCBS)	Prescription Drug Plan (through CVS)	DMO, Standard (through Aetna)	Vision Plan (through EyeMed)
U.S. Employee Coverage in Canada*	BCBS BlueCard Worldwide No limit on duration of visit	Prescription Drug Plan (through CVS via claim form submission) No limit on duration of visit; claim form must be submitted within one year	DMO, Standard (through Aetna for emergencies only via claim form submission) No limit on duration of visit	Vision Plan (through EyeMed via out-of-network claim form submission) with same benefit frequency

*For Medical, Prescription Drug, and Dental, claims are determined as in-network or out-of-network depending on provider.

Vision

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Vision Benefits at a Glance

The ADT Health and Welfare Benefits Plan includes vision coverage. You can elect this coverage when you enroll for benefits each year.

Coverage is available to employees throughout the United States, including Hawaii and Puerto Rico.

The Vision Plan is separate from ADT's other health care programs. As a result, you make separate enrollment decisions for this plan, and can make different coverage level decisions: Individual, Employee+1, or Family coverage.

Overview of the Vision Plan

The Vision Plan helps you save money on routine vision care to diagnose and correct visual acuity. Coverage includes costs for routine eye exams, eyeglass frames, contact lenses, and more. EyeMed Vision Care administers the plan. You can receive services from in-network independent providers and retailers such as LensCrafters®, Sears Optical℠, Pearl Vision, Target Optical®, and JC Penney® Optical. The plan works like this:

You can find a list of in-network vision providers online at the claims administrator's website, **eyemedvisioncare.com**. You also can call EyeMed to find out if a provider is in the network.

- The plan provides different benefits depending on whether you use in-network or out-of-network providers. For more information, see "Finding In-Network Providers" later in this section.
- The plan pays the full cost of one in-network eye exam each year after you pay a $10 copay.
- When you use in-network providers, the plan also covers one pair of frames every 12 months and one pair of lenses (either eyeglass lenses or contact lenses) every 12 months, up to a $130 allowance. Your benefits include coverage for various lens options. Some products are subject to a copay or a maximum benefit. The plan will cover standard plastic lenses in lieu of contact lenses after a $20 copay for single, bifocal, or trifocal lenses. Progressive lenses are also covered after a copay.
- If you want to purchase additional eyeglasses or contact lenses, the plan provides discounts on the additional purchases.
- The plan also provides discounts on costs for Lasik or PRK surgery from eligible providers.
- All benefits for service and eyewear purchased through in-network providers are based on the schedule shown under "How Charges Are Covered under the Vision Plan" later in this section. These providers have agreed to provide services at prenegotiated rates.
- Different benefits are provided for out-of-network providers. In most cases, out-of-network benefits are limited to a flat-dollar allowance.

You can pay for any uncovered vision expenses through your health savings account (if you participate in the Health Advantage Plan with associated Health Savings Account) or your Flexible Spending Account (if you participate in the PPO Plan).

How Charges Are Covered under the Vision Plan

The chart below summarizes the benefits paid for different types of vision charges. It also shows whether you are required to pay a copay before benefits start. Keep in mind that you are responsible for any charges that exceed the limits indicated for each charge.

Eligible Services and Supplies	Plan Pays In-Network	Plan Pays Out-of-Network
Eye Exams and Visits		
Eye Exam (with dilation as necessary)	100% after $10 copay	$21
Retinal Imaging	100% up to $39 maximum	Not applicable
Contact Lens Exam Options		
▪ Standard contact lens fit and follow-up	100% up to $40 maximum	Not applicable
▪ Premium contact lens fit and follow-up	10% discount on retail price	Not applicable
Eyeglasses		
Eyeglass Frames (any available frame at provider location)	100% up to $130; 20% discount on balance over $130	$65
Eyeglass Lenses (standard plastic lenses)		
▪ Single vision	100% after $20 copay	$11
▪ Bifocal	100% after $20 copay	$25
▪ Trifocal	100% after $20 copay	$49
▪ Standard progressive lens	100% up to $85	$25
▪ Premium progressive lens*	100% up to $105-$130	$25
Eyeglass Lens Options		
▪ UV treatment	100% up to $15 maximum	Not applicable
▪ Tint (solid and gradient)	100%	$11
▪ Standard plastic scratch coating	100%	$11
▪ Standard polycarbonate – adults	100%	$28
▪ Standard polycarbonate – kids under 19	100%	$28
▪ Anti-reflective coating		
– Standard	100% up to $45 maximum	Not applicable
– Premium Tier 1	100% up to $57 maximum	Not applicable
– Premium Tier 2	100% up to $68 maximum	Not applicable
– Premium Tier 3	20% discount	Not applicable
▪ Polarized	20% discount on retail price	Not applicable
▪ Other add-ons	20% discount on retail price	Not applicable

Eligible Services and Supplies	Plan Pays In-Network	Plan Pays Out-of-Network
Contact Lenses (contact lens allowance includes materials only)		
▪ Conventional** (one pair per year)	100% up to $130; 15% discount on balance over $130	$104
▪ Disposable** (one-year supply)	100% up to $130	$104
▪ If contacts are medically necessary	100%	$200
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% discount on retail price or 5% discount on promotional price	Not applicable
Frequency		
▪ Examinations	Once each calendar year	Once each calendar year
▪ Lenses or contact lenses	Once each calendar year	Once each calendar year
▪ Frames	Once each calendar year	Once each calendar year
Additional Discounts		
▪ Additional complete pair of eyeglasses	40% discount	Not applicable
▪ Additional pair of conventional contact lenses	15% discount	Not applicable
▪ Other items from in-network providers (excludes professional services)	20% discount	Not applicable

* Some manufacturers' lenses are available at a 20% discount. In this situation, the discount applies instead of the in-network amount indicated.

After the initial purchase that is covered by the plan, you can get replacement contact lenses mailed directly to you via the Internet at substantial savings. Details are available at **eyemedvisioncare.com. Contact lens benefits do not apply to these orders.

Important Notes

Please be aware of these plan rules:

- Plan discounts cannot be combined with any other discounts or promotional offers.
- Services or materials provided by any other group benefit plan providing vision care may not be covered.
- If it should happen that your eyeglasses or contact lenses cost less than the annual plan allowance, you cannot use any remaining balance for future purchases under the plan.
- Providers may carry certain brand-name vision materials (such as designer frames) that are not eligible for plan discounts.

Copays

You pay a copay for in-network services eye exams and eyeglass lenses. The plan pays the rest of the charge. When a copay applies, you pay it to the provider when you have the exam or order your eyeglasses.

Charges that Are Not Covered

While the Vision Plan provides coverage for many services and supplies, there are some charges that are not covered.

Expenses that are not covered by the plan include but are not limited to:

- Orthoptic or vision training.
- Subnormal vision aids and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eyes or supporting structures, except Lasik or PRK as specifically described (please note that treatment of eye diseases or injuries may be covered by your Medical Plan option).
- Any eye or vision examination, or any corrective eyewear required by an employer as a condition of employment.
- Safety eyewear.
- Plano (non-prescription) lenses and/or contact lenses.
- Non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.
- Services rendered after the date you or a dependent ceases to be covered, except when receiving vision materials that were ordered before coverage ends or when receiving services related to such order during the 31 calendar days after the order was placed.
- Coverage for lost or broken lenses, frames, glasses, or contact lenses that were ordered during one calendar year is not provided until the next year. However, you can take advantage of the discounts available under the Additional Discounts benefit. See the chart under “How Charges Are Covered under the Vision Plan” earlier in this section for details.
- Charges for a service or supply furnished by you, a member of your household, or a family member, including your spouse, your domestic partner, or a child, brother, sister or parent of yourself, your spouse or your domestic partner.

- Charges for services or supplies furnished or provided under a government plan, including those:
  - Furnished in whole or in part by or for the United States government or any other government, unless required by law; and
  - Provided or paid for, in whole or in part, by any law or government plan under which the patient is or could be covered. (This does not apply to a state plan under Medicaid or to any law or plan whose benefits, by law, are greater than those of any private insurance program or other non-governmental program.)
- Charges for services and supplies that are not medically necessary, as determined by the claims administrator and subject to review by the Plan Administrator.
- Charges for services and supplies that are not specifically covered under the plan.
- Charges for services or items for personal comfort, convenience, and safety.
- Charges for any illness or injury due to war or any act of war while covered under the plan.
- Work-related injuries or illness arising out of the course of any work for wage or profit (whether or not with the company) or work covered by any Workers' Compensation law, occupational disease, or similar law.

For more information on what is and is not covered under the plan, contact the claims administrator.

Filing Claims

Generally, you don't need to file claims when you use approved in-network providers. You'll need to file claims for reimbursement if you use out-of-network providers.

In-Network Claims

When you receive in-network care, there are no claim forms to file. Simply give the provider your vision ID card or Member ID. Pay any amounts that may be required (for example, copays, costs for special features, or charges that exceed maximums) when you order eyewear. The in-network provider will work with you to select materials and options for eyewear, and help determine what costs and benefits are available. Once you pay your portion of costs, the in-network provider will bill the plan directly for the remaining costs.

Out-of-Network Claims

When you receive out-of-network care, you will need to pay for your care upfront and then file a claim for reimbursement. Here's what you need to do:

- Complete a claim form, available from **eyemed.com**. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.
- Obtain an itemized bill from your provider on the appropriate letterhead that includes:
  - The patient's name, member ID number, and date of birth.
  - The date of service.
  - A description of the services and supplies provided.

  - A diagnosis or diagnosis code.
  - The provider's federal tax ID number.
  - The amount you paid.
- Send the claim form and bill to your claims administrator.

You will be reimbursed up to the allowed amount for the services or eyewear received. See the chart under "How Charges Are Covered under the Vision Plan" earlier in this section for details and out-of-network benefit amounts.

Claims should be submitted within 90 calendar days after the date care was received. In addition, all claims for each calendar year should be filed no later than 60 calendar days after the end of the calendar year. Generally, claims are processed and paid within 20 calendar days after your claims administrator receives all of the information that is needed to process the claim.

If it is not reasonably possible to submit your claim within these time frames, your claim will still be valid if it is furnished as soon as is reasonably possible. However, claims submitted more than one year after the date of service are not considered valid and will not be paid. Any benefit unpaid at the time of your death will be paid to your estate.

The claims administrator reserves the right to request a physical examination, at its own expense, as often as is reasonable while a claim is pending.

If a Claim Is Denied

If your claim is denied in whole or in part, you will receive a claim denial notice setting forth the reasons for the denial and explaining how to appeal the denial. You may then appeal the denial. See the **Claim Review and Appeal Processes** section of this SPD for information on the claim denial and how to file an appeal.

Coordination of Benefits if You Are Covered by another Plan

If you receive care that is also covered under another group health care plan, your benefits under this plan may be coordinated with the other coverage. For more information, see the **Coordination of Benefits** section of this SPD.

Additional Information You Should Know

Finding In-Network Providers

You can find a list of in-network providers online at the claims administrator's website, **eyemedvisioncare.com**. You also can call EyeMed for information on whether a particular provider participates in the network.

Every effort is made to ensure that provider lists are up-to-date. However, it's important to note that the providers who participate in the plan's network may change over time. To ensure that you receive the highest level of benefits available under the plan, you may wish to contact your provider before receiving care to verify that he/she currently participates in the plan's network.

Traveling Abroad

You take your health care benefits, including vision coverage, with you when you are abroad.

For more information, see the **Additional Benefits** section of this SPD.

Traveling Between U.S. and Canada

Employees may require travel between the U.S. and Canada either for Company or leisure-related reasons. Your benefits will continue with you while abroad. The chart below summarizes how your coverage options compare as a U.S. employee both in the U.S. as well as a U.S. employee travelling to Canada.

	Coverage			
Employee Location	**Medical**	**Prescription Drug**	**Dental**	**Vision**
U.S. Coverage	PPO, Health Advantage Plan with Associated Health Savings Account (through BCBS)	Prescription Drug Plan (through CVS)	DMO, Standard (through Aetna)	Vision Plan (through EyeMed)
U.S. Employee Coverage in Canada*	BCBS BlueCard Worldwide No limit on duration of visit	Prescription Drug Plan (through CVS via claim form submission) No limit on duration of visit; claim form must be submitted within one year	DMO, Standard (through Aetna for emergencies only via claim form submission) No limit on duration of visit	Vision Plan (through EyeMed via out-of-network claim form submission) with same benefit frequency

*For Medical, Prescription Drug, and Dental, claims are determined as in-network or out-of-network depending on provider.

Spending Accounts

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Flexible Spending Account and Dependent Care Account at a Glance

Overview of the FSA and DCA

The Flexible Spending Account (FSA) and Dependent Care Account (DCA) let you set aside funds on a pre-tax basis for reimbursement of health care and dependent care expenses during the year.

> The primary purpose of the FSA and DCA is to allow you to pay eligible expenses with tax-free dollars.

- The FSA helps you pay for certain eligible health care expenses that your health care plans do not cover—or cover only in part.
- The DCA reimburses you for eligible dependent child or dependent elder care expenses while you (and your spouse, if married) work or attend school.

The main benefits of participating in the accounts are the tax advantages you receive. You contribute to your account(s) before federal, Social Security, and most state and local taxes are withheld from your salary. You then pay eligible expenses from your account(s) with these tax-free dollars. This means you save money that you would otherwise pay in taxes.

You may enroll in one or both of the accounts when you become eligible to participate or during Benefits Annual Enrollment periods. Otherwise, you may enroll or make changes to your contributions during the year only if you have a qualifying status change.

> You can participate in the FSA only if you choose the PPO Medical Plan option. You cannot participate in the FSA in any year that you choose the Health Advantage Plan with associated Health Savings Account.

The accounts are regulated by the Internal Revenue Service (IRS) and are subject to applicable IRS rules.

Comparison of the FSA and DCA

	Flexible Spending Account (FSA)	Dependent Care Account (DCA)
You Are Eligible if…	You choose the PPO Plan (you are not eligible if you choose the Health Advantage Plan with associated Health Savings Account)	You are an eligible employee
You Can Contribute…	$100–$2,500	$100–$5,000 ($2,500 if married and filing separate tax returns)
To Pay For…	Qualified health-related expenses according to applicable tax rules	Dependent care expenses for child(ren) younger than age 13 or for a disabled spouse or dependent (including a parent or grandparent)
Expenses Such As…*	▪ Deductibles, coinsurance and copays ▪ Prescription drugs ▪ Contact lenses and eyeglasses ▪ Dental services and braces ▪ Charges over plan limits ▪ Hearing aids	▪ Licensed day care centers for child(ren) (includes nursery school costs, summer day camp, and before- and after-school care) ▪ Licensed day care centers for disabled dependents ▪ Adult care facilities and senior centers ▪ Dependent care provided by individuals in your home

	Flexible Spending Account (FSA)	Dependent Care Account (DCA)
Under These Guidelines…	Qualifying health-related expenses must be: ▪ Not reimbursable under any other plan ▪ Tax-deductible under IRS rules ▪ Not related to cosmetic procedures	Qualifying dependent care expenses must be: ▪ Necessary so you can work ▪ If you're married, necessary so your spouse can work or attend school full-time, or ▪ If you're married, necessary to care for your mentally or physically disabled spouse

*IRS Publication 502 contains a complete list of eligible health care expenses. IRS Publication 503 contains a detailed list of eligible dependent care expenses. To access these publications, visit **MyADTHR.com > Health & Group Benefits > Spending Accounts** or visit **aetnafsa.com** or **irs.gov**.

The rest of this section provides more detail on eligibility, contributions, covered expenses, and limitations.

How the FSA and DCA Work

Participating in the Accounts

You can participate in the FSA for health care expenses if you enroll for the PPO Medical Plan Option. **You cannot participate in the FSA during any year that you choose the Health Advantage Plan with associated Health Savings Account Medical Plan option.**

You can participate in the DCA as long as you are an eligible employee.

Once you make your elections each year, you cannot change them until the next Benefits Annual Enrollment period, unless you have a qualifying status change. See the **Enrollment** section of this SPD for more information.

Participation in either or both accounts is optional. You must enroll in each during the Benefits Annual Enrollment period if you want to participate. Your decisions remain in effect for the next calendar year, unless you leave ADT or have a qualifying status change.

Making Contributions to Your FSA and DCA

You decide the amount you want to contribute to your account(s) by estimating how much you expect your out-of-pocket health care and/or dependent care expenses to be during the upcoming calendar year.

The amount you choose to contribute is deducted from your paycheck in equal installments throughout the year. If you enroll in the middle of the year, you may still contribute the annual maximum to your account(s) for that year. In this case, the amount you elect to contribute will be divided by the number of pay periods remaining in the year.

It's important to carefully estimate your health and dependent care expenses before you make your contribution decisions each year. By law, any unused amounts remaining in your FSA or DCA at year-end must be forfeited. They cannot be rolled over for use in the next year. See "Use or Lose It" later in this section.

With both accounts, there is a minimum and maximum amount that you may contribute each year, as shown in the chart below:

	Annual Minimum	Annual Maximum
Flexible Spending Account (FSA)	$100	$2,500
Dependent Care Account (DCA)	$100	$5,000 ($2,500 if you're married and filing separate tax returns)

If you're considered a Highly Compensated Employee (HCE) as defined by the IRS, under certain circumstances your election may be reduced to the extent necessary to comply with non-discrimination requirements imposed by the Internal Revenue Code. The IRS definition of an HCE is subject to change each year. You will be notified if you are affected by these restrictions.

Additional Limits on DCA Contributions

The amount you contribute to a DCA cannot exceed your compensation for the year. If you are married and your spouse's compensation is less than yours, your contribution amount cannot exceed your spouse's income. For example, if your income is $40,000 per year and your spouse's income is $4,000 per year, the maximum you may contribute to your DCA is limited to $4,000 for that year.

If your spouse is a full-time student or is incapable of self-care, his/her income is assumed to be:

- $250 per month, if you have eligible dependent care expenses for one person; or
- $500 per month, if you have eligible dependent care expenses for two or more people.

Use It or Lose It

It's important to estimate as accurately as possible the amount you want to contribute to the FSA and/or DCA each year. If a balance remains in your account(s) after March 31 of the succeeding year after eligible expenses for the plan (calendar) year have been reimbursed, the balance will be forfeited. You **cannot** roll the remaining balance over to the next year, or transfer money between the accounts.

In addition, if you enroll or drop out mid-year due to a qualifying status change or because of a change in employment (new hire or termination), you cannot be reimbursed for health care expenses that you incur before your participation begins or after it ends. You may submit any employment-related dependent care expenses incurred during that year (before or after your participation ends); however, they will be reimbursed only up to the balance in your DCA at the time you stop participating.

In most cases, you have until March 31 of the following year to submit claims for expenses incurred during the previous year. Any prior year funds remaining in your account(s) after March 31 will be forfeited.

Your Accounts in the Plan

When you enroll, separate FSA and/or DCA accounts are established in your name. Your contributions are credited to your account(s). The funds you accumulate in your account(s) can be used to pay for eligible expenses that you incur while you participate in the plan. Your accounts do not earn interest during the year. Also, if you enroll in both the FSA and the DCA, you cannot transfer money between the two accounts. Each type of account has specific guidelines about expenses that are eligible for reimbursement.

Using Contributions after an FSA or DCA Change

If you start or end an FSA during the year because of a qualifying status change, you can only be reimbursed for expenses incurred while you are contributing to the account. You **cannot** be reimbursed for expenses that you incur before your participation begins or after it ends.

If you end a DCA during the year, you may submit any employment-related dependent care expenses incurred after you end participation, through December 31. However, keep in mind that they will be reimbursed only up to the balance in your account at the time you stop participating. If you start a DCA during the year, you may not submit expenses incurred before your participation begins.

Impact on Other Benefits

Contributions you make to the FSA and DCA are considered “salary reductions,” according to IRS rules. However, participation in the FSA and DCA does not affect other ADT salary-related benefits, such as Life Insurance and Disability Insurance, since these benefits are calculated before any deductions are made from your pay.

However, because you do not pay Social Security taxes on any pre-tax contributions, your future Social Security benefits could be reduced if you participate in an FSA or DCA.

Tax Advantages from Using the FSA and DCA

The FSA and DCA let you set aside funds on a pre-tax basis for reimbursement of health care and dependent care expenses during the year.

You contribute to your account(s) before federal, Social Security, and most state and local taxes are withheld from your salary. You then pay eligible expenses from your account(s) with these tax-free dollars. This means you save money that you would otherwise pay in taxes.

Example of Tax Advantages

The following example shows an estimate of the tax benefit an employee earning $50,000 a year receives after setting aside $2,000 in either the FSA or DCA, or a combination of the two. The example uses a combined federal and FICA tax rate of 22%, which is a modest estimate of the effective tax rate. This is only an estimate, and is provided for purposes of illustration only, since the tax savings will depend on filing status, number of withholding allowances, deductions, etc. State tax savings may also be available in some states.

	With FSA or DCA (Pre-Tax)	Without FSA or DCA (After-Tax)
Annual salary	$50,000	$50,000
Pay eligible health care expenses using an FSA	($2,000)	$0
Taxable income	$48,000	$50,000
Federal income and FICA tax (22%)	($10,560)	($11,000)
Pay the same health care expenses on an after-tax basis	$0	($2,000)
Take-home pay	$37,440	$37,000
Amount employee saved by participating in the FSA: $440		

By using an FSA, this employee has $440 more in spendable income than if he/she paid for health care expenses on an after-tax basis.

Please note: For FSA savings calculators and tools to assist you in assessing your personal situation, visit **MyADTHR.com > Health & Group Benefits > Spending Accounts** > **Flexible Spending Account Estimator**.

Tax Credits and Deductions

In some cases, you may be able to deduct certain health care expenses from your income and receive a tax credit for certain dependent care expenses when filing your federal tax return, as described below. If you do so, you cannot also be reimbursed for those expenses from your FSA.

ADT acts only as the plan administrator and sponsor for the FSA and DCA and bears no responsibility for your tax obligations. You remain fully accountable to the IRS to prove the eligibility of any expense that you submit for reimbursement.

Because personal situations vary, you should consult your tax or financial adviser to determine what is best for your personal financial situation.

Health Care Expenses

If you decide to reimburse yourself for eligible health care expenses through the FSA, you cannot claim those same expenses as deductions on your income tax return. In most cases, a health care spending account is more advantageous than the tax deduction.

Current IRS regulations require that your out-of-pocket expenses exceed 7.5% of your adjusted gross income in order to be eligible for deduction on your federal income tax return. In addition, regulations only allow you to deduct those expenses that exceed 7.5% of your adjusted gross income. By using pre-tax dollars to pay for eligible expenses, your tax advantage begins immediately.

Dependent Care Expenses

Current IRS regulations allow you to take a dependent care tax credit when you file your taxes. You may claim credit on qualified expenses up to $3,000 for one dependent and $6,000 for two or more dependents.

If you choose to reimburse yourself on a pre-tax basis through the DCA, those reimbursed expenses generally will reduce the amount of federal tax credits available to you. However, the method that produces the greatest tax savings for you depends on your personal financial situation. For specific information about how these provisions apply to your tax situation and/or to determine which approach may be best for you, please consult your tax or financial adviser.

In addition, under certain circumstances, your election may be reduced to the extent necessary to comply with certain non-discrimination requirements imposed by the Internal Revenue Code. You will be notified if you are affected by these requirements.

Flexible Spending Account

Overview

You may use the FSA to pay for eligible health care expenses that your health care plans do not cover or cover only in part—such as deductibles, copays and other eligible medical, prescription drug, dental or vision care expenses. Expenses must be incurred while you, your spouse or your eligible dependents participated in the plan.

You may participate in an FSA even if your health care coverage is not through an ADT plan.

Eligible Dependents

For purposes of the FSA, eligible dependents generally include:

- Anyone you can claim as a dependent on your federal income tax return, which typically includes your spouse or domestic partner and your qualifying child(ren); including adopted, foster, and stepchild(ren) (even if they are not covered under any ADT-sponsored health plan).

In general, your dependents for the FSA are the same persons you can claim as dependents on your federal income tax return.

- In addition, special rules allow a dependent to be eligible under an FSA even when that dependent does not qualify to be claimed as your tax dependent on your income tax return. For example, the requirement that a tax dependent cannot have annual gross income in excess of $3,400 does not apply.

Because every situation is different, you should consult a qualified tax or financial adviser about qualifying dependents under this plan. For details on who qualifies as an eligible dependent for purposes of the FSA, you also can contact the FSA claims administrator listed in the **Claim Review and Appeal Processes** section of this SPD or consult your tax or financial adviser.

Eligible Health Care Expenses

You may use the FSA for a wide variety of health care expenses that are not covered or are covered only in part under your health care plans. Expenses must be considered eligible according to IRS guidelines and must be incurred while you are participating in the FSA.

Examples of eligible health care expenses include but are not limited to:

- Acupuncture.
- Alcoholism treatment.
- Ambulance.
- Audio display television for the deaf.
- Bandages.
- Braille books and magazines, limited to the difference between the cost of the Braille items and the cost for regular items.
- Chiropractic expenses in excess of medical plan limits.
- Contact lenses and solutions.
- Cost for keeping a mentally challenged person in a halfway house or special home (not the home of a relative). Services and care must be recommended by a psychiatrist to help the person adjust from life in a psychiatric hospital to community living.
- Costs for medical services provided by physicians, surgeons, specialists, or other medical practitioners.
- Cost for services by Christian Science Practitioners.
- Crutches, canes, or similar equipment.
- Dental exams and services.
- Drug addiction treatment.
- Expenses for medical care in a nursing home.
- Eyeglasses—including lenses, frames, exams, and over-the-counter reading glasses.
- Hearing expenses, including exams, hearing aids, and batteries required to operate a hearing aid.
- Hospitalization charges in excess of the Reasonable and Customary (R&C) limits, including private room coverage.
- Laboratory fees.
- Lasik or laser eye surgery.
- Learning disability treatments.
- Medical diagnostic devices and supplies, such as blood glucose testing kits and test strips.
- Medical expenses paid to a special school if the main reason for using the school is relieving the medical or physical disability.
- Medicine or other drugs prescribed by a doctor, including birth control pills.
- Mileage for travel to and from eligible health care facilities.
- Nursing services when provided by a registered nurse or licensed practical nurse for medical care.

- Orthodontia.
- Over-the-counter drugs and medicines when obtained with a written prescription from a licensed practitioner.
- Over-the-counter medical supplies as listed below (prescription not required):
  - Bandages.
  - Eye care supplies, such as contact lens solution and patches.
  - Family planning supplies, such as condoms, pregnancy tests, ovulation prediction kits.
  - Home diagnostic tests or kits, such as blood pressure, cholesterol, diabetes, colorectal cancer, HIV, urine test, thermometers.
  - Incontinence products.
  - Joint support bandages and hosiery, such as knee or elbow supports.
  - Vaporizers and humidifiers.
- Oxygen or oxygen equipment to relieve breathing problems caused by a medical condition.
- Plan deductible, copay, and coinsurance amounts.
- Psychiatrist/psychologist fees.
- Prescription drugs and medicines.
- Purchase of a guide dog for a blind or deaf individual.
- Radial keratotomy (RK).
- Services by an optometrist.
- Smoking cessation programs.
- Special car controls for the handicapped.
- Special medical equipment (purchase or rental), if the primary purpose is medical care.
- Special telephone for the deaf.
- Sterilization fees.
- Surgery (legal operations), including experimental procedures.
- Therapies received as medical treatment, such as speech, occupational, and physical therapy or cardiac rehabilitation therapy.
- Tuition fees for a special school for a learning disabled child with severe learning disabilities caused by mental or physical impairments, including nervous system disorders. Care and services must be recommended by a doctor.
- Tutoring fees for a teacher specially trained and qualified to work with child(ren) with severe learning disabilities. Care and services must be recommended by a doctor.
- Vaccinations and immunizations.

For detailed information about eligible and ineligible expenses, visit **MyADTHR.com > Health & Group Benefits > Spending Accounts** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Flexible Spending Accounts**. You also can contact the IRS at **1-800-829-3676** to request a copy of Publication 502, Medical and Dental Expenses, or log on to **irs.gov** and type “Publication 502” in the search box to download a copy of this publication.

Ineligible Health Care Expenses

In general, health care expenses that do not qualify as medical deductions for federal income tax purposes also are not eligible for reimbursement under the FSA.

Examples of ineligible health care expenses include but are not limited to:

- Any expenses incurred in connection with an illegal operation or treatment.
- Automobile insurance premiums, including any portion of the premium providing medical coverage for persons injured through an accident in or with the covered individual's vehicle.
- Bottled water.
- COBRA premiums.
- Cosmetic surgery, except to correct congenital abnormality, bodily injury, or disfiguring disease.
- Cosmetics, such as face creams, lotions, makeup, and toiletries.
- Costs for sending a child with behavioral or disciplinary problems to a special school whose course of study and disciplinary methods may benefit the child.
- Custodial care in an institution.
- Dancing or swimming lessons, even when recommended by a qualified physician for health improvement.
- Expenditures for the general health of an individual, including expenses related to exercise, fitness, nutrition, recreation, or membership in a spa or health club.
- Expenses covered under any health plan.
- Expenses incurred before or after you begin participating in the FSA or in a previous year.
- Expenses that are used for a deduction or claimed for a tax credit on a federal tax return.
- Funeral and burial expenses.
- Hair removal (electrolysis).
- Hair transplants and hair loss treatment.
- Health club dues, YMCA dues, steam baths, etc.
- Household and domestic help, even if recommended by a qualified physician because an individual cannot perform physical housework.
- Life insurance premiums or premiums for policies that provide repayment for loss of earnings or accidental loss of life, limb, sight, etc.
- Maternity clothes, diapers, diaper service, etc.
- Medical insurance premiums, including premiums for employer-provided medical and dental coverage and for contact lens insurance.
- Over-the-counter medications, unless obtained with a written prescription from a licensed practitioner.
- Over-the-counter products that are cosmetic or used for general health purposes, such as mouthwash, sunglasses, weight loss foods and sun blocks (except for sun blocks with an SPF of 30 or greater) or tanning products.
- Personal use items (toothpaste, toothbrush and tooth whitening aids, etc.).
- Premiums for other insurance coverages.

- Transportation expenses to and from work, even if a physical condition requires a special means of transportation.
- Vacation or travel, when taken for general health purposes, improvement of morale, or relief of physical or mental discomfort.
- Vitamins and food supplements, when taken for general health purposes.

Dependent Care Account

Overview

You may use the DCA to reimburse yourself for employment-related dependent care expenses for your eligible dependents if:

- You and your spouse both work.
- You work and your spouse is actively looking for work.
- You are a single parent with primary responsibility for child care.
- You work and your spouse is a full-time student for at least five months of the year.
- You work and your eligible dependent is physically or mentally incapable of self-care.

Eligible Dependents

For purposes of the DCA, eligible dependent means:

- Your qualifying child—under age 13.
- Your spouse, tax dependent domestic partner, qualifying child, or relative who is physically or mentally incapable of self-care.

You can use your DCA to pay for eligible care for your child(ren) under age 13 and other disabled persons whom you can claim as dependents on your federal income tax return.

Typically, qualifying child means your dependent child, including adopted, foster, or stepchild, whom you claim as a dependent on your income tax return and who lives with you for more than half the year. In addition, if you are a divorced parent, you may be eligible to use a DCA if you must have dependent care services in order to work—even if you do **not** claim your child(ren) as dependents on your federal income tax return.

Because every situation is different, you should consult a tax or financial adviser about qualifying child(ren) and relatives under this plan. For details on who qualifies as an eligible dependent for purposes of the DCA, you also can contact the DCA claims administrator.

Please note: All covered dependents claimed under the DCA **must** have the same permanent residence as the employee for related expenses to be eligible under the plan. Additionally, the IRS requirement that adult tax dependents cannot have gross annual income of more than $3,400 does not apply for the DCA. This means that if your parent or grandparent lives with you and could be claimed as an exemption on your federal tax return except for the fact that he/she receives more than $3,400 in gross annual income (which includes Social Security payments), you can be reimbursed for their adult dependent care expenses even though you do not claim him/her as a dependent on your tax return.

Eligible Dependent Care Expenses

You may use the DCA for a wide variety of eligible dependent care expenses.

Examples of eligible dependent care expenses include but are not limited to:

- Before- and after-school programs.
- A day care center, nurse, or baby-sitter (in your own home or someone else's home).
- Nursery school, even when the school provides lunch and educational services.
- An adult care facility, senior care, and elder care (in your home or someone else's home).
  - Eligible adult care or elder care does **not** include expenses for an overnight nursing home facility.
- A maid or cook if part of the services are provided to a person who qualifies for dependent care.
- A housekeeper who is primarily responsible for providing dependent care.
- Payroll taxes you pay for your dependent care provider.
- Summer day camp.
- Any other qualified dependent care expense as defined by the Internal Revenue Code.

Amounts paid to a relative who provides dependent care services are also eligible as long as the relative is not your, your spouse's, or your domestic partner's:

- Dependent for whom a personal exemption deduction is allowed for federal income tax purposes.
- Child or stepchild who is under age 19 at the end of the calendar year.

For detailed information about eligible and ineligible expenses, visit **MyADTHR.com > Health & Group Benefits > Spending Accounts** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Flexible Spending Accounts**. You also can contact the IRS at **1-800-829-3676** to request a copy of Publication 503, Child and Dependent Care Expenses, or log on to **irs.gov** and type "Publication 503" in the search box to download a copy of this publication.

Ineligible Dependent Care Expenses

Certain expenses are not eligible for reimbursement through the DCA.

Examples of ineligible dependent care expenses include but are not limited to:

- Baby-sitting expenses for non-work activities.
- Care in a convalescent or overnight nursing home facility.
- Custodial care for a dependent who resides outside your home.
- The cost of food, clothing and education.
- Overnight camp.
- Services provided by one dependent to care for another.
- Expenses for which a dependent care tax credit is taken or that are reimbursed under a Flexible Spending Account.
- Expenses incurred before your participation begins.

- Transportation between your home and the place where dependent care services are provided.
- Tuition for schooling for kindergarten or higher.
- Dependent care that allows you or your spouse to do volunteer work.

Using the FSA and DCA

Overview

If you enroll in one or both accounts and incur eligible health care or dependent care expenses, you may file a claim to be reimbursed for the costs of your expenses. For the FSA, you may also pay eligible expenses with a debit card.

FSA Debit Card for Health Care Expenses

Paying for your health care expenses is easy with an FSA Debit Card. The FSA Debit Card is a Visa® card that works like a credit card. You can use the card to pay eligible health care expenses. Unlike a regular credit card, the costs of your purchases are automatically deducted from your FSA and are paid directly to your health care provider.

You can use the card to pay for eligible health care expenses and items at qualified merchants who accept Visa. **Only eligible items should be paid for with your FSA Debit Card.**

How to Use the FSA Debit Card

- Give your card to the service provider or swipe it yourself at point of purchase;
- Choose the “credit” option if you are using a terminal;
- Sign for your purchase; and
- Keep the itemized receipt—the one that describes what you purchased.

Save your receipts with your important tax documents each time you use the card, just as you would for other uses of your FSA. Occasionally, the claims administrator will require more information to verify a payment. Your quarterly (April, August and November) statement will show you if more information is needed. You can also keep track of debit card transactions that require receipts at **aetnafsadebitcard.com**, your secure website. If you do not substantiate your claims as requested, you may receive IRS Form 1099 listing this reimbursement as income to you.

If you cannot show that the card was used to pay for eligible health care expenses, you will be required to reimburse your FSA for the amount of the purchase. Your quarterly (April, August, and November) statement will notify you of any payments due. If you fail to reimburse your account when requested, you may be subject to any of the following:

- The amount due will be deducted from your next reimbursement check.
- Your card privileges may be revoked.
- Other collection efforts may be taken in accordance with ADT’s policies.

Keep the card safe as you would protect any credit card. All purchases will be charged against the account balance. The card cannot be used to get cash.

Please note: Your FSA Debit Card can be used only for eligible health care expenses. You cannot use it to pay for dependent care expenses.

Filing a Claim for Health Care or Dependent Care Expenses

You must file a claim for reimbursement of dependent care expenses from your DCA. You can also file a claim for health care expenses from your FSA, instead of using the FSA Debit Card:

- After you have incurred and paid for eligible health care or dependent care expenses, complete a claim form available at **MyADTHR.com > Health & Group Benefits > Spending Accounts**. You can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Flexible Spending Accounts**.
- Submit the completed claim form with the appropriate receipts and documentation to the claims administrator for reimbursement (at the address or fax number listed on the form).
- In most cases, claims for reimbursement are paid within three weeks of receipt. You must have a minimum of $5 in receipts to request reimbursement. You may request reimbursement for an amount less than $5 only when you make your final reimbursement request for the year.
- You can only submit claims for expenses incurred by December 31 of each year you participate. However, you have until March 31 of the following calendar year to submit claim forms for eligible expenses. If you do not submit claim forms by that date, the remaining balance in your account(s) will be forfeited.
- For information on how to file claims and where to submit your claim forms, contact the claims administrator listed in the **Claim Review and Appeal Processes** section of this SPD.

Reimbursement Guidelines

Whether you use the FSA Debit Card or you file claims for reimbursement, the following guidelines apply to reimbursement requests:

- **Flexible Spending Account (FSA).** You may request reimbursement for an amount that is greater than your account balance if your contributions for the remainder of the year will cover the amount being reimbursed. If you file a claim instead of using your FSA Debit Card, you must submit a copy of the Explanation of Benefits (EOB) or an itemized bill from your provider with your claim form.
- **Dependent Care Account (DCA).** You may only be reimbursed up to the current balance in your account. If you submit a request that exceeds your current account balance, you will be reimbursed when the funds become available in your account. You must include the name and Social Security or tax identification number of the person or organization providing the dependent care service on your claim form.

When you terminate your employment, your pre-tax contributions to your account(s) will end. In this case, expenses will then be reimbursed as follows:

- **Eligible health care expenses** incurred **before** your coverage termination date will be reimbursed to the full extent of your unused account balance.
- **Eligible dependent care expenses** incurred during the remainder of the calendar year will be reimbursed to the full extent of your unused account balance as of your termination date.

If a Claim Is Denied

If your claim is denied in whole or in part, you will receive a claim denial notice setting for the reasons for the denial and explaining how to appeal the denial. You may then appeal the denial. See the **Claim Review and Appeal Processes** section of this SPD for information on the claim denial and how to file an appeal.

How the Health Savings Account Works

You can have a health savings account if you enroll in the Health Advantage Plan with associated Health Savings Account.

A health savings account is a personal savings account that belongs to you. In some ways, it is similar to an IRA, and in other ways, to a Flexible Spending Account for health care expenses.

You can keep the health savings account and continue to make withdrawals from it on a tax-free basis for the cost of unreimbursed eligible health care expenses, even when you no longer participate in the Health Advantage Plan with associated Health Savings Account or you leave ADT. However, you can only contribute to a health savings account when you are participating in a qualified high deductible health plan (such as the Health Advantage Plan with associated Health Savings Account); you are not covered by any other non-high deductible health plan and not enrolled in Medicare. Moreover, you can only make contributions to a health savings account based on the family contribution limits if your covered eligible dependents also do not have any non-high deductible health plan coverage.

Since it is your account, you are responsible for making sure you don't exceed the contribution limits and for keeping track of which withdrawals from the account are for eligible health care expenses. You should keep your receipts and records of contributions to your account in case your tax return is audited by the IRS.

If you have a health savings account, you cannot participate in the Flexible Spending Account for health care expenses.

Like an IRA, you can withdraw the money in your health savings account at any time, for any reason. However, if you withdraw money to pay for eligible health care expenses, the money will be tax-free. You can use the money to pay for health care services or supplies at the time you receive them, or you can use it to reimburse yourself later for health care expenditures you incurred at any time after you opened your health savings account.

You may also withdraw health savings account money for a purpose other than eligible health care expenses. If you do, you must pay federal income tax on the withdrawal and, if you're under age 65, a 20% penalty tax. The 20% penalty tax does not apply if you are age 65 or older or if you are disabled.

After you set up a health savings account, you will need to attach a Form 8889 to your federal income tax return each year to report your health savings account contributions and withdrawals for the year. Form 8889 is the way you deduct your contributions to the health savings account and protect your withdrawals from taxation.

Tax treatment of health savings accounts under some state laws differs, so you will need to check the tax laws of your state when you file your state tax return. References in this section to taxation of health savings accounts apply only to federal income tax.

Your health savings account earns interest and the earnings are not taxed while they remain in the account. If you withdraw earnings to pay for eligible health care expenses, they will not be taxed upon withdrawal either.

You can think of health savings account money as triple-tax-protected: the contributions to your account are not taxed, money in your account earns interest tax-free, and when you spend it on eligible health care expenses the money withdrawn is not taxed.

You can enroll in the Health Advantage Plan with associated Health Savings Account without opening a health savings account. In fact, you are not eligible to open an health savings account if: you are also covered by your spouse's plan that is not a high deductible health plan, you enroll in Medicare Part A or B, or your spouse has a health care flexible spending account that is available to pay your health care expenses.

Eligible Dependents

For purposes of the health savings account, eligible dependents generally include anyone you claim as a dependent on your federal income tax return, which may include your spouse or domestic partner and your qualifying child(ren), including adopted, foster and stepchild(ren) (even if they are not covered under the Health Advantage Plan with associated Health Savings Account or any ADT-sponsored health plan). In addition, if you are a divorced parent, you may be able to use your health savings account to pay for eligible expenses for your child(ren)—even if you do **not** claim your child(ren) as dependents on your federal income tax return.

For more information on who qualifies as an eligible dependent for purposes of the health savings account, contact the claims administrator or consult your tax or financial adviser.

Health Savings Accounts and Domestic Partners

Although you may enroll your domestic partner in the Health Advantage Plan with associated Health Savings Account, you cannot pay your domestic partner's medical expenses from your health savings account on a tax-free basis unless he/she qualifies as a dependent on your federal income tax return. The same applies to your domestic partner's child(ren). However, if your domestic partner is enrolled in the Health Advantage Plan with associated Health Savings Account, he/she may open his/her own health savings account at a financial institution of their choice or through HealthEquity.

Eligible Health Savings Account Expenses

You can withdraw money from your health savings account on a tax-free basis to pay qualified health care expenses for yourself and your spouse or any tax dependents. You can pay your dependents' eligible expenses even if they are participating in a different health care plan that is not a high deductible health plan. You can also pay your eligible expenses after you no longer participate in the Health Advantage Plan with associated Health Savings Account, even if you have other non-high deductible health plan coverage.

There is no limit on what you can withdraw in any one year but you can only withdraw up to the balance in your account. You can use health savings account money for any eligible expense, even if not covered by the Health Advantage Plan with associated Health Savings Account. However, any amount withdrawn from your health savings account to pay expenses not covered by the Health Advantage Plan with associated Health Savings Account will **not** count against your deductible.

Eligible expenses include any unreimbursed medical expense that could otherwise be deducted on your federal income tax return. One exception is that insurance premiums for medical coverage are not eligible under the health savings account unless they are for:

- Long-term care insurance.
- COBRA continuation coverage.
- Health care coverage while receiving unemployment compensation under federal or state law.
- Medicare or other health care coverage when you are age 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).

IRS Publication 502 contains a complete list of deductible expenses. (To access Publication 502, go to **irs.gov** and enter "Publication 502" in the search box.) These expenses are similar to those you can reimburse from a Flexible Spending Account. (See the **Spending Accounts** section of this SPD for a partial list of eligible expenses.) Many drugstore receipts now indicate which expenses are eligible for reimbursement from health care flexible spending accounts. Be sure to save those receipts, because all those amounts can be reimbursed tax-free from your health savings account.

Please note: Over-the-counter medications (except insulin) are no longer reimbursable under any of the health care accounts (health savings account or Flexible Spending Account) as of January 1, 2011 per the federal Affordable Care Act of 2010, as amended, **unless** obtained with a written prescription from a licensed practitioner.

Contribution Limits

The IRS determines the maximum amount that can be contributed to a health savings account each year by employers and employees combined. ADT's contributions and your contributions are based on the coverage level you choose under the Health Advantage Plan with associated Health Savings Account—Individual, Employee+1, or Family coverage—and assume no individuals have disqualifying non-high deductible health plan coverage.

If you are between ages 55 and 65 and not enrolled in Medicare, you can make additional catch-up contributions.

See the "Comparison of PPO and Health Advantage Plan with Associated Health Savings Account" chart earlier in this section for the amounts ADT contributes and the amount that you can contribute.

You can contribute through pre-tax payroll deductions and you can also make additional contributions by check or electronic funds transfer (EFT) at any time during the year.

If your spouse is included in your Family coverage under the Health Advantage Plan with associated Health Savings Account, has no other coverage that is not a high deductible health plan, and is less than 65 years old, he/she can open a separate health savings account. However, your combined contributions cannot exceed the family limit, so it may be more cost-effective to maintain only one health savings account. If your spouse has individual coverage under a high deductible health plan of another employer and you have individual coverage under the Health Advantage Plan with associated Health Savings Account, you can each have a health savings account with contributions up to the individual limit. If either of you has Family coverage, the combined contributions to your health savings accounts cannot exceed the family limit.

If you join the Health Advantage Plan with associated Health Savings Account during the year, the contributions you make through payroll deduction and ADT's contribution will be prorated. However, you can contribute the full annual maximum to your health savings account on your own through EFT or by check, provided you remain in the Health Advantage Plan with associated Health Savings Account for all 12 months of the next calendar year.

Paying from Your Health Savings Account

You can pay expenses from your health savings account with your health savings account debit card or you can use the online payment feature to reimburse yourself or to pay your provider. Paying for your health care expenses is easy with a health savings account debit card. The health savings account debit card is a Visa® card that works like a credit card which you can use to pay for eligible health care expenses. Unlike a regular credit card, the costs of your purchases are automatically deducted from your health savings account and are paid directly to your health care provider.

You can use the card to pay for eligible health care expenses and items at qualified merchants who accept Visa. **Only eligible health care expenses should be paid for with your health savings account debit card or you may be subject to certain income tax consequences.** For additional information, contact the health savings account claims administrator or consult your tax or financial adviser.

Please note: You only have access to amounts that have already been contributed to your health savings account. If you incur an expense that exceeds the amount in your health savings account, you can pay out of pocket and reimburse yourself later when more money is deposited.

Some health savings account transactions incur a fee similar to a checking account. For information on fees and to check your balance, contact HealthEquity at the number on the back of your health savings account debit card.

How to Use the Health Savings Account Debit Card

Before you use your health savings account debit card, it's a good idea to check the balance in your account. To check your health savings account balance, call HealthEquity at the number on the back of your health savings account debit card. To use your debit card:

- Give your card to the service provider or swipe it yourself at point of purchase;
- Choose the "credit" option if you are using a terminal;

- Sign for your purchase; and
- Keep the itemized receipt—the one that describes what you purchased.

Save your receipts with your important tax documents each time you use the card, just as you would for other important tax information.

Remember to keep the card safe as you would protect any credit card, and report a lost or stolen card immediately. All purchases will be charged against your health savings account balance.

Note that your health savings account debit card should only be used for eligible health care expenses.

You can also utilize HealthEquity's online PayChoice platform to:

- View and make payments on medical and prescription drug claims;
- Make payments from your health savings account for other qualified medical expenses;
- Reimburse yourself from your health savings account;
- Create and manage future payment schedules; and
- Contribute to your health savings account.

Using Your Health Savings Account to Save for Retirement

Your health savings account is primarily intended to help you pay for medical expenses while covered by a high deductible health plan. However, it can be used as a financial planning tool for other purposes as well. If you are comfortable paying your deductible out of pocket, you can let your health savings account money build up for future needs. It can serve as a resource for paying retiree medical costs or as an emergency fund. If you wait until age 65 or older to withdraw the money for non-medical expenses, you will pay income tax on withdrawals but no penalty. If you save receipts for all unreimbursed out-of-pocket medical expenditures beginning with the day you open your health savings account, you can withdraw that amount at any time in the future, for any purpose, on a tax-free basis (because you are reimbursing yourself for eligible expenses).

When Your Health Savings Account Participation Ends

The following describes when your health savings account participation through ADT and the associated pre-tax contributions will end.

Health savings account participation through ADT ends on the earliest of:

- The last day of the month in which you terminate employment;
- The date you retire;
- The date you enroll in Medicare or certain other medical plans that are not qualified high deductible health plans;
- The date you are no longer eligible for the Health Advantage Plan with associated Health Savings Account;

- The date the Health Advantage Plan with associated Health Savings Account is terminated; or
- The last day of the plan year if you do not elect the Health Advantage Plan with associated Health Savings Account for the following plan year.

If You Live in Hawaii or Puerto Rico

ADT provides different coverage options if you live in Hawaii or Puerto Rico. These options are provided instead of the coverage offered under the PPO or Health Advantage Plan with associated Health Savings Account; you cannot participate in the PPO or Health Advantage Plan with associated Health Savings Account if you live in Hawaii or Puerto Rico. These other options are:

- If you live in Hawaii, you are eligible for the Hawaii Medical Service Association (HMSA).
- If you live in Puerto Rico, you are eligible for Triple-S Salud.

These programs have separate rules regarding enrollment, services covered and benefits provided, procedures for filing claims and for reviewing claims that have been denied, changing your coverage, and when coverage ends.

For more information, see the **If You Reside in Puerto Rico–Triple-S Salud** and **If You Reside in Hawaii–Hawaii Medical Service Association (HMSA)** sections of this SPD.

Life and AD&D

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Life and AD&D Benefits at a Glance

ADT provides Basic Term Life Insurance, Accidental Death and Dismemberment (AD&D) Insurance, and Business Travel Accident (BTA) Insurance at no cost to you, in the following amounts:

You are eligible for Basic Term Life Insurance after the standard waiting period for active and Direct Connect. See the **Enrollment** section for more details.

Plan	Coverage Amount
Basic Term Life Insurance	**1** times your base annual salary rounded up to the next highest $1,000 (maximum $1 million)
AD&D Insurance (if you die or are injured as a result of a covered accident)	**1** times your base annual salary rounded up to the next highest $1,000 (maximum $1 million)
BTA Insurance (if you die or are injured as a result of a covered accident while traveling on Company business)	**4** times your base annual salary with a minimum amount of $175,000 to a maximum of $200,000 if your base annual salary is less than $50,000, or **4** times your base annual salary with a minimum amount of $500,000 to a maximum of $3 million if your base annual salary is $50,000 or higher

You may choose to add Supplemental Life Insurance for an additional cost, as follows:

Coverage for …	Amount of Supplemental Life Insurance Coverage Available …
Yourself	**1** to **10** times your base annual salary, rounded up to the next highest **$1,000**, up to a maximum of $3 million
Your Spouse/Domestic Partner	**$10,000** increments up to $250,000 not to exceed 50% of your Supplemental Life Insurance coverage amount
Your Dependent Child(ren)	**$5,000** or **$10,000** for child(ren) from live birth and under age 19, or for full-time student dependents who are under age 23

Please note: Please review all sections of this Summary Plan Description (SPD) for complete information regarding when Evidence of Insurability (EOI) will be required for Supplemental Life Insurance.

You may also choose to add Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance, which pays a benefit in the event you or an eligible dependent suffers a serious loss or dies as the result of a covered accident.

If you purchase this coverage and you or your covered spouse/domestic partner dies, your dependent child(ren) would receive an additional benefit to help pay for post-high school education expenses—the lesser of 25% of the sum paid out by insurance or $10,000.

Coverage for …	Amount of P&F AD&D Coverage Available …
Yourself	Any multiple from **1** to **8** times your base annual salary, with no EOI, to a maximum benefit of $1 million
Your Family, Depending on Whether Your Eligible Family Member Is …	
Your Spouse/Domestic Partner Only	**60%** of your coverage amount
Your Dependent Child(ren) Only	**20%** of your coverage amount for each child
Your Spouse/Domestic Partner and Dependent Child(ren)	**50%** of your coverage amount for your spouse/domestic partner and **10%** of your coverage amount for each child

Please note: There are state-specific requirements that may change or limit the provisions of the coverages described in this SPD. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and will be part of the Group Insurance Certificate issued by the insurance carrier. See the Claims Administrator Directory for how to access additional information from the insurance carrier regarding state-specific requirements.

Beneficiaries

Naming Your Beneficiary

When you become covered under the Basic Term Life Insurance, Supplemental Life Insurance, AD&D Insurance, P&F AD&D Insurance, and BTA Insurance Plans, you will be asked to name a beneficiary. A beneficiary is the person or persons you wish to receive benefits under a Life and AD&D Insurance Plan if you die.

Unless you request otherwise, your named beneficiary for the Basic Term Life Insurance Plan is also your beneficiary for the AD&D and BTA Insurance Plans. When you elect Supplemental Life Insurance or P&F AD&D coverage for your family, you are automatically the beneficiary for your covered family member or domestic partner. Benefits are also paid to you if you or your covered dependent experiences one of the covered losses described in this SPD (such as paralysis or loss of sight) as the result of an accident. You may not name your employer as your beneficiary.

You may name an irrevocable beneficiary for tax purposes. An irrevocable beneficiary is a beneficiary who owns your life and/or accident insurance policy. If you name an irrevocable beneficiary, you must obtain that individual's consent to change the beneficiary in the future.

If you do not name a beneficiary for your Life and AD&D Insurance coverage or your beneficiary dies before you, benefits will be paid in the following order:

- Your estate.
- Your surviving spouse.
- Your surviving child(ren), in equal shares.
- Your parents, in equal shares.

Please note: Benefits will not be paid to your domestic partner if he/she is not specifically designated as your beneficiary.

Benefits will be paid according to the beneficiary on record as entered on **MyADTHR.com**. Review this information to confirm that it is accurate by going to **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform**.

Changing Your Beneficiary

Unless you have named an irrevocable beneficiary, you may change your beneficiary at any time for any reason. Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change > Enrollment Platform** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** to change your beneficiaries.

Basic Term Life Insurance

How the Basic Term Life Insurance Plan Works

The amount of life insurance you need depends on your family's needs and your financial situation. However, because your death can jeopardize your family's financial security, ADT automatically provides you with Basic Term Life Insurance coverage at no cost to you.

The Basic Term Life Insurance Plan provides coverage for your family if you die.

Please note: See "Policies Affecting Both Basic Term Life and Supplemental Insurance" later in this section for more information on Basic Term Life Insurance Plan rules.

Cost of Coverage

ADT pays 100% of the cost of your Basic Term Life Insurance coverage for active employees and employees on a leave of absence of up to nine consecutive months. Once you enroll for this coverage through ADT, you will be able to continue coverage as an individual policy if you end your employment.

Your Coverage Amount

Your Basic Term Life Insurance is equal to one times your base annual salary, rounded to the next highest $1,000. For example, if your base annual salary is $44,250, your Basic Term Life Insurance coverage amount is $45,000. Coverage is limited to a maximum of $1 million.

For purposes of the Basic Term Life Insurance Plan, base annual salary means your annual salary, excluding any cash bonuses, overtime pay, or commissions. If you are a no base salary or a fixed-base salary employee, your coverage is based on a Target Benefit Basis.

Employees with a Target Benefit Basis

If you have been assigned a "Target Benefit Basis," which is a function of your job title, your Basic Term Life Insurance benefit and the premium you pay for additional coverage are based on the Target Benefit Basis and not your current compensation. The Company periodically advises you of this Target Benefit Basis during onboarding, the Benefits Annual Enrollment period, or at other times throughout the plan year.

Imputed Income

If your Basic Term Life Insurance coverage exceeds $50,000, the value of the amount of coverage that exceeds $50,000 is subject to imputed income taxes. The monthly value used to determine imputed income is based on a table provided by the Internal Revenue Service (IRS), not by ADT or the insurance company. The total imputed income is reported each year on your W-2 and you pay taxes on this amount.

To calculate the imputed income related to your Basic Term Life Insurance:

- Subtract $50,000 from your Basic Term Life Insurance coverage amount.
- Divide by $1,000.
- Multiply by the appropriate age-related monthly IRS Uniform Premium Rates. (**Please note:** Your age for calculating your imputed income is your age at the end of the calendar year.)

For example, let's assume that you are a 45 year-old ADT employee with $85,000 in Basic Term Life Insurance coverage. According to the IRS imputed income tax table, the monthly value of your coverage amount is $.15 per $1,000 of coverage. Using the calculation above, here's how your imputed income would be determined:

- $85,000 - $50,000 = $35,000
- $35,000 ÷ $1,000 = 35
- 35 x $.15 = $5.25

This means that you would pay taxes on an additional $5.25 per month. Assuming a 30% tax withholding bracket, this means $1.58 would be withheld monthly from your paycheck for federal withholding taxes.

What the Basic Term Life Insurance Plan Does Not Cover

If you met the eligibility waiting period and you are an active employee and/or an employee on a leave of absence of up to nine consecutive months, the Basic Term Life Insurance has **no** exclusions or limitations regarding payment of benefits in the event of your death.

Supplemental Life Insurance

Everyone has different needs when it comes to life insurance. Depending on your unique situation, you and your family may have the need for additional life insurance coverage that can bring peace of mind to you and your dependents.

Please note: See "Policies Affecting Both Basic Life and Supplemental Insurance" later in this section for more information on Supplemental Life Insurance Plan rules.

How Employee Supplemental Life Insurance Works

ADT offers Supplemental Life Insurance coverage for you at favorable group rates, which allows you to tailor a life insurance program to your own specific situation. You can buy additional coverage for yourself.

Once you enroll for this coverage through ADT, you will be offered to continue coverage as an individual policy if you end your employment.

Your Coverage Amounts

As a benefits-eligible ADT employee, you may buy Supplemental Life Insurance coverage equal to one, two, three, four, five, six, seven, eight, nine, or ten times your base annual salary or Target Benefit Basis, rounded to the next highest $1,000. For example, if your base annual salary or Target Benefit Basis is $44,250, and you elect coverage equal to one times your base annual salary, your Supplemental Life Insurance coverage amount would be $45,000.

The minimum coverage amount you may purchase is one times your base annual salary. The maximum coverage amount is the lesser of ten times your base annual salary or $3 million.

For purposes of the Supplemental Life Insurance Plan, base annual salary means your annual salary, excluding any cash bonuses, overtime pay, or commissions. If you are a no base salary or a fixed-base salary employee, your coverage is based on a Target Benefit Basis. For details on coverage for no base salary or a fixed-base salary employees, contact your human resources representative. In all cases, you **must** be in active service on the date your coverage under the Supplemental Life Insurance Plan is scheduled to begin. If you are not in active service on this date, your coverage begins on the date that you return to active employment. You are not considered in active service if you are absent from work due to accidental bodily injury, illness, pregnancy, mental illness, or substance abuse.

How Spouse/Domestic Partner Supplemental Life Insurance Works

You can buy additional Supplemental Life Insurance coverage for your spouse/domestic partner. Dependent coverage is available **only** when you elect employee coverage for yourself.

Once you enroll for this coverage through ADT, you will be able to continue coverage as an individual policy if you end your employment.

Your Spouse's/Domestic Partner's Coverage Amounts

If you enroll in Supplemental Life Insurance coverage for yourself, you may also purchase coverage for your spouse or eligible domestic partner in $10,000 increments, up to $250,000. See the **Eligibility** section of this SPD for details.

Spouse/domestic partner coverage cannot exceed 50% of the amount of your Supplemental Life Insurance coverage.

If your spouse/domestic partner is confined in a hospital or elsewhere because of disability on the date the Supplemental Life Insurance would normally become effective, coverage (or an increase in coverage) will be deferred until your spouse/domestic partner is no longer confined and has performed all the normal activities of a healthy person of the same age.

If both you and your spouse/domestic partner work for ADT, you can each be covered both as a dependent **and** an employee under the Supplemental Life Insurance Plan. For example, you can elect Supplemental Life Insurance Plan coverage for yourself as an employee **and** also be enrolled as your ADT-employed spouse's/domestic partner's covered family member.

How Dependent Child(ren) Supplemental Life Insurance Works

You can buy additional Supplemental Life Insurance coverage for your child(ren). Dependent coverage is available **only** when you elect employee coverage for yourself.

Once you enroll for this coverage through ADT, you will be able to continue coverage as an individual policy if you end your employment.

Your Dependent Child(ren)'s Coverage Amounts

If you enroll in Supplemental Life Insurance coverage, you may also buy $5,000 or $10,000 of term life coverage for each of your eligible child(ren). See the **Eligibility** section of this SPD for details.

If your eligible dependent child is confined in a hospital or elsewhere because of disability on the date the Supplemental Life Insurance would normally become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age.

If you and your spouse/domestic partner are both covered employees, dependent child(ren) are eligible to be enrolled for coverage under both parents. For example, you can elect dependent coverage for your eligible child(ren) and your spouse/domestic partner may also elect to enroll your eligible child(ren) for coverage.

Please note: If you are an eligible employee, you are not eligible to also enroll for coverage as a dependent child. For example, if both you and your parent(s) are eligible employees, you may enroll for coverage for yourself under the Basic and Supplemental Life Insurance Plans, but you may not be enrolled for coverage via the dependent child option.

Guaranteed Issue Amounts

Initial Enrollment

The guaranteed issue amount is the maximum coverage you can buy for yourself or your eligible dependents without providing EOI. If you apply for coverage for yourself, your spouse/domestic partner or your child(ren) within 31 calendar days of when you are first eligible (as a new hire or following a qualifying status change that allows you to enroll in or increase your coverage), you can purchase up to the "guaranteed issue" amounts without providing EOI. If you apply for coverage at any other time, you must provide EOI for all coverage amounts. In this case, coverage does not become effective until approved by the insurance company, and could be denied. The guaranteed issue amounts are:

- **For new hire employee coverage:** The lesser of three times your base annual salary or $1 million. (**Please note:** Coverage amounts are reduced if you are age 65 or older.)
- **For employee coverage following a qualifying status change:** An increase of up to one times your base annual salary up to coverage of three times your annual base salary or $1 million. (**Please note**: Coverage amounts are reduced if you are age 65 or older.) See "Evidence of Insurability (EOI)" later in this section for more information.
- **For spouse/domestic partner coverage:** The lesser of 50% of the employee coverage amount or $30,000.
- **For child coverage:** All amounts are guaranteed issue.

You must provide EOI for coverage amounts above the guaranteed issue amount. In this case, only the guaranteed issue amount will be effective, and the insurance company must approve the amount above the guaranteed issue amount before the remainder of your coverage is effective.

Even if you have satisfied EOI previously for a benefit election change, you **must** satisfy EOI again if there is a subsequent benefit election change for the new incremental amount above your previously approved benefit level. If you do not submit satisfactory EOI, your benefit coverage amount will remain at the amount last approved by the insurance company. This does not apply to salary increases unless you cross the guaranteed issue amount for the first time with the salary increase.

For more information on enrolling, see the **Enrollment** section of this SPD.

Enrolling Mid-Year

For all mid-year enrollments, you must provide EOI for all coverage amounts for you and your spouse/domestic partner. There is no guaranteed issue amount for mid-year enrollments, except that if a dependent is enrolled within 31 calendar days of a qualifying status change, no EOI is required for the guaranteed issue amount. You may also increase your coverage, within 31 calendar days of a qualifying status change, by the lesser of one times your base annual salary up to three times your annual base salary or $1 million without EOI.

Evidence of Insurability (EOI)

Generally, EOI is required if:

- You wish to enroll more than 31 calendar days after your eligibility date or qualifying status change date.
- You request to increase your current coverage by one or more times your base annual salary during a Benefits Annual Enrollment period or after a qualifying status change.
- You previously opted out of Supplemental Life Insurance coverage or failed to provide sufficient EOI.

When EOI is required, you must:

- Complete and sign an insurance company health and medical history form;
- Submit to a medical examination, if requested; and
- Provide any additional information and attending doctors' statements, if requested.

Your coverage becomes effective on the date the insurance company approves your EOI. You may be required to furnish EOI at your own expense if you sign and submit the necessary paperwork to the insurance company more than 31 calendar days from the date your coverage is effective.

If you do not submit satisfactory EOI, coverage will remain at the level last approved by the insurance company.

What the Supplemental Life Insurance Plan Does Not Cover

Supplemental Life Insurance benefits are **not** payable if the death is caused by suicide within two years of the coverage effective date. This suicide exclusion also applies to any increases in coverage amount that became effective within two years prior to the suicide.

Policies Affecting Both Basic Term Life and Supplemental Life Insurance

If Your Pay Changes

Your Basic Term Life and Supplemental Life Insurance coverage automatically changes when your base annual salary changes. If your base annual salary increases or decreases, your benefit amount automatically increases or decreases on the same day, provided you are in active service on that day. If you are on a no base salary or a fixed-base salary, your earnings remain at your Target Benefit Basis unless there is a job change. **Please note:** Coverage maximums of $1 million for Basic Term Life Insurance and $3 million for Supplemental Life Insurance apply.

> "Active Service"—You are in active service on a day that is one of the Company's scheduled work days if either of the following conditions are met:
>
> 1. You are performing your regular occupation for the Company on a full-time basis. You must be working at one of the Company's usual places of business.
> 2. The day is a scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.
>
> You are in active service on a day that is not one of the Company's scheduled work days only if you were in active service on the preceding scheduled work day.

If the change in your base annual salary becomes effective on a non-working day, your coverage amount will change on:

- That same day, provided you were in active service on the last scheduled working day before that non-working day; or
- The date you return to active work, if you were not in active service on the date your annual earnings changed.

Age 65 Coverage Reduction

On January 1 (if your birthday falls on this day) or on the January 1 following the year in which you reach age 65, your Basic Term Life and Supplemental Life Insurance coverage will be reduced to 65% of the coverage you had before you reached age 65. This amount is then rounded to the next highest $1,000. Subsequent Basic Term Life and Supplemental Life Insurance coverage amounts are based on 65% of your base annual salary.

For example, let's assume that you reach age 65 on September 24 and your base annual salary is $85,000. The Basic Term Life Insurance Plan provides you one times your base annual salary and you elect two times your base annual salary in Supplemental Life Insurance coverage. Here's how your benefit would be determined on January 1 of the following year:

- Basic Term Life Insurance: $85,000 x 65% = $55,250 (rounded to $56,000).
- Supplemental Life Insurance: $170,000 x 65% = $110,500 (rounded to $111,000).

Since your Basic Term Life Insurance is over $50,000, it is still subject to imputed income taxes.

Your new Basic Term Life and Supplemental Life Insurance coverage will be reduced to 65% if:

- You are age 65 or older when you become eligible for coverage under this plan; or
- You are age 65 or older and your coverage amount increases because of a change in your employment status, the insurance schedule for this plan, or your earnings.

For details, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**. Since coverage for your spouse/domestic partner cannot exceed 50% of the amount of your Supplemental Life Insurance coverage, when your coverage is reduced to 65%, the coverage for your spouse/domestic partner and dependents may reduce as well.

Living Benefit

If you or your dependents are under age 60 and are terminally ill (meaning you have 12 or fewer months to live, as determined by a licensed doctor), you may elect to have a portion of your Basic Term Life and/or Supplemental Life Insurance benefit paid to you in one lump sum. Upon your death, the remaining benefit is paid to your beneficiary. In some locations, you may also choose to receive your benefit in periodic payments.

You may request a living benefit of up to 80% of your coverage, to a combined maximum of $500,000 for both Basic Term Life and Supplemental Life Insurance.

To receive your living benefit, you must provide the insurance company with satisfactory proof of your terminal illness and submit to any examination requested by the insurance company. Satisfactory written proof must be provided by an attending doctor licensed to practice in the United States. The living benefit will not be paid if you fail to provide proof of your terminal illness or submit to a requested examination.

Any living benefit you receive may be taxable. Therefore, you are strongly encouraged to consult a tax or financial adviser before taking advantage of this feature. Additionally, you should also be aware of the following provisions before making a decision about the living benefit:

- **If you are no longer terminally ill and you return to work,** the amount of the Basic Term Life and/or Supplemental Life Insurance payable at your death is reduced by the amount of any living benefit you received.
- **If you are no longer terminally ill and you do not return to work,** your coverage ends when your employment terminates or when coverage would normally end due to an extended leave of absence or you are no longer benefits-eligible. In this case, you may be eligible to convert your coverage to an individual plan if you are not eligible for any other group coverage. The amount you are eligible to convert is reduced by the amount of any living benefit you received. Coverage does not terminate when a person is no longer considered terminal. Leave of absence guidelines would apply with respect to continuation of coverage.

Accidental Death & Dismemberment (AD&D) Insurance

How the AD&D Plan Works

In case of an accident—anywhere, anytime—ADT's Accidental Death & Dismemberment (AD&D) Insurance Plan pays a benefit if the covered accident causes loss of life, limb, sight or hearing, or results in paralysis. You are automatically covered under this AD&D Plan at no cost to you, if you are benefits-eligible. ADT pays the full cost of this benefit.

Benefits under this AD&D Plan are in addition to any benefits payable under the Basic Term Life, Supplemental Life and/or BTA Insurance Plans.

Your Coverage Amount for Death

The amount of your AD&D coverage for death is the same as your Basic Term Life Insurance coverage—one times your base annual salary, rounded to the next highest $1,000, to a maximum amount of $1 million. This benefit is payable in addition to your Basic Term Life Insurance benefit if you die as the result of a covered accident.

For details, contact your human resources representative.

AD&D Benefits Payable for Loss

Benefits for loss are paid based on your AD&D coverage amount, depending on the type of loss, as shown below:

If, Due to a Covered Accident, You Lose…	The AD&D Plan Pays this Percentage of Your Coverage Amount…
Your life	100%
Two hands, two feet, or sight in both eyes	100%
Speech **and** hearing in both ears	100%
One hand and one foot	100%
One hand or one foot plus the sight of one eye	100%
One hand, one foot, or sight of one eye	50%
Speech **or** hearing in both ears	50%
Thumb and index finger on same hand	25%

If you suffer more than one loss in any one covered accident, the most that will be paid is 100% of your coverage amount.

To be eligible for AD&D benefits, your loss must occur within 365 calendar days of the date of the covered accident. In the event of your death, benefits are paid to your beneficiary; otherwise, benefits are paid to you.

Paralysis Benefit

If you become paralyzed within 365 calendar days of a covered accident, the AD&D Insurance Plan will pay benefits as follows:

- **Hemiplegia** (the complete and irreversible paralysis of upper and lower limbs on one side of the body)—50% of your coverage amount.
- **Paraplegia** (the complete and irreversible paralysis of both lower limbs)—75% of your coverage amount.
- **Quadriplegia** (the complete and irreversible paralysis of both upper and lower limbs)—100% of your coverage amount.

These benefits are in addition to any benefits payable for any loss listed under “AD&D Benefits Payable for Loss” earlier in this section. If you suffer more than one loss in any one accident, the most that will be paid is 100% of your coverage amount.

AD&D Terms

For purposes of the AD&D Insurance Plan, loss means:

- For an eye, you suffer an entire and permanent loss of sight that is irrecoverable by natural, surgical, or artificial means.
- For a hand or foot, the limb is actually severed at or above the wrist or ankle, respectively.
- For speech or hearing, you suffer an entire and permanent loss of either your speech or your hearing that is irrecoverable by natural, surgical, or artificial means.
- For thumb and index finger, the finger and thumb on the same hand are actually severed at or above the metacarpophalangeal joints.

Paralysis and severance are defined as follows under the AD&D Insurance Plan:

- **Paralysis:** Total loss of use of a limb. A doctor must determine the loss of use to be complete and irrevocable.
- **Severance:** Complete and permanent separation and dismemberment of the part of the body.

Coma Benefit

If you sustain an injury that results in a coma within 31 calendar days of a covered accident and the coma lasts at least 30 consecutive calendar days, the AD&D Insurance Plan will pay a monthly coma benefit. A coma means a profound state of unconsciousness:

- That resulted directly from a covered accident and independently from all other causes; and
- From which the individual cannot be aroused, even by powerful stimulation, as determined by a licensed doctor.

The coma benefit is equal to 1% of your coverage amount, less any amount paid or payable under the AD&D Insurance Plan as a result of the same accident. This amount will be paid for each month that the covered individual is in a coma until the comatose condition has ended, up to 100% of your coverage amount.

Seat Belt Coverage

The seat belt provision of the AD&D Insurance Plan provides additional benefits if:

- You die as a direct result of injuries sustained in a motor vehicle accident, whether as a passenger or driver; and
- You were properly wearing a seat belt or lap and shoulder harness at the time of the accident.

In this case, the AD&D Insurance Plan pays an additional 10% of your coverage amount, up to a maximum of $10,000.

The official police report of the covered accident must verify the proper use of the seat belt at the time of the accident, or the investigating officer(s) must certify, in writing, the proper use of the seat belt. This certification must be submitted with the covered person's claim to the insurance company. If certification or a police report is not available or it is unclear whether you were wearing a seat belt, the insurance company will pay a default benefit of $1,000 to your beneficiary.

Personal and Family AD&D Insurance

How Employee P&F AD&D Insurance Plan Works

Accidents can happen without warning. To help protect you from the unexpected, ADT offers you the opportunity to supplement other life and accident insurance with additional coverage through the P&F AD&D Insurance Plan.

With the P&F AD&D Insurance Plan, you are eligible for additional benefits if you are seriously injured or die as the result of a covered accident.

Your Coverage Amount

You may elect to buy coverage for yourself in amounts of one to eight times your base annual salary, rounded to the next highest $1,000. For example, if your base annual salary is $44,250 and you elect coverage equal to one times your salary, your coverage amount is rounded up to $45,000. EOI is not required. Coverage is limited to $1 million.

For purposes of the P&F AD&D Insurance Plan, base annual salary means your annual salary, excluding any cash bonuses, overtime pay, shift differentials, profit sharing payments, commissions, and any other form of payment or compensation. If you are a no base salary or fixed-based salary employee, your coverage is based on a Target Benefit Basis. For details on coverage for no base salary or fixed-based salary employees, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

How Dependent P&F AD&D Insurance Plan Works

You can buy additional P&F AD&D coverage for your eligible family members at any time.

Dependent coverage is available **only** when you elect employee coverage for yourself.

With the P&F AD&D Insurance Plan, you are eligible for additional benefits if an eligible family member is seriously injured or dies as the result of a covered accident.

Employee+1 Coverage Amounts

With Family coverage, the amount payable is based on the coverage amount you elect from the options available (that is, one, two, three, four, five, six, seven, or eight times your base annual salary up to a maximum of $1 million). The coverage amount available in the event of a loss depends on your family composition at the time of the loss, expressed as a percentage of your coverage amount, as shown in the chart on the next page:

If Your Eligible Family Members Are Your…	Their Coverage Amount Is this Percentage of Your Coverage Amount…
Spouse/domestic partner only	60%
Dependent child(ren) only	20% per child
Spouse/domestic partner and child(ren)	50% for your spouse/domestic partner 10% for each child

For example, if you elect coverage for yourself of $100,000 and coverage for your spouse/domestic partner and child(ren), the maximum amount of coverage available for your spouse/domestic partner would be $50,000 and the maximum amount of coverage available for each child would be $10,000.

You and your spouse/domestic partner can be covered both as a dependent **and** an employee under the P&F AD&D Insurance Plan. For example, you can elect P&F AD&D coverage for yourself **and** also be enrolled as your spouse's/domestic partner's covered family member.

In addition, a dependent can be covered by either you or your spouse/domestic partner.

P&F AD&D Benefits Payable

The P&F AD&D Insurance Plan pays benefits if you or a covered family member experiences one of the losses described below as a result of a covered accident. The accident must occur while you are an active employee, with the loss occurring within 365 calendar days of that covered accident. Benefits are paid in a lump sum.

Benefits are payable based on your own or your covered family member's coverage amount, depending on the nature of your loss, as shown in the chart below:

If, Due to a Covered Accident, You or Your Covered Family Member Loses…	The P&F AD&D Plan Would Pay this Percentage of the Coverage Amount…
Your or your covered family member's life	100%
Two hands, two feet, or sight in both eyes	100%
Speech **and** hearing in both ears	100%
One hand and one foot	100%
One hand or one foot plus the sight of one eye	100%
One hand, one foot, or sight of one eye	50%
Speech **or** hearing in both ears	50%
Thumb and index finger on same hand	25%

If you or a covered family member suffers more than one loss in any one covered accident, the most that will be paid is 100% of your coverage amount.

Paralysis Benefit

If you or a covered family member becomes paralyzed within 365 calendar days of a covered accident, the P&F AD&D Insurance Plan will pay benefits as follows:

- **Hemiplegia** (the complete and irreversible paralysis of upper and lower limbs on one side of the body)—50% of your coverage amount.

- **Paraplegia** (the complete and irreversible paralysis of both lower limbs)—75% of your coverage amount.
- **Quadriplegia** (the complete and irreversible paralysis of both upper and lower limbs)—100% of your coverage amount.

These benefits are in addition to any benefits payable for any loss listed under **"**P&F AD&D Benefits Payable" earlier in this section. If you suffer more than one loss in any one accident, the most that will be paid is 100% of your coverage amount.

P&F AD&D Terms

For purposes of the P&F AD&D Insurance Plan, loss means:

- For an eye, you suffer an entire and permanent loss of sight that is irrecoverable by natural, surgical, or artificial means.
- For a hand or foot, the limb is actually severed at or above the wrist or ankle, respectively.
- For speech or hearing, you suffer an entire and permanent loss of either your speech or your hearing that is irrecoverable by natural, surgical, or artificial means.
- For thumb and index finger, the finger and thumb on the same hand are actually severed at or above the metacarpophalangeal joints.

Paralysis and severance are defined as follows under the P&F AD&D Insurance Plan:

- **Paralysis:** Total loss of use of a limb. A doctor must determine the loss of use to be complete and irrevocable.
- **Severance:** Complete and permanent separation and dismemberment of the part of the body.

Coma Benefit

If you or a covered family member sustains an injury that results in a coma within 31 calendar days of a covered accident and the coma lasts at least 30 consecutive calendar days, the P&F AD&D Insurance Plan will pay a monthly coma benefit. A coma means a profound state of unconsciousness:

- That resulted directly from a covered accident and independently from all other causes; and
- From which the individual cannot be aroused, even by powerful stimulation, as determined by a licensed doctor.

The coma benefit is equal to 1% of the coverage amount, less any amount paid or payable under the P&F AD&D Insurance Plan as a result of the same accident. This amount will be paid for each month that the covered individual is in a coma until the comatose condition has ended, up to 100% of your coverage amount.

Seat Belt Coverage

The seat belt provision of the P&F AD&D Insurance Plan provides an additional benefit if:

- You or a covered member of your family dies as the direct result of injuries sustained in a motor vehicle accident, whether as a passenger or driver; and
- You or the covered member of your family was properly wearing a seat belt or lap and shoulder harness at the time of the accident.

In this case, the P&F AD&D Insurance Plan pays an additional 10% of the coverage amount, up to a maximum of $25,000.

In the case of a child, seat belt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for child(ren) of like age and weight at the time of the covered accident.

The official police report of the covered accident must verify the proper use of the seat belt at the time of the accident, or the investigating officer(s) must certify, in writing, the proper use of the seat belt. This certification must be submitted with the covered person's claim to the insurance company. If certification or a police report is not available or it is unclear whether the covered person was wearing a seat belt, the insurance company will pay a default benefit of $1,000 to the covered person's beneficiary.

Education Benefit

Education Benefits for Your Child

If you die as a result of a covered accident, the P&F AD&D Insurance Plan will pay an additional benefit for your dependent child(ren) who is:

- Enrolled as a full-time student at a college, university, or trade school at the time of the accident; or
- In the 12th grade and enrolls as a full-time student at a college, university or trade school within 365 calendar days of the accident.

Each eligible child will receive the lesser of:

- The actual annual tuition charged by the school, not including room and board;
- 25% of your covered amount; or
- $10,000 per school year.

Education benefits are payable for a maximum of four years per child, provided your child continues as a full-time student during that four-year period.

Education Benefits for Your Spouse/Domestic Partner

Your surviving spouse/domestic partner will also be entitled to receive an additional benefit if he/she enrolls in any accredited professional or trade program to secure an independent source of income. Provided that expenses are incurred within 12 months after your death, the P&F AD&D Insurance Plan will pay the full cost of this training, up to a maximum of $10,000.

Family Extension Benefit

If you die in a covered accident and have coverage for your spouse/domestic partner and/or dependent child(ren), your covered family members' P&F AD&D coverage can continue until:

- The date your spouse remarries or your domestic partner enters into another domestic partnership (in this case, coverage ends for all covered family members);
- The date your spouse/domestic partner obtains coverage under another group plan;
- The date your dependent child(ren) no longer meets the definition of an eligible dependent under the P&F AD&D Insurance Plan (in this case, coverage will continue for your spouse/domestic partner, if any, and any other eligible dependents); or five years from the date of your death; or
- The date the policy ends.

Please note: The insurance company must receive your spouse's/domestic partner's written request and the required premium to continue the coverage within 31 calendar days of the premium due date next following the date of your death.

In the event that a covered family member suffers a loss for which a P&F AD&D benefit is payable under the P&F AD&D Insurance Plan, the benefit will be the same as the benefit payable for him/her prior to your death.

Exposure and Disappearance

If you or your family members have unavoidable exposure to the elements as the result of an accident covered under the P&F AD&D Insurance Plan, and as a result experience a covered loss, the P&F AD&D Insurance Plan will pay benefits as specified under "P&F AD&D Benefits Payable" earlier in this section.

If you or your family members are involved in an accident while traveling by automobile, airplane, or another type of vehicle and your body (or that of your family member) is not found within one year, P&F AD&D benefits will be payable as if you (or your family member) had died.

Additional P&F AD&D Benefits

In addition to the benefits described above, the P&F AD&D Insurance Plan provides additional support services and benefits when a family is facing emotional and financial difficulties following a covered accidental death or dismemberment. These additional services and benefits include:

- Bereavement and trauma counseling;
- Burn benefit;
- Home alteration and vehicle modification benefit;
- In-hospital indemnity benefit;
- Occupational HIV benefit (available to you only); and
- Rehabilitation benefit.

For more information about these services, call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance** followed by **Accident Insurance**.

Business Travel Accident (BTA) Insurance

How the BTA Insurance Plan Works

If you are involved in a covered accident while traveling on Company business, ADT's BTA Insurance may pay a benefit to you or your beneficiary. Provided you are traveling on Company business, you are covered 24 hours a day, worldwide. **Please note:** The BTA policy provides accident coverage only; it does not pay benefits for losses caused by or related to an illness.

Coverage is in effect as soon as you leave home or work to travel on ADT business and continues until you return to your home or place of permanent employment.

All active full-time ADT employees are covered under the BTA Insurance Plan as of their date of hire. You are automatically enrolled in this BTA Insurance Plan at no cost to you. Benefits under the BTA Insurance Plan are in addition to any benefits payable under the Basic Term Life Insurance, AD&D Insurance, Supplemental Life Insurance, or P&F AD&D Insurance Plans.

Please note: For illness assistance while traveling please refer to the **Additional Benefits** section of this SPD for information regarding the BlueCard Worldwide and Travel Assist programs.

Your Coverage Amount

The amount and type of coverage for BTA Insurance is shown in the table below:

Base Annual Salary (Active Employees)	Coverage Amount
Under $50,000	4 x base annual salary with a minimum of $175,000 and a maximum of $200,000 4 x Target Benefit Basis for employees on a no base salary or a fixed-based salary with a minimum of $175,000 and a maximum of $200,000
$50,000 and higher	4 x base annual salary with a minimum of $500,000 and a maximum of $3 million 4 x Target Benefit Basis for employees on a no base salary or a fixed-based salary with a minimum of $500,000 and a maximum of $3 million

Please note: If you are on foreign currency (non-U.S.) payroll and are employed in a non-U.S. division/subsidiary of ADT, the exchange rate applied in determining your base annual salary will be set at each annual anniversary date of the policy, using U.S. dollar exchange rates quoted in *The Wall Street Journal* for the day closest to the anniversary date of the policy.

Dependents' Coverage Amounts

Your spouse/domestic partner and your eligible dependent child(ren) are also covered while accompanying you on a business trip, provided the trip is authorized by ADT and at the Company's expense. Your spouse's coverage is $25,000; coverage for each dependent child is $10,000.

BTA Benefits Payable

BTA coverage is provided to you 24 hours a day for accidents sustained anywhere in the world during business travel for the Company. Coverage begins when you leave your home or place of permanent employment, whichever occurs last, and continues until you return to your home or place of permanent employment, whichever is first. Travel to and from work, vacations, and leaves of absence are not covered.

The benefit paid depends on the type of loss, as shown in the chart below. For benefits to be paid, the loss **must** occur within one year of the covered accident.

If, Due to a Covered Accident, You Lose…	The BTA Insurance Plan Pays this Percentage of Your Coverage Amount…
Your life	100%
Two hands, two feet, or sight in both eyes	100%
Speech **and** hearing in both ears	100%
One hand and one foot	100%
One hand or one foot plus the sight of one eye	100%
One hand, one foot, or sight of one eye	50%
Speech **or** hearing in both ears	50%
Thumb and index finger on same hand	25%

If you suffer more than one loss in any one covered accident, the most that will be paid is 100% of your coverage amount.

Paralysis Benefit

If you become paralyzed within 365 calendar days of a covered accident, the BTA Insurance Plan will pay benefits as follows:

- **Hemiplegia** (the complete and irreversible paralysis of upper and lower limbs on one side of the body)—50% of your coverage amount.
- **Paraplegia** (the complete and irreversible paralysis of both lower limbs)—75% of your coverage amount.
- **Quadriplegia** (the complete and irreversible paralysis of both upper and lower limbs)—100% of your coverage amount.

These benefits are in addition to any benefits payable for any loss listed under “BTA Benefits Payable” earlier in this section. If you suffer more than one loss in any one accident, the most that will be paid is 100% of your coverage amount.

BTA Terms

For purposes of the BTA Insurance Plan, loss means:

- For an eye, you suffer an entire and permanent loss of sight that is irrecoverable by natural, surgical, or artificial means.
- For a hand or foot, the limb is actually severed at or above the wrist or ankle, respectively.
- For speech or hearing, you suffer an entire and permanent loss of either your speech or your hearing that is irrecoverable by natural, surgical, or artificial means.
- For thumb and index finger, the finger and thumb on the same hand are actually severed at or above the metacarpophalangeal joints.

Paralysis and severance are defined as follows under the BTA Insurance Plan:

- **Paralysis:** Total loss of use of a limb. A doctor must determine the loss of use to be complete and irrevocable.
- **Severance:** Complete and permanent separation and dismemberment of the part of the body.

Coma Benefit

If you sustain an injury that results in a coma within 31 calendar days of a covered accident and the coma lasts at least 30 consecutive calendar days, the BTA Insurance Plan will pay a monthly coma benefit. A coma means a profound state of unconsciousness:

- That resulted directly from a covered accident and independently from all other causes; and
- From which the individual cannot be aroused, even by powerful stimulation, as determined by a licensed doctor.

The coma benefit is equal to 1% of the coverage amount, less any amount paid or payable under the plan as a result of the same accident. This amount will be paid for each month that the covered individual is in a coma until the comatose condition has ended, up to 100% of your coverage amount. No benefits are payable for the first 30 calendar days.

Seat Belt Coverage

The seat belt provision of the BTA Insurance Plan provides additional benefits if:

- You die as a direct result of injuries sustained in a motor vehicle accident, whether as a passenger or driver; and
- You were properly wearing a seat belt or lap and shoulder harness at the time of the accident.

In this case, the BTA Insurance Plan pays an additional 10% of your coverage amount, up to a maximum of $25,000.

The official police report of the covered accident must verify the proper use of the seat belt at the time of the accident, or the investigating officer(s) must certify, in writing, the proper use of the seat belt. This certification must be submitted with the covered person's claim to the insurance company. If certification or a police report is not available or it is unclear whether you were wearing a seat belt, the insurance company will pay a default benefit of $1,000 to your beneficiary.

Exposure and Disappearance

If you have unavoidable exposure to the elements as the result of the forced landing, stranding, sinking, or wrecking of a vehicle in which you were traveling on Company business—and as a result, experience a covered loss—the BTA Insurance Plan will pay benefits as specified under "BTA Benefits Payable" earlier in this section.

If you are involved in an accident while traveling by automobile, airplane, or another type of vehicle in the course of a trip covered by this policy and your body is not found within one year, BTA benefits will be payable as if you had died.

Child Care Benefit

If you die as the result of a covered accident, your surviving dependent child is eligible for a child care benefit if your child satisfies the following requirements:

- On the date of the covered accident, the child was enrolled in an accredited child care facility; **or**
- The child is enrolled in an accredited child care facility within 365 continuous calendar days from the date of the accidental death; **and**
- The child is less than seven years of age.

The child care benefit for each child who qualifies is payable in an amount up to 5% of your coverage amount, but not more than $5,000 per year. This benefit is payable only while the dependent child continues to be enrolled in an accredited child care facility.

This benefit will be paid once a year for not more than four years.

This benefit will be paid to the individual who has legal physical custody of the dependent child or who has primary responsibility for the dependent child's expenses.

For purposes of this BTA Insurance Plan, an accredited child care facility:

- Is a child care facility that operates pursuant to state and local laws;
- Is licensed by the state for such child care facilities; and
- Has been provided with a tax identification number by the IRS.

An accredited child care facility does **not** include a hospital, the child's home, a nursing or convalescent home, a facility for the treatment of mental disorders, an orphanage, or a treatment center for drug and alcohol abuse.

Travel Assistance Benefit

If you (or your covered family members if you covered them in the P&F AD&D Insurance Plan) are traveling 100 or more miles away from your home, you will be eligible to access Europ Assistance USA, which includes solutions that range from pre-travel intelligence and contingency planning to 24-hour emergency medical evacuation and repatriation programs. This 24/7 support network manages and provides medical, legal, informational, and personal services to ensure that travelers have access to the best possible care anywhere in the world.

To obtain a brochure and ID card, contact **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance** followed by **Accident Insurance**. You will need to provide the policy number that is on the ID card when requesting covered services.

Services and Coverage

The program offers the following services:

- Pre-departure services; for example, up-to-date information on:
  - Immunization requirements;
  - Visa and passport requirements;
  - Foreign exchange rates;

  - Embassy/consular referral; and
  - Travel/tourist advisories.
- Emergency medical evacuation and repatriation:
  - If an unexpected medical emergency requires you to be evacuated to a medical facility for medically necessary treatment, Europ Assistance USA will arrange and pay for your transportation to the nearest adequate facility that can properly treat your condition.
  - If you should die while traveling, all necessary government authorizations will be arranged, and the program will pay for the return of your remains to your place of residence for burial or cremation.
- Arrangements for and payment of:
  - The safe return home of any dependent child(ren) under the age of 19 if you are hospitalized;
  - A traveling companion's return to his/her original destination if your medical condition results in delays; and
  - A visit by a person of your choice if you are traveling alone and are to be hospitalized for at least seven consecutive calendar days.
- Medical assistance services, including:
  - Medical referrals for local doctors, dentists, and medical treatment centers if you are injured or become ill while traveling;
  - Prescription assistance to refill a prescription that has been lost, stolen, or depleted; and
  - Arrangements for payment of medical expenses up to $5,000 with the Company's written guarantee of reimbursement.

  Please note: All medical evacuation and repatriation services **must** be pre-authorized with Europ Assistance USA. Medical assistance services may involve third-party expenses, which are your responsibility as the covered individual. Maximum benefit limits may apply.

- Assistance with lost or stolen items (for example, locating and replacing luggage, documents, and any other personal possessions);
- Legal assistance with local attorneys, embassies and consulates;
- Translation and interpretation services for all major languages;
- Emergency travel services, including:
  - Emergency message relays to put you in touch with family members, friends, and business associates;
  - Emergency travel arrangements; for example, changing or making airline, hotel, or car rental reservations on your behalf; and
  - Emergency cash advances.

What Travel Assistance Does Not Cover

Medical evacuation and repatriation if:

- The travel was undertaken for the specific purpose of securing medical treatment or for a self-inflicted injury.
- The injury or illness requiring medical services resulted from being under the influence of any controlled substance (unless such controlled substance was prescribed by a doctor and was taken in accordance with the prescribed dosage).

- Medical care being provided is consistent with western medical standards.
- It is not medically necessary to transport you to another hospital or medical facility.
- Based upon your medical condition and/or local conditions and circumstances, it is determined that medical evacuation or medical repatriation is not appropriate. (Europ Assistance USA has the sole discretion in making that determination.)

What the AD&D, P&F AD&D, and BTA Plans Do Not Cover

Certain losses are not covered by the AD&D, P&F AD&D, and BTA Insurance Plans, including but not limited to losses caused by or resulting from any of the following:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
- War or any act of war, whether declared or undeclared.
- Involvement in any type of active military service. (Reserve Corps or National Guard duty training is not excluded, until training extends beyond 31 consecutive calendar days.).
- Illness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated foods.
- Participation in the commission or attempted commission of any felony or an assault, or active participation in an insurrection or riot.
- Being intoxicated while operating a motor vehicle.
  - An insured person will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be intoxicated, if operating a motor vehicle.
  - An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the insured person's intoxication.
- Operating a motor vehicle while under the influence of any drug, narcotic, or other intoxicant, including any prescribed drug for which the insured person has been provided a written warning against operating a vehicle while taking it.
- The deliberate ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a doctor and taken in accordance with the prescribed dosage.
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface:
  - Except as a passenger on any civilian aircraft, including aircraft leased by ADT, with a current and valid normal, transport, or commuter-type standard airworthiness certificate as defined by the FAA or an equivalent certification from a foreign government; or any aircraft which is not subject to a certificate of airworthiness but whose design and regular purpose is for transporting passengers, and, is operated by the Armed Forces of the United States or the Armed Forces of any foreign government.
  - Being flown by the primary insured person or in which the primary insured person is a member of the crew; owned, controlled by, or under lease to a primary insured person or a member of their family or household.

- Being used for any specialized aviation activity:
  - Acrobatic or stunt flying, aerial photography, crop dusting, seeding or spraying, endurance tests, exploration, fire fighting, giving or receiving flying instructions, flight on a rocket-propelled or rocket launched aircraft, an ultra-light or glider, hang gliding, parachuting, pipe line or power line inspection, racing, sky diving, sky writing, tests or experimental purposes; or
  - Flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

Applying for Benefits

Filing a Claim

To file a claim for the Basic Term Life, Supplemental Life, and AD&D Insurance Plans, you, your beneficiary, or your authorized representative must call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance** to file a claim. You, your beneficiary, or your authorized representative must submit a written application with the insurance company within certain time periods after the occurrence of any loss, as specified below:

- **Basic Life and Supplemental Life Insurance:** no time limit. (**Please note:** You, your beneficiary, or your authorized representative will receive the required paperwork in the mail following telephonic notification of a claim.)
- **AD&D or P&F AD&D Insurance:** 30 calendar days.
- **BTA Insurance:** 30 calendar days.

If it is not possible to file the claim within these stated time periods, it must be filed as soon as possible after the loss, within a reasonable time frame. To file the claim, return the completed claim form, together with written proof of injury or death to the address listed in the **Claim Review and Appeal Processes** section of this SPD for processing.

Call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance** to request forms. You may also contact the appropriate insurer for forms and information about applying for benefits.

See the **Claim Review and Appeal Processes** section of this SPD for more information on filing an appeal to a denied claim.

Applying for a Living Benefit

The living benefit becomes payable when you have been certified by a licensed doctor as being terminally ill with a life expectancy of 12 months or less. The claim should be filed as soon as possible after this diagnosis. For the necessary forms and a list of supporting documentation, call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance**. You may also contact the appropriate insurer for forms and information about applying for benefits.

Continuing Coverage on Leave of Absence

Under certain circumstances, if you are no longer an active employee you may be eligible to continue your coverage under the Basic Term Life, Supplemental Life, AD&D, and P&F AD&D Insurance Plans.

As long as you are still employed by ADT and continue to pay the required premiums, you may continue your coverage for up to nine months after the date you stop active work depending on the type of leave. For specific information regarding continuation of coverage on a leave of absence, please call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

If you are laid off, you may continue your coverage by paying the required premiums through the end of the month following the month of the layoff.

In the event of your death while insured under Family coverage, your dependents' coverage will end and they will have an opportunity to convert their coverage to an individual policy or "port" the existing coverage.

For more information, call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance** or call the insurance company.

Conversion and Portability Options

Depending on the policy, you may have certain rights that allow you to convert your coverage to an individual policy or to port your supplemental coverage when your Life and AD&D Insurance coverage ends. These plan features give you the opportunity to retain a level of coverage without providing EOI. Conversion rights allow you to continue your coverage in an individual policy, but often with certain restrictions as to the type of policy and typically at higher individual premium levels than you would have paid for group coverage. Portability is similar to conversion, but is often less costly because these policies continue at favorable group premium rates.

With Basic Term Life Insurance, you convert your group coverage (which was term coverage) to an individual whole life policy with cash value. Premiums for individual whole life coverage are generally higher than the premiums for group term coverage offered through the Company.

You can also convert your Supplemental Life Insurance coverage, or continue Supplemental Life Insurance coverage through the Supplemental Life Insurance Plan's portability feature (up to a maximum of $250,000 for employees, $50,000 for a spouse, or $10,000 for a dependent child), which provides a more appealing, economical option for continuing coverage. With portability, the new group individual policy is a term policy which you'll receive at a group rate. You'll pay more than you did as an active employee but less than if you converted to an individual policy.

You can also continue P&F AD&D coverage through the P&F AD&D Plan's conversion features.

Converting Coverage

If coverage under a plan ends, you may convert coverage for the following plans to individual policies:

Basic Term Life and Supplemental Life Insurance

You may convert your Basic Term Life and Supplemental Life Insurance coverage to an individual policy if your coverage under the group policy ends for reasons other than: failure to pay premiums, you transfer out of a covered class, or all term life insurance of the Group Contract for your class ends by amendment or otherwise. On the date your coverage under the group policy ends, you must have been insured for five years under the group policy for that insurance (or for that insurance and any insurance company rider or group contract replaced by that insurance) to be available for conversion. The amount of coverage that may be converted is based on the reason your group coverage ended.

You must apply for converted coverage and pay the first premium within 31 calendar days after the date your group coverage ends. The cost of your converted coverage will be based on the policy that you choose and your age at the time you convert coverage. You are not required to provide EOI.

If you die within the 31-calendar-day conversion application period, your beneficiary will receive a benefit even if you had not yet applied for converted coverage. The maximum amount payable will be the amount of insurance you were eligible to convert under the plan. Any premium paid for conversion coverage will be returned to your beneficiary.

Portability Options for Supplemental Life Insurance and P&F AD&D Insurance Plans

Supplemental Life Insurance

When your coverage ends for a reason other than failure to pay premiums, retirement, disability, or replacement of ADT's plan by another plan, you can exercise a portability (port) option that allows you to transfer your Supplemental Life Insurance coverage to a group term policy without providing proof of good health. To be eligible, your coverage must end before Normal Retirement Age.

Under this provision, the amount you as an employee can convert is limited to $250,000

The amount of Supplemental Life Insurance that can be continued for your spouse/domestic partner is limited to $50,000.

Please note: You **must** elect the portability option on the employee portion of the Supplemental Life Insurance for your dependents to port their coverage, except in the case of your death, divorce, or termination of domestic partnership. To port dependent coverage, child(ren) must be under age 19 (23 for full-time students) and spouses/domestic partners must be prior to Normal Retirement Age.

By "porting" coverage, you will have the advantage of continuing your Supplemental Life Insurance at attractive term insurance group rates. If you have coverage that exceeds $250,000 for you or $50,000 for your spouse, the remaining amount after porting can be converted to an individual life insurance policy commonly known as a whole life (cash value) policy. For residents of New York, this option also applies for any cutbacks that could occur while covered under the portability policy.

To elect portability, you must apply and pay the premium within 31 calendar days of the termination of your Supplemental Life Insurance. **EmployeeAccess** will give you the necessary information, including a contact telephone number so you can review the portability option.

If you wish to "port" your Supplemental Life Insurance coverage, call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance**.

You may also convert P&F AD&D coverage for yourself if your coverage terminates for any reason other than termination of the policy. You may apply for coverage up to the amount of your coverage under the group plan to a maximum amount of $250,000. No medical exam or certification is required. The maximum amount available to convert may vary based on your age at time of conversion.

To elect conversion, you must apply and pay the premium within 31 calendar days of the termination of your P&F AD&D Insurance Plan. **EmployeeAccess** will give you the necessary information, including a contact telephone number so you can review the portability option.

If you wish to convert your P&F AD&D Insurance coverage, call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance** followed by **Accident Insurance**.

Conversion and Portability Examples

The following table is meant to provide you with examples of your conversion and portability options, but may not represent all situations. Should you need additional information call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance**.

Termination of Benefits Due to:	Basic Life*	Supplemental Life*	P&F AD&D*
Loss of Employment (dismissals, resignations, layoffs)	Eligible for conversion only	Eligible for both conversion and port options	Eligible for conversion only
Employee Retirement	Eligible for both conversion and port options	Eligible for conversion only	Eligible for conversion only
Employee Disability	Eligible for both conversion and port options	Eligible for both conversion and port options	Eligible for conversion only
Employee Leave of Absence	Eligible for both conversion and port options	Eligible for both conversion and port options	Eligible for conversion only
Divorce	Eligible for both conversion and port options	Eligible for both conversion and port options	Not applicable
Death of Employee	Not applicable	Eligible for both conversion and port options	Not applicable
Ineligibility but NOT Disabled or Leave of Absence (example: employee moving from full-time to part-time)	Eligible for both conversion and port options	Eligible for both conversion and port options	Eligible for conversion only
Child Reaching Age Limit	Not applicable	Eligible for conversion only	Not applicable

*You are not eligible to convert or port your coverage if benefits end due to failure to pay premiums, cancellation of coverage, or if coverage is replaced by another group insurance plan for which you are or will be eligible within 31 calendar days.

Please note: Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations, and exclusions of your insurance coverage. In the event of any difference between this document and the insurance policy, the terms of the insurance policy apply.

Disability

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Disability Benefits at a Glance

A disabling illness or injury can be financially devastating. ADT offers you Short-Term Disability (STD) income replacement coverage as well as the opportunity under the ADT Health and Welfare Benefits Plan to purchase Long-Term Disability (LTD) insurance for yourself at favorable group rates to help you and your family should you become temporarily or permanently disabled.

For information about benefits for short-term or long-term medical absences, contact **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Disability Management Services**.

Please note: For claims administrator contact information, see the **Claim Review and Appeal Processes** section of this SPD. Some of the terms used in this section have technical meanings and are defined in the **Glossary** section of this SPD.

This section describes disability coverage available to ADT LLC ("ADT," "The ADT Corporation," "an ADT employer," or "the Company") employees.

STD income replacement benefits are as follows:

STD Income Replacement Benefits at a Glance	
Eligibility …	This STD Plan applies to active employees of ADT and its participating subsidiaries/affiliates who are regularly scheduled to work at least 20 hours per week and who have completed 90 calendar days of active service with the Company as defined in the **Glossary** section of this SPD ("STD eligible employee")**.** The 90 calendar days is calculated by excluding periods of absence. The STD Plan does not apply to employees covered by a collective bargaining agreement unless participation in this STD Plan has been negotiated as part of the applicable collective bargaining agreement. Puerto Rico employees are not eligible for the ADT STD Plan, but are covered under the Puerto Rico SINOT Plan (see "Puerto Rico SINOT Rules" later in this section).
Benefits Begin …	After completing a waiting period of seven consecutive days of disability, benefits begin on the eighth calendar day of disability.
You receive the following income replacement … ▪ If your service at ADT is between 90 calendar days and two years: ▪ If your service at ADT is over two years:	 ▪ 180 calendar days at 66.6% of your base annual salary ▪ 180 calendar days at 80% of your base annual salary
Benefit Maximum …	None
You Pay …	The STD Plan is not insurance, it is an income replacement program provided to U.S. employees, which ADT provides at no cost to you.

Please note: The STD Plan is an income replacement plan and is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

LTD coverage may replace part of your income if you are unable to work for an extended period of time because of a covered illness or injury—so you have financial protection when you need it most.

Here's an overview of the benefits provided if you purchase LTD insurance:

LTD Benefits at a Glance	
Eligibility …	This LTD Plan applies: ▪ To active full-time employees of ADT who are not classified as Direct Connect employees who have completed 31 calendar days of active service' or ▪ To Direct Connect employees who have completed 91 calendar days of active service ("LTD eligible employees"). The LTD Plan does not apply to employees covered by a collective bargaining agreement unless participation in this LTD Plan has been negotiated as part of the applicable collective bargaining agreement. Puerto Rico employees are eligible for the LTD Plan.
Benefits Begin …	After the lesser of 180 calendar days or exhaustion of any loss of time benefits, salary continuation, or sick leave benefits. **Please note:** Puerto Rico employees are eligible and would need to apply after five months of continuous disability.
Plan Pays …	Depending on the election made by an LTD eligible employee: ▪ Option 1: 50% of base annual salary ▪ Option 2: 60% of base annual salary
Benefit Maximum …	Up to $15,000 per month
You Pay …	LTD premiums with after-tax dollars, so benefits are generally not taxable when received.

How Short-Term Disability Coverage Works

If you become disabled and cannot work due to injury or illness, your financial security could be affected. To help protect your income on a short-term basis, ADT offers coverage through the STD Plan. For additional information and the official description of the STD Plan, see the Short-Term Disability Policy, which is available online at **InsideADT > Human Resources Home > Policies & Procedures**.

Please note: If there is any discrepancy between the terms of the official Short-Term Disability Policy and this SPD, the terms of the Short-Term Disability Policy will apply.

Cost of Coverage

ADT automatically provides you with STD Plan coverage at no cost to you if you're an eligible U.S. employee, have completed at least 90 calendar days of active employment, and are regularly scheduled to work at least 20 hours per week.

Applying for STD Benefits

To apply for STD Plan benefits, you must call **EmployeeAccess** at **1-888-833-1839** and select Health and Group Benefits followed by Disability Management Services and speak with the disability administrator's intake department. To ensure that you receive any benefits to which you are entitled, you must report any injury or illness to your supervisor and the disability administrator within the first seven calendar days of an inability to perform your job, and you must seek appropriate medical attention within the first three calendar days of an inability to perform your job. It is important that you report your claim timely to ensure that your absence is accounted for and that your benefits begin promptly. Late reported claims may result in unpaid benefits.

The disability administrator will acknowledge your claim and will request that you provide verification of your claim by providing documentation of your inability to work from your medical provider.

As part of the benefit application process, you will be required to:

- Identify any other income benefits you are receiving or may be eligible to receive, such as Workers' Compensation, benefits from another employer, and other third-party benefits; and
- Provide proof that you have applied for state benefits, where applicable. See "State Disability Programs" later in this section.

Throughout the course of your disability, you will be asked to provide medical documentation that verifies your ongoing disability. This must be provided in a timely way to ensure your benefits are not interrupted. Furthermore, the disability administrator may periodically request that a physician of its choice conduct an independent medical examination at no cost to you. Failure to cooperate with such a request may result in the delay or loss of benefits.

In addition to the requirement that you provide medical documentation, you must report your claim to the disability administrator within seven calendar days of being unable to work.

Receiving STD Benefits

STD Benefit Waiting Period: The first seven calendar days you are absent from work due to a disability from first day of

To be eligible to receive STD income replacement benefits under the STD Plan, you must be able to demonstrate that you have been disabled from work for seven consecutive days. This is your STD benefit waiting period. For information on payment during the waiting period, when applicable, refer to the Short-Term Disability Policy online at **InsideADT** > **Human Resources Home** > **Policies & Procedures.**

If you've been continuously disabled during your benefit waiting period and your disability has been approved, the STD Plan pays a percentage of your base annual salary after the waiting period. The percentage is based on your length of service with ADT. If your length of service with ADT is greater than 90 calendar days but less than two years, you may be eligible to receive up to 66.6% of your base annual salary for 180 calendar days. If your length of service is two years or greater, you may be eligible to receive up to 80% of your base annual salary for 180 calendar days. **Please note:** Your STD benefit may be reduced by other income benefits you receive or are assumed to receive.

Benefits are available only to an employee who is (i) under a certified physician's ongoing care, and (ii) under active treatment. A certified physician must certify the starting, continuing, and ending dates of your disability and provide supporting medical documentation when requested by the disability case manager.

> "Active treatment" means being physically examined by the treating physician at intervals recommended by the physician, or as otherwise prescribed by the STD Plan.

The fact that you present a physician's certificate indicating an illness or disability does not necessarily establish eligibility for STD benefits. The disability administrator will determine if you've met the STD Plan's requirements and are eligible for benefits.

Although not a condition to eligibility for STD benefits, you are encouraged to enroll and participate in the Company's health coaching, member management and maternity management programs and/or Employee Assistance & Work/Life Program, which can assist in managing your health, improving your quality of life, and dealing with the stress created by your disability. These programs are offered at no cost to eligible employees. Your disability case manager can assist you in evaluating which program may best support your current health needs.

Your STD Benefit Amount

Calculating Your Benefit

If you are disabled, STD benefit payments begin once you've completed the benefit waiting period and your disability claim has been approved. Your STD benefit is based on your weekly base annual salary or hourly rate of pay (before taxes) as of the date you became disabled. For employees who earn commission, calculation of income will be determined by the compensation plan or current business unit methodology.

Please note: Employees with no base salary or a fixed-based salary should contact their human resources representative to obtain the appropriate method of calculation.

Benefits are paid directly to you according to your normal payroll schedule (either weekly or semi-monthly) based on when leave is approved.

Example—weekly, salaried. Your weekly STD benefit would be calculated as follows if your base annual salary is $70,000 and is paid on a weekly schedule:

- **If your service is between 90 calendar days and two years:** $70,000 x 66.6% = $46,620 ÷ 52 = **$896.54** per week
- **If your service is over two years:** $70,000 x 80% = $56,000 ÷ 52 = **$1,076.92** per week

Example—weekly, hourly. Your weekly STD benefit would be calculated as follows if your hourly rate of pay is $23 and you're normally scheduled to work 36 hours per week:

- **If your service is between 90 calendar days and two years:** 36 x $23 = $828 x 66.6% = **$551.45** per week
- **If your service is over two years:** 36 x $23 = $828 x 80% = **$662.40** per week

Please note: If you are paid weekly and your disability after the waiting period starts mid-pay period, you may have a partial payment for the first disability benefit payment. To determine a partial payment calculation, divide the weekly benefit by the number of calendar days in a pay period and multiply the daily rate times the days paid.

Example—semi-monthly, salaried. Your weekly STD benefit would be calculated as follows if your base annual salary is $70,000 and is paid on a semi-monthly schedule:

Semi-monthly = annual salary divided by 24 pay periods.

- **If your service is between 90 calendar days and two years:** $70,000 / 24 = $2,916.66 (per semi-monthly pay cycle) x 66.6% = **$1,942.50** semi-monthly
- **If your service is over two years:** $70,000 / 24 = $2,916.66 (per semi-monthly pay cycle) x 80.0% = **$2,333.33** semi-monthly

If you are paid semi-monthly and your disability after the waiting period starts mid-pay period, you may have a partial payment for the first disability benefit payment. To determine the partial payment calculation, divide the semi-monthly benefit by the number of calendar days in a pay period and multiply the daily rate times the days paid:

- If your disability period (after waiting period) begins between the 1st and the 15th of the month and your salary is $70,000:
  - $70,000 / 24 = $,2,916.66. $2,916.66 / 15 = 194.44 (daily rate in pay period) x 66.6% = **$129.50** (any partial days would be paid at 129.50 per day)
  - $70,000 / 24 = $,2,916.66. $2,916.66 / 15 = 194.44 (daily rate in pay period) x 80.0% = **$155.55** (any partial days would be paid at $155.55 per day)
- If your disability period (after waiting period) begins between the 16st and the 31st of the month and your salary is $70,000:
  - $70,000 / 24 = $2,916.66. $2,916.66 / 16 (change to 15 calendar days if month ends on 30th or 13 calendar days if month ends on 28th) = $182.29 (daily rate in pay period) x 66.6% = **$121.41** (any partial days would be paid at $121.41 per day)
  - $70,000 / 24 = $2,916.66. $2,916.66 / 16 (change to 15 calendar days if month ends on 30th or 13 calendar days if month ends on 28th) = $182.29 (daily rate in pay period) x 80.0% = **$145.83** (any partial days would be paid at $145.83 per day)

Definition of Pay

If you are paid a base annual or a fixed-based salary, your STD benefit is based on your **weekly** base annual salary. Your weekly base annual salary is your regular weekly pay immediately before your disability.

If you are paid on an hourly basis, definition of pay is based on the product of:

- The number of hours you are normally scheduled to work in a week; multiplied by
- Your hourly rate of pay in effect immediately before your disability (before taxes).

If you are on a no base salary, your STD benefit is based on the total of last 12 month wages divided by 52 weeks and divided by normal scheduled hours per week.

Definition of pay does **not** include any overtime pay, bonuses, tips and tokens, fringe benefits, shift differential, or other extra compensation. Training wages, car allowances, and cell phone reimbursements will be discontinued for all eligible employees receiving STD benefits.

Employees receiving a paycheck for paid STD benefits from the Company will continue to have their monthly elective benefits, including contributions for health benefits, deducted at the employee contribution rate. Employees not receiving a paycheck should contact their human resources representative. Additional information regarding payment for benefits during an unpaid leave of absence is also available in the Leave of Absence section of this SPD.

State Disability Programs

Certain states require that employers provide benefits under a state-defined disability plan. If you work in California, Hawaii, New Jersey, New York, or Rhode Island, state disability benefits are provided, up to a certain number of weeks. Contact **EmployeeAccess** at **1-888-833-1839** and select Health and Group Benefits followed by Disability Management Services followed by **Sedgwick** and speak with the disability administrator's intake department.

Under no circumstances will the total aggregate benefits from a state disability plan and ADT STD Plan exceed the greater of the benefit to be provided under either plan. Proof of eligibility from the state will be required prior to payment of STD benefits from the Company. If there is an overpayment of benefits, the overpayment will be deducted from your subsequent benefit and/or payroll check(s), as permitted by law.

Puerto Rico SINOT Rules

If you are an employee in Puerto Rico, you may be eligible for benefits under the Seguro Incapacidad No Ocupacional Temporal (SINOT). For additional information, contact **SINOT** at **1-787-754-5353**.

Job Accommodations

ADT may offer you modified and alternate work duty when appropriate after Short-Term Disability is completed if requested as a Job Accommodation through the disability vendor or directly to Human Resources. You are responsible for discussing the possibility of light duty work with your certified physician at each appointment. If light duty is available, and you are medically able to perform the duties, but you nevertheless choose not to return to work at the light duty assignment, you will not be eligible for continued STD benefits.

> "Modified and alternate duty" provides temporary alternative work tasks that fit your current physical limitations.

While on modified or alternate duty assignments, you will be paid for the hours you work at your regular rate of pay. Your remaining hours will be paid according to the STD benefits to which you are entitled.

Claims

You must request benefits under this STD Plan within the first seven calendar days of an absence by contacting the disability administrator. Where you are aware of and able to apply for STD benefits and fail to request leave within the first seven calendar days of your STD date, leave will be denied for the time period prior to the request. For example, if you are deemed disabled by your health care provider on March 1 but do not apply for short-term disability until March 15, you would be considered eligible for disability consideration beginning March 15 and would still need to satisfy the waiting period, if applicable, prior to commencing the STD leave.

Appeals

The STD Plan is **not** an ERISA plan. Therefore, the disability administrator will make a comprehensive effort to validate each request for STD benefits, but is not obligated to follow the ERISA claims procedure rules. STD benefits must be approved by the disability case manager before benefits are paid. For example, if you fail or refuse to comply with this STD Plan, including deadlines, and the Company determines that there are no mitigating circumstances acceptable to the Company, you may be denied STD benefits notwithstanding a physician's certificate.

If the request for STD benefits is not approved:

1. You will be responsible for contacting a human resources representative to discuss your return to work or the availability of any other Company leave, whether paid or unpaid, to cover a continued absence. Your failure to contact a human resources representative within five calendar days of receipt of a denial of STD benefits may result in disciplinary action up to and including termination of employment.
2. You will be responsible for providing a return-to-work certificate and all future absences will be counted against your sick or personal days, if available. Otherwise, all future absences will be unpaid.
3. If you wish to seek review of a denial of benefits, you're responsible to follow the appeal process as outlined in the denial letter provided by the disability administrator.
4. You will be responsible for submitting payment for your monthly elected benefits when on an unpaid leave. Contact **EmployeeAccess** at **1-888-833-1839** for further assistance and see the "Definition of Pay" later in this section that discusses paying for benefits during an unpaid leave.

Second Period of Short-Term Disability

If you return to work after receiving STD benefits and you become disabled again as a result of the same or a related disability within 180 calendar days of returning, the second period of disability will be treated as a continuation of the first short-term disability and benefits will resume, as applicable. In this case, your disability is considered one period of disability and you are not required to complete a new benefit waiting period before STD benefits begin again.

If your disability recurs 180 calendar days or more after the date your prior claim is ended or because of unrelated causes, it is considered a new claim. A new benefit waiting period and all other policy provisions will apply.

When STD Benefits End

Your STD benefits end on the earliest of the following dates:

- You are no longer considered disabled, as defined by plan provisions.
- You fail to provide proof of your continued disability when requested by the disability administrator.
- You are no longer receiving appropriate care.
- You refuse to submit to an exam requested by the disability administrator.
- You die (any benefit payments owed at the time of your death may be paid to your estate, spouse, child[ren], or parents).
- You are terminated or resign from employment.

- You refuse to receive recommended treatment that is generally acknowledged by your physician to cure, correct, or limit the disabling condition.
- You have received benefits for the maximum duration of time allowed under the STD Plan.

You cannot receive STD benefits under the STD Plan if you undertake outside employment during your STD leave, and that outside employment activity is inconsistent with restrictions that are the basis of the leave under the STD Plan. If you wish to engage in outside employment or attend school while receiving STD benefits, you should obtain prior written approval from the disability administrator.

While on STD leave, you cannot accrue vacation or personal time. An amount equivalent to the salary or wages attributable to any holidays falling during the STD leave will be paid as STD benefits and not as holiday pay. All merit increases and performance appraisals will be delayed while you are on leave.

How Long-Term Disability Insurance Works

The LTD Plan, underwritten by an insurance company, provides financial protection by replacing part of your income if your long-term disability claim is approved. Benefits are payable after you complete the LTD Plan's benefit waiting period, which is the lesser of the following:

- You have been continuously disabled for 180 calendar days; or
- You have exhausted any loss of time benefits, salary continuation, or sick leave benefits.

Your benefit waiting period is the amount of time you must be disabled before benefits begin.

LTD Benefit Waiting Period: The lesser of 180 calendar days or the exhaustion of any Company-sponsored short-term disability or salary continuance benefit, whichever applies.

If at the end of the benefit waiting period, you are prevented from performing one or more of the material duties of your occupation, but your current monthly earnings are greater than 80% of your base annual salary, your benefit waiting period will be extended for a total period of 12 months from the original date of disability, or until such time as your current monthly earnings are less than 80% of your base annual salary, whichever occurs first.

For the purposes of extending your benefit waiting period, your current monthly earnings will not include the pay you could have received for another job or a modified job if such job was offered to you by your employer, or another employer, and you refused the offer.

Your failure to pass a physical examination required to maintain a license to perform the material duties of your occupation, alone, does not automatically mean that you are disabled.

Cost of Coverage

If you elect to participate in the LTD Plan, you pay the full cost of coverage. You'll pay on an after-tax basis through convenient payroll deductions. This means that under current tax law, any benefits you may receive from the LTD Plan while you are disabled are not taxable.

Enrolling for Coverage

As a new hire, you will be automatically enrolled in LTD coverage Option 1 at the 50% benefit level. You may increase your coverage to Option 2 at the 60% benefit level within 31 calendar days of first becoming eligible without having to provide Evidence of Insurability (EOI). If you wish to enroll in the LTD Plan or increase your coverage level (e.g., move from Option 1 to Option 2), after this initial enrollment period, you must provide EOI and the insurance company must approve this proof of good health before coverage is effective. If denied, you will not have the coverage level you requested under the LTD Plan. Note that EOI requirements also apply to any changes due to qualifying events. You may, however, decrease or drop LTD coverage at any time. See "Initial Enrollment" and "If You Don't Enroll" under the **Enrollment** section of this SPD for more details on LTD enrollment.

In all cases, you must be in active service on the date that your coverage under the LTD Plan is scheduled to begin. If you are not in active service on this date, your coverage begins on the date that you have returned to active service for one full day.

You are **not** considered in active service if you are absent from work due to an accidental bodily injury, sickness, pregnancy, mental illness, or substance abuse treatment. See "Changes in Your Coverage Amount" later in this section for a definition of "active service."

To enroll visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change Benefits** or call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Evidence of Insurability (EOI)

If you disenroll in LTD coverage or increase your benefit level following your initial 31 calendar days of first becoming eligible, you must provide EOI if you wish to re-enroll or increase your benefit level at a later date. This may be provided at your own expense. To provide EOI, you must:

- Visit **MyADTHR.com > Health & Group Benefits > View, Enroll or Change Benefits** or you can also call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**;
- Submit to a medical examination, if requested; and
- Provide any additional information and attending physicians' statements, if requested.

Your coverage becomes effective on the date the insurance company approves your EOI, in writing.

Please note: Depending on your health status, you may be denied coverage by the insurance company.

Preexisting Conditions

A preexisting condition limitation applies in the event of newly added benefits. If you have a preexisting condition and have been enrolled in the LTD Plan for less than 12 months, you are not eligible for LTD benefits related to that preexisting condition if at the time of your disability, you received medical treatment, care, or services (including diagnostic measures), or took prescribed drugs or medicines within six months before your most recent effective date of coverage in the LTD Plan.

A preexisting condition is any accidental bodily injury, illness, mental illness, pregnancy, or episode of substance abuse (including any manifestations, symptoms, findings, or aggravations) for which medical care was provided during the 180-day period before your coverage under this LTD Plan began.

You are considered to have received medical care when:

- A physician or other health care provider is consulted or medical advice is given; or
- Treatment is recommended, prescribed by, or received from a physician or other health care provider.

Applying for LTD Benefits

How to Apply

If you are receiving benefits under the STD Plan for at least 17 weeks and are enrolled in the LTD Plan, the short-term disability administrator will transition your claim to the long-term disability vendor at 17 weeks for review. The long-term disability administrator may request additional paperwork for their determination. It is important that you review all correspondence you receive and complete and return the necessary paperwork as soon as possible. You must fully complete and submit all necessary paperwork to the administrator to be considered for LTD benefits.

In any other situation (such as a Workers' Compensation illness/injury or Puerto Rico SINOT), to apply for LTD benefits after 180 calendar days of consecutive absence, you must call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Disability Management Services** followed by **LTD** to request an Application for Long-Term Disability Income Benefits. You must complete and return this form to the insurance company no later than 30 calendar days after the date your disability began or as soon possible. The LTD insurance company will acknowledge your claim and may request additional proof of loss.

As part of the proof of loss, you will be required to:

- Identify any other income benefits you are or may be eligible to receive, such as Social Security Disability benefits; and
- Provide proof that you have applied for such other income benefits.

You will be asked to provide ongoing proof of your disability. In addition, the insurance company may periodically request that a physician of its choice conduct an independent medical examination at no cost to you. Failure to cooperate with such a request may result in the delay or loss of benefits.

Please note: To ensure that you receive any benefits to which you are entitled, you must report any injury or illness to your supervisor as soon as possible. For more information on applying for LTD benefits, contact **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **Disability Management Services** or call the insurance company.

Applying for Social Security Disability Benefits

Your LTD benefit will be reduced by any disability benefits paid, payable or for which there is a right under the Social Security Act.

After submitting your proof of loss to the insurance company, you are required to apply for Social Security Disability benefits. When appropriate, the insurance company will provide assistance in applying for your Social Security benefits, estimate your LTD Plan benefit, and authorize benefit advances while your application is still pending.

If your application for Social Security Disability benefits is denied, you must follow all appeals procedures established by the Social Security Administration for reconsideration of a denied claim, including a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Receiving LTD Benefits

To receive benefits, you must be continuously disabled through the entire benefit waiting period. Your disability will be treated as continuous even if you return to active service for a period of time up to 180 calendar days during your benefit waiting period. The days that you return to active service do **not** count toward the benefit waiting period. For example, let's assume you were out of work for 170 calendar days due to a covered illness, then returned to work for 10 days and were unable to continue working. The 170 calendar days you were originally out of work would count toward your benefit waiting period. The 10 calendar days during which you returned to work would not count toward your benefit waiting period.

If you've been continuously disabled during your benefit waiting period and your disability has been approved, the LTD Plan pays a percentage of your base annual salary, up to a maximum of $15,000 per month. Your LTD benefit will be reduced by other income benefits, including Social Security benefits, you (or your dependents) receive or are assumed to receive.

Your LTD Benefit Amount

Calculating Your Benefit

If you are disabled, benefit payments begin once you have completed the benefit waiting period and your disability claim has been approved. Benefits are paid directly to you at the end of each month. Please note that exclusions and limits apply to disabilities caused by, or resulting from, a preexisting condition.

"Disability"—You are considered disabled for LTD purposes, if:

- During the benefit waiting period and during the first 24 months following the benefit waiting period you are:
  - Unable to perform the materials duties of your own occupation; OR
  - Unable to earn 80% or more of your indexed pre-disability earnings (calculated based on your base annual salary/target benefit basis).
- After benefits have been payable for 24 months, you are:
  - Unable to perform the material duties of any occupation. "Any occupation" means any occupation for which you are qualified by education, training, or experience; OR
  - Unable to earn 60% of your Indexed Earnings.

For example, your monthly LTD benefit would be calculated as follows if your base annual salary is $70,000:

- **Option 1:** $70,000 x 50% = $35,000 ÷ 12 = $2,916.67 per month
- **Option 2:** $70,000 x 60% = $42,000 ÷ 12 = $3,500.00 per month

Definition of Pay

If you are paid a base annual salary, your monthly LTD benefit and the premium you pay for LTD coverage are based on your **monthly** base annual salary. Your monthly base annual salary is your regular monthly pay immediately before your disability.

If you are paid on an hourly basis, definition of pay is based on the product of:

- Your regularly scheduled hours immediately before your disability; multiplied by
- Your hourly wage in effect immediately before your disability.

Please note: If you are on a no base salary or a fixed-based salary you are assigned a “Target Benefit Basis” for the definition of pay for the LTD benefit.

Base annual salary does **not** include any overtime pay, bonuses, tips and tokens, fringe benefits, or other extra compensation.

Any increase in salary while you are on continuous disability will not be effective (used to calculate your LTD benefit) for that same period of disability.

Employees with a Target Benefit Basis

If you have been assigned a ”Target Benefit Basis,” which is a function of your job title immediately before your disability, your monthly LTD benefit and the premium you pay for LTD coverage are based on the Target Benefits Basis and not your current compensation. The Company periodically advises you of this Target Benefits Basis during onboarding, the Benefits Annual Enrollment period, or at other times throughout the plan year.

Changes in Your Coverage Amount

If the amount of your earnings increases or decreases, the amount of your coverage will be adjusted accordingly to reflect the change. If you are on a no base salary or a fixed-based salary, your earnings remain at your Target Benefit Basis unless there is a job change. The change in your coverage amount will not take effect unless you are:

- An active full-time employee; and
- In active service on that date (that is, you are not absent from work because you are disabled).

If you are not in active service on the date your earnings increase or decrease, the change in your coverage amount will become effective on the date you return to active service.

Please note: If your coverage amount changes, your premium cost will also change accordingly.

> "Active service"—You are in active service on a day that is one of the Company's scheduled work days if either of the following conditions are met:
>
> 3. You are performing your regular occupation for the Company on a full-time basis. You must be working at one of the Company's usual places of business.
> 4. The day is a scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.
>
> You are in active service on a day that is not one of the Company's scheduled work days only if you were in active service on the preceding scheduled work day.

Working While Disabled

If you remain disabled after the benefit waiting period and you work while you are disabled, your monthly LTD benefit equals either 50% or 60% of your base annual salary rounded to the nearest dollar (not to exceed $15,000 per month), reduced by any Disability Earnings.

> "Disability Earnings" mean any wage or salary for any work performed for any employer during your disability, including commissions, bonus, overtime pay, or other extra compensation.

During the first 24 months of disability benefits if any month you have Disability Earnings, your monthly benefit payable will be calculated as follows:

1. Add your gross disability benefit and Disability Earnings.
2. Compare the sum from #1 to your Indexed Earnings.
3. If the sum from #1 exceeds 100% of your Indexed Earnings, then subtract the Indexed Earnings from the sum in #1.
4. Your gross disability benefit will be reduced by the difference from #3, as well as by other income benefits
5. If the sum from #1 does not exceed 100% of your Indexed Earnings, your gross disability benefit will be reduced by other income benefits.

After disability benefits are payable for 24 months, the monthly benefit payable is the gross disability benefit reduced by other income benefits and 50% of Disability Earnings.

Benefit payments are also subject to certain minimums and maximums. Your minimum monthly LTD benefit is $100 per month after any other sources of disability income have been subtracted. However, if there is an overpayment due, this benefit may be reduced to recover the overpayment. The maximum benefit is $15,000 per month.

If you are disabled for any portion of a month, your benefit is based on 1/30 of your monthly benefit for each day during the month that you are disabled.

Please note: You are still required to pay the premium for your LTD and any other benefit coverages during any period which you are receiving LTD benefits. Contact **EmployeeAccess** at **1-888-833-1839** for further assistance and see the "Definition of Pay" earlier in this section that discusses paying for benefits during an unpaid leave.

Rehabilitation

If you are disabled and the insurance company determines you are a suitable candidate for rehabilitation, you must participate in a "rehabilitation program." Rehabilitation is the process of you and the insurance company working together to plan, adapt, and put into use options and services to meet your return to work needs. The insurance company must agree on the terms and conditions of the rehabilitation program.

The rehabilitation program may include, at the insurance company's discretion, vocational testing and/or training, alternative treatment plans (such as support groups), workplace modification, job placement, transitional work, and similar services.

Please note: You may be required to participate in a rehabilitation assessment, at the insurance company's expense, and/or the rehabilitation plan. The insurance company will work with you, ADT, your physician and others, as appropriate, to develop your rehabilitation program. If you refuse to participate in the rehabilitation efforts, disability benefits will not be payable.

No LTD benefits will be paid, and insurance will end if the insurance company determines you are able to participate in a rehabilitation program and refuse to do so without good cause.

Maximum Benefit Duration

LTD benefits are paid until:

- You are no longer disabled as determined under the applicable definition of disability set forth under "Calculating Your Benefit" earlier in this section; or
- The later of your Social Security Normal Retirement Age (in effect under the Social Security Normal Retirement Act on the policy effective date); or
- The date you reach the end of the maximum period of payment, which is determined by your age when your disability begins, as shown in the chart below:

Age on Date Disability Begins	**Maximum Benefit Duration**
Age 62 or under	To your 65th birthday or the date the 42nd monthly benefit is payable, if later
63	The date the 36th monthly benefit is payable
64	The date the 30th monthly benefit is payable
65	The date the 24th monthly benefit is payable
66	The date the 21st monthly benefit is payable
67	The date the 18th monthly benefit is payable
68	The date the 15th monthly benefit is payable
69 or older	The date the 12th monthly benefit is payable

Limited Benefit Periods for Mental or Nervous Disorders

LTD benefits will be paid on a limited basis during your lifetime for a disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly LTD benefits have been paid, no further benefits will be payable for any of the following conditions:

1. Anxiety disorders.
2. Delusional (paranoid) disorders.
3. Depressive disorders.
4. Eating disorders.
5. Mental illness.
6. Somatoform disorders (psychosomatic illness).

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the conditions listed above.

Limited Benefit Periods for Alcoholism and Drug Addiction or Abuse

LTD benefits will be paid on a limited basis during your lifetime for a disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly LTD benefits have been paid, no further benefits will be payable for either of the following conditions.

- Alcoholism.
- Drug addiction or abuse.

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the conditions listed above.

When LTD Benefits End

Your LTD benefits end on the earliest of the following dates:

- You are no longer considered disabled, as defined by plan provisions.
- You fail to provide proof of your continued disability when requested by the LTD Plan.
- You are no longer receiving appropriate care.
- You refuse to submit to an exam requested by the insurance company.
- You die (any benefit payments owed at the time of your death may be paid to your estate, spouse, child[ren], or parents).
- You refuse to receive recommended treatment that is generally acknowledged by your physician to cure, correct, or limit the disabling condition.

- You have received benefits for the maximum duration of time allowed under the LTD Plan.

"Indexed base annual salary"—After 12 months of receiving disability benefits, your base annual salary is adjusted annually on January 1 by adding the lesser of 10% or the percentage change in the Consumer Price Index (CPI-W). The adjustment is made if you:

- Have been disabled for 12 or more consecutive months; and
- Are receiving benefits at the time the adjustment is made.

CPI-W means the index as of July 31 for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

If you are receiving or you are entitled to receive LTD benefits at the time the group insurance policy ends, your benefits will continue as long as you remain disabled because of the same disability. Your benefits will end as of the date the LTD Plan would have stopped paying benefits if the policy had remained in effect.

If you are receiving or you are entitled to receive LTD benefits at the time your employment is officially terminated, your benefits will continue as long as you remain disabled because of the same disability and meet all other conditions under the policy.

Survivor Benefit

The LTD Plan provides an additional benefit to your survivor if you die while receiving benefits under the LTD Plan. Your survivor is your:

- Spouse, who is not legally separated or divorced from you at the time of your death; or
- If there is no surviving spouse, your unmarried son or daughter under age 21, who is primarily dependent on you for support and maintenance (this includes a stepchild, legally adopted child, and child related to you by blood or marriage who lived with you in a regular parent-child relationship and was eligible to be claimed as a dependent on your federal income tax return).

The term "spouse" includes a same-sex spouse and a domestic partner, provided you have executed and filed a Domestic Partner Affidavit with the LTD Plan and have not terminated that partnership.

Please note: If you do not have a spouse or any child(ren), the benefit will be paid your estate.

The LTD Plan must receive proof for the survivor benefit within one year of the date of your death.

A lump-sum payment equal to 100% of the sum of the last full disability benefit payable to you plus the amount of any disability benefit which had been reduced for that month will be payable as the survivor benefit.

If the survivor benefit is payable to your minor child, the LTD Plan will not make payments to the minor child until a person has been appointed as the child's legal guardian.

When LTD Coverage Ends

When Coverage Ends

Your coverage under the LTD Plan ends on the earliest of the following dates (coverage will end on the actual date of the event):

- The group insurance policy ends.
- The group insurance policy no longer insures the class of employees to which you belong.
- You fail to make any required premium contribution.
- You are no longer in active service (including when the Company terminates your employment).
- You are no longer a full-time active employee in an eligible class.

Events that will cause you to lose eligibility include, but are not limited to:

- A temporary layoff;
- A reduction in your regular work hours;
- Certain leaves of absence; or
- A general work stoppage (including a strike or lock-out).

LTD coverage may **not** be converted to an individual or non-group plan.

Continuation of Insurance

Disability insurance continues if your active service ends because of a disability for which benefits under the LTD Plan are or may become payable. Premiums will be waived while disability benefits are payable. If you do not return to active service, your participation in the LTD Plan ends when the disability ends or when benefits are no longer payable, whichever occurs first.

If your active service ends because of an ADT-approved unpaid leave of absence, layoff, military leave, or family medical leave, your insurance will continue as follows:

- For an ADT-approved unpaid leave of absence, up to one month after the end of the month in which the leave begins;
- For layoff, up to one month after the end of the month in which the layoff begins;
- For military leave, up to nine months; and
- For an ADT-approved family medical leave, up to the later of the period of your approved FMLA leave or the leave period required by law in the state in which you are employed.

If You Were Covered under a Prior Plan

You may have been covered under a prior plan before becoming covered under this LTD Plan. Prior plan means the LTD insurance coverage carried by ADT or an ADT employer on the day before this LTD Plan's effective date, provided an agreement to do so has been made between the prior plan and ADT.

In this case, the preexisting condition limitation under this LTD Plan does not apply as of the earliest of the following dates:

- If your coverage for the disability was not limited by a preexisting condition restriction under the prior plan—the policy effective date; or
- If your coverage was limited by a preexisting condition restriction under the prior plan—the date the restriction would have ceased to apply had the prior plan remained in force.

If you received monthly benefits under the prior plan, the benefit waiting period under this LTD Plan will not apply if you become disabled again due to the same injury or illness, and:

- You returned to work as an active full-time employee before the effective date of this LTD Plan;
- You have a recurrence of the same disability under this LTD Plan within six months after returning to work; and
- There are no benefits available for the recurrence under the prior plan.

Offsets to LTD Benefits

Other Sources of Income

- Any amounts received (or assumed to be received, per the insurance company's *Assumed Receipt of Benefits* provision) by you or your dependents under:
  - The Canada and Quebec Pension Plans;
  - The Railroad Retirement Act;
  - Any local, state, provincial, or federal government disability or retirement plan or law payable for injury or illness provided as a result of employment with the Company;
  - Any sick leave or salary continuation plan of the Company;
  - Any work loss provision in mandatory "No-Fault" auto insurance.
- Any Social Security Disability benefits or retirement benefits you or any third party receive (or are assumed to receive, per the insurance company's *Assumed Receipt of Benefits* provision) on your own behalf or for your dependents; or that your dependents receive (or are assumed to receive, per the insurance company's *Assumed Receipt of Benefits* provision) because of your entitlement to such benefits.
- Any Retirement Plan benefits funded by the Company. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Company. It does not include an individual deferred compensation agreement, a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account, or 40l(k) plan.
- Any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for LTD, and contains the same or similar provision for reduction because of other insurance, the Company will pay for our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
- Any amounts received (or assumed to be received, per the insurance company's *Assumed Receipt of Benefits* provision) by you or your dependents under any Workers' Compensation, occupational disease, unemployment compensation law, or similar state or federal law payable for injury or illness arising out of work with the Company, including all permanent and temporary disability benefits. This includes any damages, compromises, or settlement paid in place of such benefits, whether or not liability is admitted.

- Any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration, or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive—see "Assumed Receipt of Benefits") benefits under any applicable law because of your entitlement to benefits.

Increases in Other Income Benefits

Any increase in other income benefits during a period of LTD due to a cost of living adjustment will not be considered in calculating your LTD benefits after the first reduction is made for any other income benefits. This section does not apply to any cost-of-living adjustment for Disability Earnings.

For purposes of this LTD Plan, a retirement plan is any defined benefit or defined contribution plan that provides benefits for your retirement that are not funded 100% by your own contributions. It does not include the following types of plans:

- A profit sharing plan.
- A thrift, savings or stock ownership plan.
- A non-qualified deferred compensation plan.
- A 401(k) plan, an individual retirement account (IRA), a tax-sheltered annuity (TSA), a Keogh Plan, a 403(b) plan or a 457 deferred compensation arrangement.

Assumed Receipt of Benefits

The insurance company will assume you (and your dependents, if applicable) are receiving benefits for which you are eligible from other income benefits. The insurance company will reduce your LTD benefits by the amount from other income benefits we estimate are payable to you and your dependents.

The insurance company will waive Assumed Receipt of Benefits, except for Disability Earnings for work you perform while LTD benefits are payable, if you:

- Provide satisfactory proof of application for other income benefits;
- Sign a Reimbursement Agreement;
- Provide satisfactory proof that all appeals for other income benefits have been made unless we determine that further appeals are not likely to succeed; and
- Submit satisfactory proof that other income benefits were denied.

The insurance company will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

How Increases in Other Income Affect LTD Benefits

An increase in benefits paid under any federal or state law will not reduce your LTD benefit if the increase:

- Takes effect after the date LTD benefits become payable under this LTD Plan; and
- Is a general cost-of-living increase to federal or state benefits that is required by law and applies to all persons entitled to those benefits.

Lump-Sum Payments of Other Income

Your monthly benefit will be reduced as follows if you receive a lump-sum award from any other income source during your period of disability:

- The lump-sum payment is prorated over the period for which the sum is given; or
- If no time is stated, the lump-sum will be prorated over five years. If no specific allocation of a lump-sum payment is made, then the total payment will be another income source.

If your claim is overpaid due to payments you receive from the other income sources, you will be required to pay the overpaid amount to the insurance company for repayment to the LTD Plan.

Duration of LTD Benefits

Successive Periods of Disability

If you return to work after receiving benefits under the LTD Plan—and become disabled again as a result of the same or a related disability—your LTD benefits will resume if you have:

- Been continuously insured under the LTD Plan; and
- Returned to work for less than six months.

In this case, your disability is considered one period of disability and you are not required to complete a new benefit waiting period before LTD benefits begin again.

If your disability recurs six months or more after the date your prior claim is ended or because of unrelated causes, it is considered a new claim. That means it is subject to a new benefit waiting period and all other policy provisions.

Concurrent Disabilities

If you are collecting an LTD benefit and a new disability occurs, the LTD Plan treats the new disability as part of the same period of disability. As a result, your LTD benefit continues while you remain disabled. Your LTD benefit is subject to the following:

- The maximum benefit duration period; and
- Any limits or exclusions that apply to the new cause of disability.

Disabilities Not Covered

LTD benefits are not payable for any disability caused by, contributed to, or resulting from:

- Suicide, attempted suicide, or self-inflicted injury while sane or insane.
- War or any act of war, whether or not declared.
- Active participation in a riot.
- Commission of a felony.
- The revocation, restriction, or non-renewal of your license, permit, or certification necessary to perform the duties of your our occupation unless due solely to injury or illness otherwise covered by the LTD Plan.

In addition, the insurance company will not pay LTD benefits for any period of LTD during which you are incarcerated in a penal or corrections institution.

LTD benefits also are not payable under the LTD Plan for any disability:

- For which you are not under the appropriate care of a physician; or
- If you fail to cooperate with the insurance company in the administration of the claim. (Cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.)

Additional Benefits

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Additional Benefits at a Glance

ADT provides access to a number of additional programs that provide benefits for employees both inside and outside of the ADT Health and Welfare Benefits Plan (the "Plan"), as well as access to insurance carriers who provide employees with the opportunity to purchase voluntary, non-ERISA benefits. These programs include:

- Adoption Assistance Program.
- Auto and Home Insurance Program.
- BlueCard Worldwide Program.
- Employee Discount Program.
- Estate Guidance.
- Funeral Planning & Parent Funeral Planning.
- Legal Services Plan.
- Travel Assist Program and Identity Management Services.
- Tuition Reimbursement Program.

The BlueCard Worldwide Program is provided under the Plan and is subject to the requirements of the Employee Retirement Income Security Act (ERISA).

ADT does not sponsor the Legal Services Plan, but does provide employees with access to ARAG, the carrier that provides the plan, as a convenience for employees. The Legal Services Plan also is not subject to the requirements of ERISA.

The other programs are provided outside of the Plan and are not subject to the requirements of ERISA.

Adoption Assistance Program

Eligibility and Benefits

ADT recognizes that the cost of adoption is often beyond the reach of families who wish to adopt a child. To help offset these costs, the Company provides adoption assistance to regular full-time employees with at least six months of service. This assistance is intended to help with the adoption of child(ren) under the age of 18 who are not otherwise related to the employee, spouse, or domestic partner.

Through the Adoption Assistance Program, you can be reimbursed up to a maximum of $5,000 per child for certain expenses related to a legal adoption. This maximum applies even if both parents work at ADT. The amount reimbursed is intended to be approximately equal to the financial support ADT provides through the Medical Plan to natural parents for pregnancy and childbirth. **Please note:** Adopted child(ren) and those in the process of being adopted may be eligible for medical, dental, life insurance, and other benefits provided under the Plan. For more information, see the applicable sections of this SPD and be careful to observe the procedures and deadlines associated with enrollment for such coverage. For additional information call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits**.

Requesting Adoption Assistance

To request adoption assistance benefits, you must complete the Adoption Assistance Program Expense Reimbursement Application available from **EmployeeAccess** by calling **1-888-833-1839** and selecting **Health and Group Benefits** or online at **MyADTHR.com > Discounts & More > Adoption Assistance Program**. You must also provide a copy of the adoption decree within one month of finalizing the adoption. If the adoption decree is not available within one month, the deadline will be extended to within one week after receipt of the decree. In the case of an adoption of a child from another country, a copy of the adopted child's passport also must be provided. You will be eligible for reimbursement of expenses within 30 calendar days after receiving the official adoption decree.

The Adoption Assistance Program Expense Reimbursement Application must be provided for approval to **EmployeeAccess**, which will process the application for reimbursement of approved expenses.

Covered expenses include:

- Reasonable and customary public/private adoption agency fees.
- Legal and court fees.
- Travel expenses (including meals and lodging while away from home).
- Child care charges when the child temporarily lives at another location before placement in your home.
- Other expenses directly related to and for the principal purpose of the legal adoption of an eligible child.

Expenses that are not covered include:

- Medical expenses.
- Expenses that are paid by any federal, state, or local program.
- Expenses for biological parents (e.g., medical, living, counseling).
- Voluntary contributions to an adoption agency.
- Costs to obtain guardianship or custody of a child that are not associated with the legal adoption of the child.

It's important to note that expenses reimbursed through the Adoption Assistance Program are not subject to federal income tax withholding, but may be taxable income to you depending on your family's adjusted gross income. The amount paid is reported on the annual W-2 as additional compensation, but is not included in gross wages. You are strongly encouraged to consult a qualified tax or financial adviser before requesting reimbursement to understand the tax consequences to you of this benefit.

For more information about the ADT Adoption Assistance Program, please see the ADT Adoption Assistance Program plan document available by calling **EmployeeAccess** at **1-888-833-1839.**

Auto and Home Insurance Program

The Auto and Home Insurance Program lets you take advantage of discounted group rates. Participation is voluntary. If you enroll, you pay the full cost of coverage.

If you are interest in the program, visit **ADTvoluntarybenefits.com** or call **1-800-711-4810** to learn about coverage, rates, and discounts from up to five of the nation's top insurance companies. Use your ADT employee ID and date of birth to establish your account.

BlueCard Worldwide Program

The BlueCard Worldwide Program gives you access to medical assistance services, doctors, and hospitals around the world when you or your dependents are traveling or living abroad.

You are covered automatically when you enroll in the PPO Plan or the Health Advantage Plan with associated Health Savings Account. Any dependents you enroll for medical coverage are also eligible for coverage under the BlueCard Worldwide Program.

If You Need Medical Care in a Foreign Country

To take advantage of the BlueCard Worldwide Program when you are traveling or living abroad, follow these steps:

1. Before you leave, contact the PPO or Health Advantage Plan to verify your international benefits and obtain coverage details. Coverage outside the United States may be different from the coverage described in the **Medical** section of this SPD.

2. Always carry your current Blue[SM] ID card. You can get a Blue ID card at **BCBS.com/bluecardworldwide**.

3. In an emergency, go directly to the nearest hospital. If you need to locate a doctor or hospital, need inpatient care, or need other medical assistance services, call the BlueCard Worldwide Service Center at **1-800-810.BLUE (2583**) or call collect at **1-804-673-1177**, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

4. In addition to contacting the BlueCard Worldwide Service Center, call the PPO or Health Advantage Plan for pre-certification or pre-authorization. Refer to the phone number on the back of your Blue ID card. Note that this number is different from BlueCard Worldwide Service Center phone number listed above. See the **Medical** section of this SPD for more information on pre-certification and pre-authorization.

5. In most cases, you should not need to pay up front for inpatient care at BlueCard Worldwide hospitals except for any out-of-pocket expenses (for example, deductibles, copays, coinsurance, and any services that are not covered) you normally pay. The hospital should submit your claim on your behalf.

6. You may need to pay up front for care received from a doctor and/or hospital and then file a claim for reimbursement of expenses.

For More Information

If you need more information about the BlueCard Worldwide Program:

- Call your Blue Plan (the PPO or Health Advantage Plan).
- Visit **BCBS.com/bluecardworldwide**.
- Call the BlueCard Worldwide Service Center at **1-800-810-2583** or collect at **1-804-673-1177**.

Filing Claims

If the BlueCard Worldwide Service Center arranged your hospitalization, the hospital will file the claim for you. You will need to pay the hospital for the out-of-pocket expenses you normally pay.

For outpatient and doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center, you will need to pay the health care provider and submit a claim to the Medical Plan. To file a claim:

- Obtain a claim form from the PPO or Health Advantage Plan, online at **BCBS.com/bluecardworldwide**, or from the BlueCard Worldwide Service Center.
- Complete the claim form and send it with copies of your bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

If a Claim Is Denied

If your claim is denied in whole or in part, you will receive a claim denial notice setting forth the reasons for the denial and explaining how to appeal the denial. You may then appeal the denial. See the **Claim Review and Appeal Processes** section of this SPD for information on the claim denial and how to file an appeal.

Employee Discount Program

The Employee Discount Program offers discounted corporate pricing on many items and services, such as computers, electronics, apparel, travel, and restaurants.

The program is available to you and family members who live with you. You don't need to enroll, but you will need to set up an account at **ADT.corporateperks.com**, using your ADT employee ID and the password "savings." If you are a new employee, it can take 30 calendar days from your date of hire until you can access your account.

Estate Guidance

Estate guidance services are provided to all employees covered by the Basic Term Life Insurance Plan. Coverage is provided under The Hartford through ComPsych®. This service helps you create a simple, legally binding will, including the following services:

- Online assistance from licensed attorneys if you have questions.
- Ability to save drafts for up to six months. During this period, you can revise your will at no cost, as long as you haven't already printed or downloaded it.
- Additional estate planning services are also available for purchase, including the creation of living wills and trusts, guidance about divorce proceedings, and durable power of attorney.

All information is kept secure and confidential. For additional information, visit **estateguidance.com/wills** and use access code WILLHLF. **Please note:** If you have elected the Legal Service Voluntary Benefit, you may have additional benefits for estate planning through that program.

If you are enrolled in the Supplemental Life Insurance Plan, you can extend the estate guidance services above to your parents, stepparents, and in-laws through the Parent Conversations program. You can provide your parents access to the estate guidance resources to begin creating their will.

For additional information, visit **estateguidance.com/wills** and use access code WILLHLF.

Funeral Planning

Funeral planning services including concierge services are provided to all employees covered by the Basic Term Life Insurance Plan. Coverage is provided under The Hartford through Everest. Services are provided to you, your spouse/domestic partner, and dependent child(ren) up to age 26. Services include:

- 24/7 advisor assistance which provides around-the-clock access to Everest advisors that can assist with all funeral planning issues.
- PriceFinder[SM] Research Reports, a nationwide database of funeral home prices where you receive unlimited access to reports on demand to compare costs.
- Online planning tools to allow you to leverage Everest's online planning, research, and knowledge tools to create a funeral plan. You can store, update, retrieve, and print this information on demand.
- At-need family support provides concierge services by licensed funeral directors at or near the time of death. In addition, this support will communicate with the funeral home you choose, provide you pricing information, and negotiate funeral costs on your behalf to lower cost.
- Express Pay claim processing, a claims payment service that allows your beneficiary to use applicable insurance proceeds to pay for immediate funeral expenses.

For additional information, visit **everestfuneral.com/hartford** and use access code HFEVLC, or call **1-866-854-5429**.

If you are enrolled in the Supplemental Life Insurance Plan, you can extend the funeral services above to your parents, stepparents, and in-laws through the Parent Conversations program. You can provide your parents access to the funeral planning coverage resources to begin documenting their funeral wishes.

For additional information, visit **everestfuneral.com/hartford** and use access code HFEVLC, or call **1-866-854-5429**.

Legal Services Plan

Legal services coverage is optional. You decide whether you want to enroll and pay the costs of coverage through convenient after-tax payroll deductions.

The Legal Services Plan provides professional legal consultation and representation, comprehensive legal insurance, and the ability to create and store legally valid documents online. You also have access to a nationwide network of more than 9,300 attorneys. When you work with a Network Attorney, the attorney fees are 100% paid-in-full for most covered legal matters.

This plan is not sponsored, endorsed, or administered by ADT. For information about plan coverage, eligibility, and enrollment, you can contact ARAG at **araglegalcenter.com**, using access code 17949adt or at **1-800-247-4184**.

If you need some basic legal support and have not enrolled in the Legal Services Plan, there is legal support through the Employee Assistance & Work/Life Program, administered by ComPsych. You can contact ComPsych at **1-855-4ADT-EAP (1-855-423-8327)** or at **guidanceresources.com**. For more information about the Employee Assistance & Work/Life Program, see the **Wellness Programs** section of this SPD.

Travel Assist Program

Travel Assist services are provided to all employees covered by the Basic Term Life Insurance Plan. Coverage is provided by The Hartford. The Travel Assist Program is available when you're more than 100 miles from your main residence for 90 calendar days or less. The program provides the following services to you and your family:

- Emergency medical services, including:
  - Medical referrals.
  - Medical monitoring.
  - Medical evacuation.
  - Repatriation.
  - Traveling companion assistance.
  - Dependent child(ren) assistance.
  - Visit by a family member or friend.
  - Emergency medical payments.
  - Return of mortal remains.

  In a medical emergency, Europ Assistance USA pays for the assistance as described above, but you are personally responsible for paying your medical/hospital expenses.

- Pre-trip information outlining any visa and passport requirements, immunization requirements, as well as assistance with foreign exchange rates and embassy and consular referrals.
- Emergency personal services, including:
  - Medication and eyeglass prescription assistance.
  - Emergency travel arrangements.
  - Emergency cash.
  - Locating lost items.
  - Bail advancement.

  Europ Assistance USA provides the described personal services listed above to you in an emergency, but you are personally responsible for the cost of air fare that is not approved as medically necessary by your physician, food, hotel and car expenses, and related attorney fees. For emergency cash advances and bail advancement, you must guarantee reimbursement through a valid credit card.

Identity Theft Assistance Services

Identity Theft Assistance Services are provided as part of the Travel Assist Program to all employees covered by the Basic Term Life Insurance Plan. Coverage is provided by The Hartford. The following services are provided to you and your family:

- Identity Theft Resolution Services guide you through the process of restoring your identity should you become a victim of identity theft. A dedicated fraud specialist will work with you to notify all involved parties of the fraud and will provide assistance with placing fraud alerts and freezes on credit reports and enrolling in state identity theft passport programs, if available.
- Proactive Identity Services include education to detect early signs of identity theft and assistance with obtaining copies of your credit reports and placing alerts on your records with the credit agencies.
- Identity Theft Resolution and Assistance also provides the opportunity to review your credit information and history over the phone to determine if a fraud or theft has occurred. Theft Affidavit Assistance is available to answer any questions about completing the Affidavit, and help is available to replace credit, debit, and other membership cards.
- Other services include help with medical identity theft, documentation recovery, translation services, and emergency cash advances when you are traveling or in the event of a disaster and protection of information during relocation.

To learn more, call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Life and Accident Insurance**.

How to Obtain Travel Assistance

If you require travel assistance, please contact Europ Assistance USA at the number located on your Travel Assistance ID card. Be sure to have your employer's name (ADT), a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number and the Company policy number, which can be obtained through your human resources department.

If you have a serious medical emergency, please obtain emergency medical services first (contact the local "911"), and then contact Europ Assistance USA to alert them to your situation.

Tuition Reimbursement Program

The Tuition Reimbursement Program supports you in pursuit of eligible educational efforts so you can enhance your job performance and develop your career potential.

Eligibility

You are eligible for ADT's Tuition Reimbursement Program if you:

- Have completed six months of continuous full-time or part-time service (with a regular work schedule of 20 hours or more per week); and
- Are an active employee in good standing at the time a course begins and is completed.

Approved Courses

The program covers career-related coursework that is not intended to prepare you for a new career or occupation. Approved courses are those that:

- Are part of an approved degree program (for example, Associate, Bachelor's or Graduate) offered by an accredited U.S. institution;
- Enhance your job performance; and
- Increase your career potential within ADT.

You must obtain approval from you manager before enrollment. Tuition reimbursement benefits may be denied if you do not obtain prior manager approval.

Coverage includes required electives outside the major course of study in order to fulfill degree requirements. It also includes expenses associated with credits received through College Level Equivalency Programs (CLEPs), when those credits count toward your degree requirements.

The program does not cover:

- Courses that interfere with your ability to perform your work for ADT.
- Courses that are designed to prepare you for a different career.
- Dropped courses (however, benefits are not denied for a layoff occurring before you complete a course).

Benefits

You may be eligible to receive a reimbursement of up to 100% of eligible tuition expenses, registration fees, laboratory fees, books, and CLEP fees.

Benefits are subject to all of these limits:

- Two courses per semester;
- 18 credit hours per calendar year; and
- $7,500 each calendar year.

You will receive the first $5,250 of benefits provided by ADT under the Tuition Reimbursement Program on a tax-free basis. Any additional benefit you receive from the Tuition Reimbursement Program will be taxable compensation to you. If you have any questions about whether additional benefits can be deducted on your tax return, contact your tax adviser.

Applying for Reimbursement

You can request reimbursement for eligible tuition expenses once you have completed the coursework with a grade of C or better for undergraduate courses, or B or better for graduate courses (or pass, if the course is only offered on a pass/fail grading option).

To apply for benefits, you will need to complete an application and submit original receipts, grades, CLEP results, and any promissory notes or other documentation relating to grants or scholarships. All documentation must be submitted within 90 calendar days of completing your course(s).

Benefits are subject to the guidelines established in the official plan document for the Tuition Reimbursement Program and will not discriminate in favor of Highly Compensated Employees.

For additional information, or a copy of the plan document, call **EmployeeAccess** at **1-888-833-1839** and select **Other Programs** followed by **Additional Options** or visit **MyADTHR.com > Discounts & More > Tuition Reimbursement**.

Coordination of Benefits

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Coordination of Benefits

If You Are Covered by Another Plan

If you or a covered family member is covered under another group medical or dental plan (for example, a plan sponsored by your spouse's employer), ADT's Medical and Dental Plans coordinate payment with benefits paid by the other plan(s) so the benefits paid from all plans combined do not total more than the amount the ADT plan would have paid if you only had coverage through the ADT plan. This is called Coordination of Benefits (COB).

When a medical or dental claim is submitted for an individual who has coverage under more than one plan, the plan that determines its benefits first is the one that is considered "primary." The primary plan determines what benefits are payable without regard to the other plan.

A plan is primary for an individual if:

- It does not contain a COB provision; or
- It covers the individual as an employee.

The other plan is considered to be the "secondary" plan.

> Because the ADT plans coordinate benefits with other plans, in most cases, it may not be cost-effective to be covered by more than one medical or dental plan. If you have medical and/or dental coverage elsewhere, review ADT's COB provisions before enrolling in the ADT plans.

The maximum amount you receive from **both** plans will not be more than the amount you would have been eligible to receive under the ADT plan had the ADT plan been the primary plan.

When COB rules reduce the plan's benefits, each benefit will be reduced proportionately and then charged against any applicable benefit limits under the plan. If the primary plan benefit is greater than what ADT would have paid if it was the primary plan, the ADT plan will pay nothing as the secondary plan.

Which Plan Pays First

If the order of payment cannot be determined under the rules described below, the plan that has covered the individual longest will pay first.

For You or Your Spouse/Domestic Partner

If your spouse or domestic partner also has coverage under another employer-sponsored plan, that employer-sponsored plan is primary and pays benefits first. In this case, the ADT plan is considered "secondary" for your spouse/domestic partner. As the secondary plan, the ADT plan pays benefits, if at all, only after the primary plan has paid its benefits.

For Your Dependent Child(ren)

If your dependent child(ren) have coverage under more than one plan, the primary plan is determined by the birthday rule. This rule states that:

- The plan of the parent whose birthday falls first during the calendar year pays first, regardless of the year of birth. For example, if your birthday is in March and your spouse's or domestic partner's birthday is in November, your plan is the primary plan for your covered dependent child(ren). Your spouse's or domestic partner's plan is the secondary plan.
- If both parents have the same birthday, the plan that has covered one parent longer is the primary plan.
- If the other plan does not use the birthday rule, but uses a rule based on gender, the rules of the other plan will apply.

If You Are Separated or Divorced

If you and your dependent child(ren)'s other parent are separated or divorced, the following rules determine which plan is primary and which is secondary for your covered dependent child(ren):

- If there is a court decree establishing financial responsibility for the health care of a child, the plan of the parent with financial responsibility is the primary plan.
- If there is a court decree establishing custody, the plan of the parent with custody is the primary plan.
- When the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent:
  - The plan of the parent with custody is primary;
  - The plan of the stepparent is secondary; and
  - The plan of the parent without custody pays last.
- If there is a court order establishing joint custody without stating which parent is responsible for health care, the birthday rule will apply.

Other COB Rules

If You Have Coverage as a Retired or Laid-Off Employee and as an Employee on Another Plan

If you have coverage as a retired or laid-off employee and are also covered as an employee under another plan, the plan that covers you as an active employee is primary for you and your spouse/domestic partner and your dependent child(ren). The plan under which you are considered retired or laid off is secondary. This rule does not apply if the other plan does not have this rule and the plans do not agree on the order of benefits.

If You Have COBRA Continuation Coverage

If you have continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and are also covered under another plan as an active employee, the plan that covers you as an active employee is primary for you and your spouse/domestic partner and your dependent child(ren). This rule is not applied if the other plan does not have this rule and the plans do not agree on the order of benefits.

If You Are in an Automobile Accident

Generally, if you are in an automobile accident, ADT's Medical and Dental Plans would coordinate coverage with your automobile insurance as outlined in "If You Are Covered by Another Plan" in this section. However, even if a plan is your primary or secondary plan, in states with no-fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident. In no-fault states, all medical expenses related to an automobile accident must be submitted to the automobile insurance carrier first. The ADT plan will pay benefits for covered expenses not payable under the no-fault automobile insurance according to the Coordination of Benefits (COB) rules described in this section. Then, you can submit claims under another plan, such as your spouse's employer's plan, for any expenses not paid by the plan. Depending on the COB provisions of the other plan, you may or may not receive additional benefits.

If You Are Eligible for Medicare

If you continue working for ADT past age 65, although you may be entitled to Medicare, the Company may continue to be the primary source of coverage for you and, possibly, for your spouse/domestic partner, or your covered dependent child(ren). Social Security may allow you to defer your Medicare coverage without penalty until you retire. Contact your local Social Security office before your 65th birthday for details.

You may choose to elect Medicare instead of coverage under the ADT Medical Plan. If you elect Medicare as your primary plan, coverage under the ADT plan will end for you, your spouse/domestic partner, or your covered dependent child(ren), if covered, and you will not be able to re-enroll in the ADT Medical Plan until the next Benefits Annual Enrollment.

You also have the option of enrolling in Medicare Part D for prescription drug coverage. ADT will supply annual notices of creditable coverage to help you decide if enrolling in Medicare Part D makes sense due to your personal situation. If you enroll in Medicare Part D and have ADT prescription drug coverage, the rules outlined in this section for determining primary and secondary plans will apply in the same manner.

Medicare is secondary (and the ADT Medical Plan is primary) if you, your spouse/domestic partner, or your covered dependent child is entitled to Medicare and entitled to Social Security disability benefits, but only while coverage under the ADT Medical Plan is due to your "current employment status" under Medicare rules (generally while you're employed and during the first six months you're receiving disability benefits from an employer). If coverage under the ADT Medical Plan is other than because of your "current employment status" (after your employment ends or after the sixth month that you receive disability benefits), Medicare is primary.

Medicare is secondary (and the ADT Medical Plan is primary) if you or your spouse/domestic partner, or your covered dependent child is suffering from End-Stage Renal Disease (ESRD) (that is, he or she is on kidney dialysis or needing a kidney transplant) for the first 30 months of ESRD treatment (the 30-month period begins with the month in which eligibility for Medicare benefits for ESRD begins). Thereafter, Medicare is primary. When this provision determines that Medicare is primary, the ADT Medical Plan is secondary regardless of whether you, your spouse/domestic partner, or your covered dependent child (whoever is eligible) has enrolled in Medicare.

Please note: Refer to the Retiree Wrap SPD for more information about medical coverage for retirees and covered spouses/domestic partners age 65 or over.

Medicare Payments to a Government Facility

There are special rules related to Medicare payments to a government facility, such as a Veterans Administration medical center, that does not get reimbursements from Medicare. In that case, the ADT Medical Plan pays benefits as if the service had not been provided by a government facility. Therefore, the ADT Medical Plan pays benefits based on what Medicare should pay even though Medicare doesn't actually pay the claim.

Payment Rules

Right to Receive and Release Needed Information

You must give the Claims Administrator any needed information at the time a claim is submitted. An exchange of needed information with any other insurance company, group, or person also may be necessary.

Facility of Payment

If you, your spouse/domestic partner, or your covered dependent child receives benefits under another plan that should have been paid under the ADT plan, the claims administrator has the right to pay the other plan directly. The amount paid to the other plan is considered a benefit paid to you or on your behalf under the ADT plan and will apply toward any applicable plan maximums.

Continuing Coverage under COBRA

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Continuing Coverage under COBRA

About COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, is a federal law that requires employers with group health plans to offer employees and certain members of their families ("qualified beneficiaries") the opportunity to temporarily continue health care coverage under certain circumstances when coverage would otherwise end ("qualifying events"). This coverage is commonly referred to as "COBRA continuation coverage" or "COBRA coverage."

While enrolled in COBRA continuation coverage, qualified beneficiaries have the same enrollment and election change rights as active employees. In addition, any plan change that affects active employees also affects qualified beneficiaries.

Under federal law, domestic partners are not considered qualified beneficiaries under COBRA. However, most, but not all, ADT health care claims administrators extend "COBRA-like" coverage to domestic partners and their dependent child(ren). Where this coverage is available, covered domestic partners can elect COBRA-like coverage under circumstances similar to those that apply to spouses.

Please note: Since offering "COBRA-like" coverage to domestic partners and their dependent child(ren) is not required by law, not all plans or plan options offer these COBRA-like coverage rights. You should check with the claims administrators for your plans for more information about their policies regarding continuation coverage for domestic partners and their dependent child(ren).

What Coverage May Be Continued under COBRA

Coverage may be continued under the Medical Plan, Dental Plan, Vision Plan, and the Employee Assistance & Work/Life Program (EAP) through COBRA as long as the qualified beneficiary was covered under the specific plan on the day before coverage would otherwise end because of a qualifying event. In some instances, you may also continue participation in the Flexible Spending Account (FSA), but not under the Dependent Care Account (DCA), through COBRA. Electing the Medical Plan under COBRA continues your access to the ADT Wellness Program.

The monthly cost of COBRA continuation coverage is based on the **full** monthly premium for the benefits in which you enroll, not your employee contributions. In general, your monthly cost for COBRA continuation coverage would equal 102% of the total cost of coverage, which you pay on an after-tax basis.

Please note: The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. Keep in mind that the coverage described in this section may change as permitted or required by changes in any applicable law. In some states, state law provisions may also apply to the claims administrators offering coverage under the ADT plan.

How COBRA Works

Qualifying Events and Time Frames for COBRA Continuation Coverage

To be eligible for COBRA continuation coverage, you must have experienced a qualifying event. After the qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. Child(ren) who are born to or placed with you for adoption while you're covered under COBRA are also considered qualified beneficiaries and can be added to your existing COBRA continuation coverage. In some instances, this coverage may not be available to child(ren) of a domestic partner.

The following chart lists the qualifying events which allow for continuation of medical, dental, and vision coverage under COBRA when coverage would otherwise end, and who initiates the COBRA election process, and for how long coverage can be continued under COBRA based on the qualifying event. Qualified beneficiaries must have the applicable coverage at the time of the qualifying event to be eligible to continue that coverage under COBRA.

> The time frame for continuing coverage under the FSA is different. See "Special Rules for the Flexible Spending Account (FSA)" later in this section.

Qualified Beneficiaries

The following individuals can become qualified beneficiaries under COBRA if ADT health care coverage is lost during a qualifying event:

- You.
- Your covered spouse.
- Your covered domestic partner.
- Your covered dependent child(ren).
- Your domestic partner's covered child(ren).

COBRA Continuation Coverage

Qualifying Event	Who Initiates the COBRA Election Process	Maximum Continuation Coverage Period
▪ Termination of your employment (other than for gross misconduct) ▪ Reduction in your hours of employment that would cause you to lose eligibility for coverage ▪ Retirement	ADT or the COBRA Administrator will send you, your spouse/domestic partner, and/or your dependent child(ren) a COBRA election form, along with cost information within 30 calendar days after notification of the qualifying event. The COBRA Administrator will send a COBRA notice to you no later than 14 calendar days after receiving notice from ADT. This COBRA notice will explain your right to continue coverage.	You and your spouse/domestic partner and covered dependent child(ren) may continue medical, dental, and vision coverage for up to 18 months.

Qualifying Event	Who Initiates the COBRA Election Process	Maximum Continuation Coverage Period
▪ Divorce or legal separation between you and your spouse (unless a Qualified Medical Child Support Order [QMCSO] provides otherwise) ▪ Termination of your relationship with your domestic partner ▪ Your child or a child of your domestic partner no longer meets the definition of a dependent under the ADT health plans ▪ You become eligible for Medicare (under Part A, Part B, or both) ▪ Your death	You, your spouse/domestic partner, or your dependent child must notify ADT or the COBRA Administrator within 60 calendar days of the qualifying event. Within 14 calendar days of being notified of the qualifying event, the COBRA Administrator will provide a COBRA notice and election form informing you, your spouse/domestic partner, and/or your dependent child(ren) of the right to choose COBRA coverage.	Your spouse/domestic partner and covered dependent child(ren) may continue medical, dental, and vision coverage for up to 36 months.
▪ You, your spouse/domestic partner, or your covered dependent child is determined to be disabled under Title II or Title XVI of the Social Security Act	You, your spouse/domestic partner, or your dependent child must notify ADT within 60 calendar days of receiving the Social Security Administration's disability determination and before the end of the initial 18-month COBRA continuation coverage period.	The initial 18-month period of COBRA continuation coverage may be extended for medical, dental, and vision coverage for up to 11 months (for a total of up to 29 months of COBRA continuation coverage). See "More about a Disability Qualifying Event" later in this section.

You and your covered family members have 60 calendar days from the date of the qualifying event or the date of receiving the COBRA notice, whichever is later, to elect to continue coverage under COBRA. **If you do not elect COBRA within 60 calendar days, you will not be eligible to continue coverage under COBRA, and your coverage will end according to the plan's normal provisions.**

If you notify ADT of a qualifying event for COBRA coverage (as described in the chart above), and the claims administrator determines that continuation coverage is not an option for you, ADT or the COBRA Administrator will send you and your dependents a notice explaining that COBRA coverage is not available to you and the reasons why.

You, your spouse/domestic partner, and each dependent child have an independent right to elect COBRA continuation coverage. For example, your spouse/domestic partner or dependent child may elect COBRA continuation coverage even if you do not elect it. In addition, you or your spouse/domestic partner may elect COBRA continuation coverage for all family members.

More about a Disability Qualifying Event

The Social Security Administration (SSA) must determine that you (or another qualified beneficiary) were disabled at any time within 60 calendar days of the qualifying event (i.e., the disability started at some time before the 60th calendar day of COBRA continuation coverage).

The 11-month extension applies to all disabled and non-disabled individuals entitled to COBRA continuation coverage as a result of the same qualifying event to which the disability extension applies, subject to giving notice requirements.

> If a child is born to or placed with you for adoption while you are continuing coverage under COBRA and added to COBRA continuation coverage within 31 calendar days of birth or placement, the additional 11-month coverage period will apply if the child is determined to be disabled within the first 60 calendar days of his/her COBRA continuation coverage.

Notice of the disability must be provided in writing and must include the following information:

- The name and address of the disabled qualified beneficiary;
- The date the qualified beneficiary became disabled;
- The date the SSA made its determination of disability; and
- The signature, name, and contact information of the individual sending the notice.

If the SSA determines that the individual is no longer totally disabled, COBRA continuation coverage ends. The qualified beneficiary who experienced the qualified event which the disability related to must contact ADT within 31 calendar days after the determination. COBRA continuation coverage ends on the first day of the month that is 31 or more calendar days after the SSA's determination that the disability has ended.

Special Rules for the Flexible Spending Account (FSA)

Under certain circumstances, a qualified beneficiary may elect to continue participation under the Flexible Spending Account (FSA) (not under the Dependent Care Account [DCA]) by electing COBRA continuation coverage. You may want to consider continuing FSA participation if you have a remaining balance in your FSA at the time of the qualifying event (for example, termination of employment) and you do not have expenses incurred before the qualifying event that have not been submitted for reimbursement. In the case of continued FSA participation under COBRA, FSA participation ends at the end of the plan year (December 31) in which the qualified beneficiary experiences a qualifying event.

COBRA continuation coverage under the FSA will be the coverage in effect at the time of the qualifying event (that is, the elected annual contribution to the FSA minus expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year.

To continue FSA participation under COBRA, you are required to pay your previous contribution amount plus 2% on an after-tax basis.

When COBRA Continuation Coverage Begins

COBRA coverage begins on the date regular coverage would normally end.

When COBRA Continuation Coverage Ends

COBRA continuation coverage continues until the **earliest** of:

- The end of the applicable 18-month, 29-month, or 36-month COBRA continuation coverage period.
- The date a COBRA continuation coverage participant does not pay the required monthly contribution within 31 calendar days of its due date.
- The date a COBRA continuation coverage participant first becomes covered after the date of his/her election under another group medical, dental, or vision plan that doesn't contain a pre-existing condition.
- The date a COBRA continuation coverage participant first becomes entitled to Medicare after the date of his/ her COBRA continuation coverage election.
- The date on which there has been a final determination by the SSA that the COBRA continuation coverage participant who elected to extend coverage for up to the 29 months due to a disability is no longer disabled. If this happens, you must notify the COBRA Administrator within 30 calendar days after the date the SSA makes its determination about the lack of disability.
- The date of a COBRA continuation coverage participant's written request to cancel coverage.
- The date ADT stops providing any group health plan coverage.

If COBRA Continuation Coverage Will End Early

If COBRA continuation coverage will terminate before the end of the maximum coverage period, ADT or the COBRA Administrator will send you and your dependents a Notice of Early Termination of COBRA Coverage. As an example, coverage may end early because:

- You have not paid the premiums;
- You have new coverage under another group health plan; or
- You have enrolled in Medicare.

Electing COBRA Coverage

The following are the procedures you must follow to enroll in COBRA continuation coverage. If you have questions you should call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **COBRA** for assistance.

Please note: Verbal communication, email, and faxing required documentation are not acceptable ways to deliver your COBRA election notice, and no election notice delivered via verbal communication, email, or facsimile will be considered valid or sufficient.

Initial Election

To elect COBRA, you must complete the election form that you receive with your COBRA election notice. Submit the completed form to the COBRA Administrator within the time frame specified on the form (usually within 60 calendar days). If applicable, you must also return supporting documentation to the COBRA Administrator during the required 60-calendar-day period.

You, your spouse/domestic partner, or your dependent child(ren) **must** mail or hand-deliver the election form to the COBRA Administrator. **If necessary forms and documentation are not returned during the 60-calendar-day election period, the individual whose coverage is ending will lose the right to elect COBRA coverage.**

Extending COBRA after a Second Qualifying Event

If you experience a second qualifying event and want to extend your COBRA continuation coverage, you, your spouse/domestic partner, or your dependent child must notify the COBRA Administrator of the second qualifying event within 60 calendar days after the **later** of:

- The date of the second qualifying event; or
- The date coverage would have been lost because of the event.

If necessary forms and documentation are not returned during the 60-calendar-day election period, the individual whose coverage is ending will lose the right to elect COBRA coverage.

For more information about second qualifying events, contact the COBRA Administrator by calling **EmployeeAccess** at **1-888-833-1839** and selecting **Health and Group Benefits** followed by **COBRA** for assistance.

Request for COBRA Continuation Coverage Notice Requirements

When providing notice requesting COBRA continuation coverage, the notice must include information about you or the other qualified beneficiary requesting continuation coverage and the qualifying event that entitles the individual to COBRA coverage. In addition, you or your qualified beneficiary must provide the COBRA Administrator with documentation as proof of the qualifying event. Acceptable documentation includes the items listed below and any other supporting documentation approved by the COBRA Administrator:

- **Death—**a copy of the death certificate.
- **Divorce—**a copy of the divorce decree.
- **Legal separation—**a copy of the separation agreement.
- **Child no longer qualifying as a dependent—**a copy of a driver's license or birth certificate showing the child's age (if the child reaches the eligibility age limit for coverage).

If the notice and/or supporting documentation are not returned to the COBRA Administrator during the required 60-calendar-day period, any individual losing coverage will lose the right to elect COBRA coverage.

Cost of COBRA Continuation Coverage

Once you elect COBRA coverage, you, your spouse/domestic partner, and/or your dependent child(ren) will be charged the full cost of coverage under the plan, plus a 2% administrative fee. The cost of COBRA continuation coverage for the additional 11 months of coverage due to Social Security disability (from the 19th through the 29th month) will be 150% of the full cost of coverage.

When COBRA Continuation Payments Are Due

The initial payment for COBRA continuation coverage is due 45 calendar days from the date of your election. After the first payment, you must pay for coverage on a monthly basis. You have a grace period of at least 30 calendar days to submit your monthly COBRA payment. Keep in mind, however, that:

- If the first payment is not received within 45 calendar days, you, your spouse/domestic partner, and/or your dependent child(ren) will lose the right to continued plan coverage as a result of that qualifying event, and your coverage under the plan will end as of the date of the qualifying event.
- If any subsequent payment is received more than 30 calendar days after the first day of the calendar month for which the payment is due, your coverage under the plan will end as of the last day of the month for which payment has been received.
- COBRA continuation coverage cannot be reinstated under the plan's COBRA provisions once it is lost.

For more information on COBRA continuation coverage, rights and obligations, please contact **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** followed by **COBRA** for assistance.

Claim Review and Appeal Processes

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Claim Review and Appeal Processes

How to file a claim for benefits is explained in the specific benefit plan section in this Summary Plan Description (SPD). This section explains what happens once your claim is received by the claims administrator or insurance company and your rights if your claim is denied.

Who May File a Claim or Appeal

Either you or your authorized representative may file a claim or an appeal of denied claims for plan benefits. An “authorized representative” is a person you authorize, in writing, to act on your behalf. The plan also will recognize a court order giving a person the authority to submit claims and appeals on your behalf. In case of an urgent care claim, a health care professional with knowledge of your condition may always act as your authorized representative. All communications from the plan will be directed to your authorized representative unless your written designation provides otherwise.

Claims and Appeals Time Frames

Almost all of the benefit plans described in this SPD have a specific amount of time, by law, to evaluate and respond to benefit claims and appeals. These time limits apply to plans subject to the Employee Retirement Income Security Act (ERISA). The period of time the plans have to evaluate and respond to a claim or appeal begins on the date the claim or appeal is first filed. In addition, there are specific timelines and information requirements that you must comply with when filing a claim or appeal, or the claim or appeal may be denied and the rights you might otherwise have may be forfeited.

If you have any questions regarding how to file a claim or appeal a denied claim, contact the appropriate claims administrator or insurer. See “Claims Administrators Contact Information” later in this section of this SPD for a list of the claims administrators and insurance companies responsible for processing claims and deciding claims and appeals for benefit plans offered through the ADT Health and Welfare Benefits Plan.

Improperly Filed Claims

If a claim isn’t filed according to the plan’s claim procedures, you will be notified as soon as possible. The notification, with the exception of Long-Term Disability and Life Insurance, will be provided no later than five business days after the claim is received by the plan.

If the claim is an urgent care case, you will be notified within 24 hours. Notice of an improperly filed claim may be provided verbally, or in writing if you request. The notice will identify the proper procedures to be followed in filing the claim.

To receive notice of an improperly filed claim, you or your authorized representative must have provided information regarding the claim to the claims administrator or insurance company for the plan, including:

- The identity of the claimant; and
- The specific reason, treatment, service, or product for which benefits are being requested.

If you do not provide the above information and any additional information requested, you will not be considered to have filed a claim under the plan.

Eligibility/Participation Appeals

If your request for eligibility for coverage under the Plan is denied, in whole or in part, in a letter from the claims administrator or otherwise, you may request a review of the denial. Your request for review must be in writing, and it should contain the reasons why you believe you're entitled to benefits, as well as any additional information or documentation to support your claim.

Please note: You must send your written appeal to ADT Health and Group Benefits to the following address(es) within **180 calendar days** of the statement date listed on the claim form.

Regular Mail:

ADT Health and Group Benefits
Attention: Appeals
P.O. Box 199575
Dallas, Texas 75219-9575

Or

Overnight Mail:

ADT Health and Group Benefits
Attention: Appeals
Building 5 / Floor 1
2828 N. Haskell Ave
Dallas, TX 75204-2909

If you do not send the written appeal within the 180-calendar-day period, your appeal will not be reviewed, and you will forfeit any right to any further review of your denied claim.

Who Determines Benefit Claims Payments and Denials

As Plan Administrator, ADT generally has delegated to the claims administrators and insurance companies the exclusive right to interpret and administer the provisions of the plans—and to determine benefit payments under the plans. The claims administrators' and insurers' decisions are final and binding except in those instances in which you have appeal rights to an Independent Review Organization (IRO) under the Affordable Care Act of 2010, as amended.

In reviewing your claim, the applicable claims administrator or insurer will apply the plan terms and use their discretion in interpreting plan terms. Benefits will be paid only if you've met the eligibility and participation requirements and the claims administrator or insurance company determines you are entitled to the benefits.

Adverse Benefit Determination

An “adverse benefit determination” is a denial, reduction, or termination of a benefit, a retroactive rescission of coverage, or a failure to provide or pay, in whole or in part, a benefit. It can also include a denial of participation in the plan. Additionally, for health care coverage, an adverse benefit determination may also mean a claim is denied on the grounds that the treatment is experimental or investigational or not medically necessary. This includes concurrent care determinations. You may receive an adverse benefit determination in response to an initial claim for benefits or in response to your appeal of the denial of your initial claim.

If your claim for a benefit is denied, in whole or in part, you or your authorized representative will receive written notification of the adverse benefit determination within the time period specified for the plan, after receipt of your application for claims payment or your appeal unless special circumstances require an extension of time for processing the claim. If an extension is necessary, you will be notified in writing.

Adverse Benefit Determination for Initial Claims

In the event of an adverse benefit determination of an initial claim, you or your authorized representative will receive notice of the determination. The notice will include:

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

- Information describing the claim you made, and identifying the date of service, the specific health care provider providing service, the claim amount, and the diagnosis, treatment, and denial codes;
- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based, including the standards that the plan used to deny the claim;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan’s internal appeal and external review processes, a description of how to initiate an appeal, and the time limits applicable to such procedures;
- A statement that you are entitled to receive, upon request and, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, and that you are authorized to review, free of charge, any new or additional evidence or rationale that the plan or claims administrator considered, relied on, or generated in connection with your claim;
- Contact information for certain government entities that may assist a claimant with appeals and external reviews;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- For health care and Long-Term Disability claims, any specific rule, guideline, protocols, or other similar criteria that was used as a basis for the adverse determination—or a statement that a copy of such information will be made available free of charge upon request;

- For health care and Long-Term Disability claims, an explanation of the scientific or clinical judgment used in adverse determinations based on medical necessity, experimental treatment, or other similar exclusions or limits—or a statement that an explanation will be provided free of charge upon request;
- For Long-Term Disability claims, the following statement: "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and
- For health care claims, a description of the expedited review process for adverse determinations involving urgent care. (This notice can be provided verbally within the time frame for the expedited process, as long as written notice is provided no later than three business days after the verbal notice.)

Adverse Benefit Determination of Appeals

In the event of an adverse benefit determination upon appeal, you or your authorized representative will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A description of any voluntary review procedures offered by the plan;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- For health care and Long-Term Disability claims, any specific rule, guideline, protocols, or other similar criteria that was used as a basis for the adverse determination—or a statement that a copy of such information will be made available free of charge upon request;
- For health care and Long-Term Disability claims, an explanation of the scientific or clinical judgment used in adverse determinations based on medical necessity, experimental treatment, or other similar exclusions or limits—or a statement that an explanation will be provided free of charge upon request; and
- For Long-Term Disability claims, the following statement: "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Notices Following Appeal

For all ERISA claims, the claims administrator will provide you with written notification of the determination on appeal.

Judicial Review

You must pursue all the claim and appeal rights described in this section before you seek any other legal recourse regarding claims for benefits. You may not bring any action at law or in equity to recover benefits unless and until the appeal rights described in this section have been exercised and the benefits requested in the appeal have been denied, in whole or in part (or there is any other adverse benefit determination).

At this point there will be no further review available under the internal and external review processes. Thus, if you wish to seek judicial review of any adverse benefit determination, you must file a civil action under the applicable state or federal law.

Claim Review and Appeal Process by Benefit Plan

Health Plans

Review of Your Initial Claim

The first time that the plan considers your benefits claim and makes a decision on your claim is called "the initial benefit determination." Notices of benefit determinations may be provided in writing or in electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

There are different types of claims under the ADT health care plans (i.e., the Medical, Prescription Drug, and Dental Plans) as described below.

Urgent Care Claims

Urgent care claims are pre-service claims that have to be decided more quickly because using the normal time frames for decision-making:

- Could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or
- In the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

If you provide insufficient information for the claims administrator to decide an urgent care claim, the claims administrator will notify you within 24 hours after receipt of your claim, of what information is needed to complete the claim review. You'll be given a reasonable amount of time, taking into account the circumstances but not less than 48 hours, to provide the specified information. The claims administrator will notify you of its benefit determination as soon as possible, but no later than 48 hours after the plan's receipt of the specified information or the end of the period you were given to provide the specified additional information, whichever happens first.

If no additional information is needed from you when the claim is first submitted, the claims administrator will notify you of the determination, whether adverse or not, as soon as possible considering the medical urgency, but not later than 72 hours after receipt of the claim.

The claims administrator may provide notices of urgent benefit determinations verbally, followed by written or electronic notice within three business days.

Pre-Service Claims

Pre-service claims are claims for benefits that must be approved before receiving health care (e.g., requests to pre-certify a hospital stay or for elective health care services and supplies.).

For pre-service health claims, the claims administrator will notify you of the determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but no later than 15 calendar days after receipt of the claim. This period may be extended by 15 calendar days, if the claims administrator:

- Determines that an extension is necessary because of matters beyond the claims administrator's control; and
- Notifies you within the initial 15-calendar-day period of the circumstances requiring the extension and the date by which the claims administrator expects to give a decision.

If such an extension is necessary because you don't submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You'll be given at least 90 calendar days from receipt of the notice to provide the specified information.

Post-Service Claims

Post-service claims are claims involving the payment or reimbursement of costs for medical care that has already been provided.

For post-service health claims, the claims administrator will notify you of an adverse determination within a reasonable period of time, but no later than 30 calendar days after receipt of the claim. This period may be extended by 15 calendar days if the claims administrator determines that an extension is necessary because of matters beyond the claims administrator's control and notifies you, within the initial 30-calendar-day period, of the circumstances requiring the extension and the date by which the claims administrator expects to provide a decision. You'll be given at least 45 calendar days from receipt of the notice within which to provide the specified information.

Concurrent Care Claims

Concurrent care claims are claims for which the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or you request to extend the course of treatment beyond the approved period of time or number of treatments.

Concurrent care claims may be considered urgent care, pre-service, or post-service claims, and different notice and appeal time frames apply:

- If an ongoing course of treatment will be reduced or terminated, you'll be notified far enough in advance so that you have the opportunity to appeal and obtain a decision on appeal before the benefit is reduced or terminated.

- If you request an extension of ongoing treatment in an urgent care situation, you'll be notified as soon as possible given the health care situation, but no later than 24 hours after the claims administrator receives your claim. (The request to extend treatment must be submitted to the plan at least 24 hours before the end of the prescribed time period or number of treatments to be considered.) Coverage of ongoing treatment will continue during the pendency of an appeal you have filed.

  If you request an extension of ongoing treatment in a non-urgent circumstance, the request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies. If your claim is denied, and you initiate an appeal of your adverse benefit determination, coverage of ongoing treatment will continue during the pendency of an appeal you have filed.

Claim Appeal Process

First-Level Appeals

If you receive notice of an adverse benefit determination of an initial claim and you disagree with the decision, you're entitled to apply for a full and fair review of the claim and the adverse benefit determination. You or your authorized representative will have at least 180 calendar days after receiving the denial notice to file an appeal.

You may be able to resolve the denied claim without a formal appeal by calling the appropriate claims administrator to discuss the situation.

If you file an appeal with the claims administrator, the request must be made in writing and include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant to your appeal.

For appeals of adverse benefit decisions involving urgent care claims, the plan will accept either verbal or written requests for appeals for an expedited review. All necessary information may be transmitted between the plan and you or health plan providers by telephone, fax, or other available expeditious methods.

The initial adverse benefit determination will not be taken into account in conducting this review. The review will be conducted by a representative of the claims administrator who is neither the person who made the adverse benefit determination that is the subject of the review nor the subordinate of that person.

When the denial determination is based, in whole or in part, on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of health care involved in your claim. The health care professional will not be the same person as, nor the subordinate of, the person who was consulted on the initial decision.

As part of this process, you will have the opportunity to submit written comments, documents, records, and other information relating to the claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations.

The review will take into account all comments, documents, records, and other information submitted relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

You're also entitled to access to, and a copy of, any internal rule, guideline, protocol, or other similar criteria used as a basis for a decision on your denied claim, upon request and free of charge. Similarly, if your claim is denied based on a determination involving a medical judgment, you're entitled to an explanation of the scientific or clinical reasons for that determination, free of charge upon request.

The claims administrator will notify you of the determination on review within the following time frames:

- **For appeals of urgent care health claims**, as soon as possible considering the medical urgency, but no later than 24 hours from the receipt of your request for appeal of a denied claim;
- **For appeals of pre-service claims**, within a reasonable period of time given the medical situation, but no later than 15 calendar days from the receipt of your request for appeal of a denied claim;
- **For appeals of post-service claims**, within a reasonable period of time, but no later than 30 calendar days after receipt of the request for appeal of a denied claim; and
- **For appeals of concurrent care health claims**, the applicable time frame in one of the above bullets depending on whether the appeal is for an adverse determination of an urgent care, pre-service, or post-service claim.

Second-Level Appeals

If you're not satisfied with the claims administrator's first-level appeal decision, you have the right to request a second-level appeal. Your second-level appeal must be submitted to the appropriate claims administrator within 60 calendar days from the date you received the first-level appeal decision.

You'll receive a decision from the claims administrator on your second-level appeal within the following time frames:

- **For second-level appeals of pre-service claims**, within a reasonable period of time given the medical situation, but no later than 15 calendar days from the receipt of your request for review of the first-level appeal decision; and
- **For second-level appeals of post-service claims,** within a reasonable period of time, but no later than 30 calendar days after receipt of your request for review of the first-level appeal decision.

Voluntary External Review

You may file a voluntary appeal of any final standard appeal determination for coverage denials related to medical necessity or coverage rescission to an IRO. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

> You must complete all of the levels of the standard appeals process described in this section **before** you can file a voluntary external appeal.

You must request this voluntary level of review within 120 calendar days after you receive the final denial notice under the standard appeal processes, described in this section. If you file an appeal to an IRO, any applicable statute of limitations will be tolled (i.e., put on hold) while the appeal is pending.

In order to file an appeal with an IRO, contact your claims administrator who will assign an IRO to your case on an impartial basis. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

All decisions the IRO makes regarding your health claim appeal are deemed final and binding.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider, you must write your claims administrator within 30 calendar days of the incident. Contact information can be located on your ID card.

You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. The claims administrator will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Spending Accounts

Review of Your Initial Claim

The first time that the plan considers your benefits claim and makes a decision on your claim is called “the initial benefit determination.” Notices of benefit determinations may be provided in writing or in electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

When you file a claim for reimbursement from the Flexible Spending Account (FSA) and the Dependent Care Account (DCA), the plan has up to 30 calendar days to evaluate and respond to claims for benefits covered by ERISA. The 30-calendar-day period begins on the date the claim is first filed. This period may be extended by 15 calendar days provided the claims administrator or its delegate:

- Determines that an extension is necessary due to matters beyond the control of the plan; and
- Notifies you within the initial period of the circumstances requiring the extension and the date by which the plan expects to provide a decision.

If such an extension is necessary because you don’t submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You’ll be given at least 45 calendar days from receipt of the notice to provide the specified information.

Claim Appeal Process

If your claim is denied, you or an authorized representative will have at least 180 calendar days after receiving the denial notice to file an appeal.

You must submit a written request for a review of the denial of the claim. You can submit written comments, documents, records, or other information relating to the claim for benefits. All documents you submit will be considered upon review, whether or not they were considered in the initial review. You'll be provided, upon request and free of charge, access to and copies of all documents and other information relevant to the claim for benefits. In your request for a review, state the reasons that you believe your claim was improperly denied and include all additional information that you consider relevant in support of your claim.

After receiving a request for review, the claims administrator will provide a final decision within 60 calendar days. If your appeal is denied, you will receive notice of the adverse benefit determination.

Short-Term Disability Plan

The Short-Term Disability Plan is an income replacement plan and is not subject to ERISA. Therefore, please see the **Disability** section of this SPD for additional claims and appeals information regarding your Short-Term Disability benefit.

Long-Term Disability Plan

Review of Your Initial Claim

The first time that the Long-Term Disability Plan considers your benefits claim and makes a decision on your claim is called "the initial benefit determination." Notices of benefit determinations may be provided in writing or in electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

The Long-Term Disability Plan has up to 45 calendar days to evaluate and respond to claims for benefits covered by ERISA. The 45-calendar-day period begins on the date the claim is first filed.

This period may be extended twice, by 30 calendar days for each extension, if the insurance company:

- Determines that an extension is necessary due to matters beyond the control of the insurance company; and
- Notifies you within the initial period (and within the first 30-calendar-day extension period, if applicable) of the circumstances requiring the extension and the date by which the insurance company expects to make a decision.

In addition, the notice of extension must include:

- The standards on which entitlement to a benefit is based;
- The unresolved issues that prevent a decision on the claim; and
- The additional information needed to resolve those issues.

You'll be given at least 45 calendar days from receipt of the notice to provide the specified information. Furthermore, the time limits described for claims are tolled (i.e., put on hold) pending the receipt by the insurance company of additional information solicited from the claimant.

Claim Appeal Process

You have 180 calendar days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 calendar days following receipt of the written request for review. If the insurance company determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 calendar days (90 calendar days in total). The insurer will notify you, in writing, if an additional 45-calendar-day extension is needed.

If an extension is necessary because you did not submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you'll be afforded at least 45 calendar days to provide the specified information. If you deliver the requested information within the time specified, the 45-calendar-day extension of the appeal period will begin after you have provided that information. If you do not deliver the requested information within the time specified, the insurance company may decide your appeal without that information. Furthermore, the time limits described for claims are tolled (i.e., put on hold) pending the insurance company's receipt of additional information it has requested from you to determine the appeal.

As part of the process, you will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will be provided, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. The initial determination will not be taken into account in this review.

The review will be conducted by the insurance company and will be made by a person who is neither the person who made the initial adverse benefit determination that is subject to review nor the subordinate of the person who was consulted in the initial decision.

In the case of a claim denied on the grounds of a medical judgment, the insurer will consult with a health professional with appropriate training and experience. If your appeal is denied, you will receive notice of the adverse benefit determination. See "Adverse Benefit Determination," earlier in this section, for more information.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction. Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

Life and AD&D Insurance Plans

Review of Your Initial Claim

The first time that the plan considers your benefits claim and makes a decision on your claim is called "the initial benefit determination." Notices of benefit determinations may be provided in writing.

Life Insurance

If your Life Insurance claim is approved, you will receive an Explanation of Benefits (EOB) form with your payment. If your Life Insurance claim is denied, you will be provided written notice of the denial.

For life insurance claims, the plan has up 45 calendar days to evaluate and respond to claims for benefits covered by ERISA. The 45-day period begins on the date the claim is first filed. This period may be extended by two 30-day extensions if the insurance company:

- Determines that an extension is necessary due to matters beyond the control of the insurance company; and
- Notifies you within the initial period of the circumstances requiring the extension and the date by which the insurance company expects to make a decision.

The 45-calendar-day period (or 30-day extensions) for the insurance carrier to make its decision will be suspended until you provide the specified information.

Accident Insurance

If your claim for Accidental Death and Dismemberment (AD&D), Business Travel Accident (BTA), or Personal and Family AD&D (P&F AD&D) Insurance is approved or denied, you will receive a notice of benefit determination in writing.

For AD&D (other than disability) and BTA Insurance claims, as well as claims for benefits under the P&F AD&D Insurance Plan, the plan has up to 90 calendar days to evaluate and respond to claims for benefits covered by ERISA. The 90-calendar-day period begins on the date the claim is first filed. This period may be extended by 90 calendar days if the insurance company:

- Determines that an extension is necessary due to matters beyond the control of the insurance company; and
- Notifies you within the initial period of the circumstances requiring the extension and the date by which the insurance company expects to make a decision. If an extension is necessary because you didn't submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You'll be given at least 45 calendar days from receipt of the notice to provide the specified information.

Claim Appeal Process

You or your authorized representative will have at least 90 calendar days (or, for Life Insurance only, at least 180 calendar days) after receiving the denial notice to:

- File an appeal by submitting a request for review, in writing, to the insurance company;
- Request (free of charge) reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- Submit written comments, documents, records, and other information relating to the claim to the insurance company.

The insurer will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination, and may require additional documents as it believes necessary or desirable in making such a review.

A final decision on the review will be made not later than 60 calendar days (45 calendar days for Life Insurance) following receipt of the written request for review. If special circumstances require an extension of time for processing, you'll be notified of the reasons for the extension and the date by which the insurer expects to make a decision.

If an extension is required because you did not submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to the insurance company. The 60-calendar-day extension (45-calendar-day extension for Life Insurance) of the appeal review period will begin after you have provided that information.

If your appeal is denied, you will receive a written notice of the adverse benefit determination.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction. Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

Claims Administrators Contact Information

General Administration

Contact	Website, Phone Number, and Fax Number	Mailing Address
EmployeeAccess	**Website:** MyADTHR.com **Phone:** 1-888-833-1839 (Monday through Friday from 8 a.m. to 8 p.m. Eastern time) **Fax:** 1-866-617-2288	ADT Health and Group Benefits P.O. Box 199575 Dallas, TX 75219-9575

Benefit Plans

Contact	Website, Phone Number, and Fax Number	Mailing Address
Accidental Death & Dismemberment (AD&D) Insurance Plan—The Hartford **Personal and Family AD&D Insurance Plan—The Hartford**	**Website:** N/A **Phone:** 1-888-563-1124 **Fax:** N/A **Please note:** Please initiate all claims by contacting **EmployeeAccess** at **1-888-833-1839** and following the necessary prompts.	The Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999

Contact	Website, Phone Number, and Fax Number	Mailing Address
Basic Term Life Insurance Plan—The Hartford **Supplemental Life Insurance Plan—The Hartford**	**Website:** N/A **Phone:** 1-888-563-1124 **Fax:** N/A **Please note:** Please initiate all claims by contacting **EmployeeAccess** at **1-888-833-1839** and following the necessary prompts.	The Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999
Business Travel Accident (BTA) Insurance Plan—The Hartford	**Website:** N/A **Phone:** 1-888-563-1124 **Fax:** N/A **Please note:** Please initiate all claims by contacting **EmployeeAccess** at **1-888-833-1839** and following the necessary prompts.	The Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999
COBRA Administration—CONEXIS	**Website:** mybenefits.conexis.com **Phone:** 1-877-722-2667 **Fax:** N/A	CONEXIS P.O. Box 14225 Orange, CA 92863-1225
Dental Plan—Aetna	**Website:** aetna.com **Phone:** 1-877-238-6200 **Fax:** N/A	Aetna, Inc. P.O. Box 14094 Lexington, KY 40512
Dependent Care Account (DCA)—Aetna	**Website:** aetna.com/members/fsa **Phone:** 1-800-416-7053 **Fax:** 1-888-238-3539	Aetna, Inc. P.O. Box 4000 Richmond, KY 40476-4000
Flexible Spending Account (FSA)—Aetna	**Website:** aetna.com/members/fsa **Phone:** 1-800-416-7053 **Fax:** 1-888-238-3539	Aetna, Inc. P.O. Box 4000 Richmond, KY 40476-4000
Hawaii Medical Service Association (HMSA)	**Website:** hmsa.com **Phone:** 1-800-776-4672 **Fax:** N/A	HMSA Attn: Appeals coordinator P.O. Box 1958 Honolulu, HI 96805-1958
Long-Term Disability (LTD) Plan—Cigna	**Website:** cigna.com/customer-forms **Phone:** 1-800-36-cigna (24462) **Fax:** N/A	Life Insurance Company of America 1601 Chestnut Street Philadelphia, PA 19192-2235
Medical Plan—Blue Cross Blue Shield (BCBS)	**Website:** bcbsal.com **Phone (toll-free):** 1-866-208-5663 **Fax:** N/A	Blue Cross and Blue Shield of Alabama 450 Riverchase Parkway East Birmingham, Alabama 35244

Contact	Website, Phone Number, and Fax Number	Mailing Address
Medical Plan BlueCard Worldwide®—Blue Cross Blue Shield	**Website:** bluecardworldwide.com **Phone (toll-free)**:1-800-810-2583 **Phone (collect)**: 1-804-673-1177 **Fax:** N/A	BlueCard Worldwide Service Center P.O. Box 261630 Miami, FL 33126
Prescription Drug Plan—CVS Caremark	**Website:** caremark.com **Phone:** 1-855-548-5653 **Fax:** N/A	CVS Caremark Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084
Triple-S Salud—Blue Cross Blue Shield of Puerto Rico	**Website:** ssspr.com **Phone:** 1-787-774-6060 **Phone (reimbursement):** 1-787-749-4021 **TTY:** 1-787-792-1370 **Fax (customer service):** 1-787-706-4014 or 1-787-706-2833	Triple-S Salud, Inc. Customer Service Department P.O. Box 363628 San Juan, PR 00936-3628
Vision Plan—EyeMed Vision Care	**Website:** eyemed.com **Phone:** 1-866-723-0513 **Fax:** 1-866-723-0513	EyeMed Vision Care 4000 Luxottica Place Mason, Ohio 45040
Wellness—Staywell Health Management	**Website:** ADTwellness.staywell.com or MyADTHR.com **Phone:** 1-855-428-6328 **Fax:** N/A	StayWell Health Management 3000 Ames Crossing Road Suite 100 St. Paul, MN 55121-2520

If You Reside in Puerto Rico—Triple-S Salud

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If You Reside in Puerto Rico—Triple-S Salud

Triple-S Salud, Inc. (“Triple-S Salud”) is the Medical Plan option under the ADT Health and Welfare Benefits Plan available to eligible employees, spouses/domestic partners, and child(ren) residing in Puerto Rico. Triple-S Salud, Inc. is an independent licensee of the Blue Cross and Blue Shield Association, San Juan, Puerto Rico.

Triple-S Salud provides medical (with prescription drug), dental, basic vision, and basic Employee Assistance Program (EAP) coverage.

To fully understand your rights, privileges, and responsibilities under the Triple-S Salud option, be sure to refer to both the applicable information in this Health and Welfare Benefits Plan Summary Plan Description (SPD) and the plan document provided by Triple-S Salud annually. Keep the Triple-S Salud plan document with this SPD together, as they comprise the ADT Health Plan SPD for eligible employees, spouses/domestic partners, and child(ren) residing in Puerto Rico.

Triple-S Salud at a Glance

The following is a high-level summary of the coverage available to you through Triple-S Salud. You and ADT share the cost of this coverage.

Please note: Services received out-of-network will only be covered in emergencies. For a list of participant providers, visit **www.ssspr.com** or call **1-787-774-6060**.

For coverage details and additional definitions of terms, refer to the Triple-S Salud plan document.

Medical Coverage

Preventive coverage to help you stay healthy before illness occurs and coverage to help you pay for covered medical expenses. Some services and supplies are subject to Triple-S Salud pre-certification.

Type of Service	Coverage (In-Network Only)
Preventive Care	Plan pays 100%. You pay $0.
Annual Cash Deductible The amount you pay before you and the plan start sharing the cost of services.	You pay: ▪ $300 individual ▪ $600 family
Office Visits	You pay a: ▪ $10 copay for primary care ▪ $12 copay for specialist visit ▪ $15 copay for sub-specialist visit ADT pays 100% of the covered expenses after your copay.

Type of Service	Coverage (In-Network Only)
Emergency Room Visit	You pay a: ▪ $50 copay for illness ▪ $0 copay for accident
Hospitalization	You pay a $25 copay.
Coinsurance	For services that don't have copays: ▪ Plan pays 80% ▪ You pay 20%
Out-of-Pocket Maximum The most you pay in covered expenses in a calendar year before the plan pays 100%.	You pay: ▪ $2,000 individual ▪ $4,000 family

Prescription Drug Coverage

Generic drugs are dispensed, except in cases in which a generic drug is not available. If a generic drug is available and you choose a brand-name drug, you will pay the copay for the generic drug plus the difference between the cost of the brand-name drug and the cost of the generic drug.

Type of Medication	Coverage (In-Network)
Generic Drugs	
30-calendar-day supply at a network pharmacy 90-calendar-day supply via mail order or 90-calendar-day dispensing program at participating pharmacies	You pay: ▪ 10% coinsurance ($5 minimum) ▪ $5
Brand-Name or New Drug	
30-calendar-day supply at a network pharmacy 90-calendar-day supply via mail order or 90-calendar-day dispensing program at participating pharmacies	You pay: ▪ 20% coinsurance ($10 minimum) ▪ $35

Dental Coverage

The plan pays a maximum of $1,000 per plan year for each covered person. This maximum applies to the combination of basic, preventive, periodontal, and prosthesis dental services, but does not apply to preventive, restorative, endodontic, and diagnostic services and extractions for child(ren) under age 19. Some services are subject to Triple-S Salud pre-certification.

Type of Service	Coverage (In-Network)
Diagnostic and Preventive Services	You pay: ▪ Nothing for most services ▪ 20% coinsurance for fixed space maintainers
Restorative, Surgical, and Other Services	You pay: ▪ Nothing for most services ▪ 30% coinsurance for composite resin restorations on posterior teeth and surgical extractions
Prosthesis Services Crowns, dentures, bridges, etc.	You pay: ▪ 50% coinsurance for most services ▪ 50% coinsurance for crowns and crowns with high noble retainers
Periodontal Services	You pay: ▪ 20% coinsurance
Orthodontic Services	You pay: ▪ 50% coinsurance of the submitted charge (reimbursement) The plan pays a maximum of $1,500 per covered person.

Basic Vision Coverage

When you enroll in the Triple-S Salud plan, you automatically have Basic Vision coverage. You may choose to purchase additional coverage through EyeMed Vision Care.

Type of Service	Coverage (In-Network)
Exam One every 12 months.	You pay: ▪ 20% coinsurance if you see an in-network provider
Eyeglasses and contacts	Plan pays: ▪ Up to $150 every 24 months for a combination of frames, lenses, and contact lenses

For more information about vision coverage, see the **Vision** section of this SPD.

Other ADT Health and Welfare Benefit Plans

As an eligible employee residing in Puerto Rico, you are also eligible for the following Health and Welfare Benefits Plans:

Benefit Plan	Description	Who Pays for Coverage
Basic Term Life Insurance	Pays one times your base annual salary to your beneficiary(ies) if you die in a covered non-work-related accident while working for ADT.	ADT
Accidental Death and Dismemberment (AD&D) Insurance	Pays one times your base annual salary to your beneficiary(ies) if you die as a result of a covered non-work-related accident. If you are seriously injured as a result of a covered non-work-related accident, you receive all or a portion of your AD&D benefit, depending on the covered accidental injury.	ADT
Business Travel Accident (BTA) Insurance	Pays four times your base annual salary to your beneficiary(ies) if you die as a result of a covered accident while traveling on ADT business. If you are seriously injured as a result of a covered accident while traveling on ADT business, you receive all or a portion of your BTA benefit, depending on the covered accidental injury.	ADT
Employee Assistance & Work/Life Program (EAP)	Provides confidential face-to-face counseling services, plus 24/7 phone access to trained professionals who can help you navigate life's ups and downs. This program also provides education and support for work/life issues you encounter. If you enroll in Triple-S Salud, you also have access to the Quick Help Employee Assistance Program. However, the Employee Assistance & Work/Life Program offers greater benefits.	ADT
Vision Care	Provides coverage for services and supplies such as eye exams, eyeglass frames, lenses, contact lenses, etc. available through EyeMed Vision Care in addition to the coverage available through Triple-S Salud.	You, with pre-tax contributions
Long-Term Disability Insurance	Provides a continued source of income after SINOT* benefits run out minus any Social Security benefits paid. You can choose an option to replace 50% or 60% of your annual base salary.	You, with after-tax contributions
Supplemental Life Insurance**	Pays one to 10 times your base annual salary (depending on the option you select) to your beneficiary(ies) if you die while covered under this plan. If you enroll, you may also purchase coverage for your spouse/domestic partner (up to $250,000) and your eligible child(ren) ($5,000 or $10,000).	You, with after-tax contributions

Benefit Plan	Description	Who Pays for Coverage
Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance**	Pays a benefit if the covered person becomes seriously injured or dies. If you enroll, you may also purchase coverage for your spouse/domestic partner (in an amount equal to 50 % or 60% of the coverage amount you select for yourself) and your eligible child(ren) (in an amount equal to 10% or 20% of the coverage amount you select for yourself).	You, with after-tax contributions

*Puerto Rico law also provides up to 26 weeks of disability benefits for non-work-related disabilities under **Seguro por Incapacidad No Occupacional Temporal** (**SINOT**). You are enrolled in this coverage automatically. You and ADT share the cost of this benefit.
**Evidence of Insurability (EOI) may be required before this insurance becomes effective if you are enrolling for the first time or increasing coverage.

Where to Find Other Important Information

Keeping in mind that this Health and Welfare Benefits Plan SPD and the Triple-S Salud plan document together are your health and welfare SPD if you reside in Puerto Rico, the following guides you to other important information.

Information	Health and Welfare Benefits Plan SPD	Triple-S Salud Plan Document
Eligibility	X	
Enrollment	X	
Life Events	X	X
Medical Coverage		X
Prescription Drug Coverage		X
Dental Coverage		X
Vision Coverage	X	X
Long-Term Disability Coverage	X	
Life and AD&D Coverage	X	
Coordination of Benefits		X
Employee Assistance & Work/Life Program	X	
Continuing Coverage under COBRA		X
Claim Review and Appeal Processes	X (Benefit plans other than Triple-S Salud)	X
Special Notices	X	

Information	Health and Welfare Benefits Plan SPD	Triple-S Salud Plan Document
Administrative Information	X (Benefit plans other than Triple-S Salud)	X
Your Rights under ERISA	X	
Glossary	X (Benefit plans other than Triple-S Salud)	X

If You Reside in Hawaii—Hawaii Medical Service Association (HMSA)

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If You Reside in Hawaii—HMSA

Health Plan Hawaii Plus (the "plan")—a Health Maintenance Organization (HMO) provided by Hawaii Medical Service Association (HMSA)—is the Medical Plan option under the ADT Health and Welfare Benefits Plan available to eligible employees, spouses/domestic partners, and child(ren) residing in Hawaii. The plan is administered by Blue Cross Blue Shield Association of Hawaii.

Health Plan Hawaii Plus provides medical (with prescription drug) and vision coverage.

To fully understand your rights, privileges, and responsibilities under the plan, be sure to refer to:

- The applicable information in this Health and Welfare Benefits Plan Summary Plan Description (SPD); and
- Information HMSA provides to plan participants:
  - The Guide to Benefits;
  - The Health Plan Hawaii Member Handbook; and
  - Plan certificate riders.

Keep all of the above documents together, as they comprise the ADT Medical Plan SPD for eligible employees, spouses/domestic partners, and child(ren) residing in Hawaii.

Keep in mind that you can also contact **Employee Access** at **1-888-833-1839** if you have any questions.

Please note: If you legally reside in Hawaii, under Hawaii law, you must have medical coverage. If you already have other coverage, you can decline ADT's Medical Plan coverage. If you waive medical coverage during new hire elections and/or during Benefits Annual Enrollment you will be sent Form HC-5 Employee Notification to Employer which you must complete, sign, and return.

Health Plan Hawaii Plus at a Glance

The following is a high-level summary of the coverage available to you through Health Plan Hawaii Plus. You and ADT share the cost of this coverage. For coverage details and additional definitions of terms, refer to the Guide to Benefits, provided by HMSA.

Medical Coverage

Preventive coverage to help you stay healthy before illness occurs and coverage to help you pay for covered medical expenses. Some services and supplies are subject to precertification.

Type of Service	Coverage (In-Network Only)
Preventive Care	Plan pays 100%. You pay $0.
Copayment (Copay) A fixed dollar **or a fixed percentage of the eligible expense** you pay for most covered services and supplies.*	You pay a: ▪ $20 copay
Office Visits	You pay a: ▪ $20 copay for primary care ▪ $20 copay for specialist visit ADT pays 100% of the covered expenses after your copay.
Emergency Room Visit	You pay a: ▪ $20 copay for illness ▪ $20 copay for accident
Hospitalization	Plan pays 100%. You pay $0.
Out-of-Pocket Maximum The most you pay in covered expenses in a calendar year before the plan pays 100%.	You pay: ▪ $2,500 individual ▪ $7,500 family

* For services provided at a participating facility, your copay is based on the lower of the facility's actual charge or the maximum allowable fee.

Prescription Drug Coverage

If you obtain your prescription drugs and supplies from a non-participating provider, you pay a copay plus a percentage of the cost of the prescription drug or supply. In addition, some prescription drugs and supplies are only covered through a participating provider.

Type of Medication	You Pay per Prescription (Participating Provider)	You Pay per Prescription (Non-Participating Provider)
Generic Drugs A prescription drug prescribed or dispensed under its commonly used generic name rather than under a brand name. In general, generic drugs are less expensive than brand-name drugs.		
30-calendar-day supply at a retail pharmacy	▪ $7 copay	▪ $7 copay and 20% coinsurance
90-calendar-day supply via mail order	▪ $11 copay	▪ Not covered
Preferred Brand-Name Drug A brand-name drug, supply, or insulin identified as preferred on the HMSA Select Prescription Drug Formulary.		
30-calendar-day supply at a retail pharmacy	▪ $30 copay	▪ $30 copay and 20% coinsurance
90-calendar-day supply via mail order	▪ $65 copay	▪ Not covered
Other Brand-Name Drug A brand-name drug, supply, or insulin that is not identified as preferred on the HMSA Select Prescription Drug Formulary.		
30-calendar-day supply at a retail pharmacy	▪ $30 copay	▪ $30 copay and 20% coinsurance
90-calendar-day supply via mail order	▪ $65 copay	▪ Not covered

Vision Care Coverage

When you enroll in the Health Plan Hawaii Plus plan, you automatically have Vision coverage. You also can purchase additional vision coverage through EyeMed.

Type of Service	You Pay (Participating Provider)	You Pay (Non-Participating Provider)
Exam One per calendar year. You must use a participating provider; however, a referral from your Primary Care Physician (PCP) is not required.	$20 copay	Not covered
Lenses and Contacts One pair per calendar year. Single Multifocal Contacts	▪ $25 copay ▪ $10 copay ▪ $25 copay plus any remaining charge after the plan pays $130	▪ All charges over $16 plan payment ▪ All charges over $25 plan payment ▪ All charges over $50 plan payment
Frames One frame every 24 months.	$15 copay	All charges over $12 plan payment

Other ADT Health and Welfare Benefit Plans

As an eligible employee residing in Hawaii, you are also eligible for the following ADT Health and Welfare Benefits Plans:

Benefit Plan	Description	Who Pays for Coverage
Basic Term Life Insurance	Pays one times your base annual salary to your beneficiary(ies) if you die in a covered non-work-related accident while working for the Company.	ADT
Accidental Death & Dismemberment (AD&D) Insurance	Pays one times your base annual salary to your beneficiary(ies) if you die as a result of a covered non-work-related accident. If you are seriously injured as a result of a covered non-work-related accident, you receive all or a portion of your AD&D benefit, depending on the covered accidental injury.	ADT
Business Travel Accident (BTA) Insurance	Pays four times your base annual salary to your beneficiary(ies) if you die as a result of a covered accident while traveling on Company business. If you are seriously injured as a result of a covered accident while traveling on Company business, you receive all or a portion of your BTA benefit, depending on the covered accidental injury.	ADT

Benefit Plan	Description	Who Pays for Coverage
Employee Assistance & Work/Life Program (EAP)	Provides confidential face-to-face counseling services, plus 24/7 phone access to trained professionals who can help you navigate life's ups and downs. This program also provides education and support for work/life issues you encounter.	ADT
Dental Plan	Two Dental Plan options (the Standard Dental Plan and the Dental Maintenance Organization [DMO]) from which to choose the one that best meets your dental care needs.	You and ADT share the cost
Flexible Spending Accounts	To pay for eligible health care expenses with pre-tax dollars (Flexible Spending Account [FSA]) or to pay for eligible dependent day care expenses with pre-tax dollars (Dependent Care Account [DCA]).	You, with pre-tax contributions
Vision Care	Provides coverage for services and supplies such as eye exams, eyeglass frames, lenses, contact lenses, etc. available through EyeMed Vision Care in addition to the coverage available through HMSA.	You, with pre-tax contributions
Short-Term Disability	Provides a continued source of income for up to 25 weeks of a non-work-related injury or illness. The benefit is based on your years of service.	ADT
Long-Term Disability Insurance	Provides a continued source of income during a long-term disability minus any Social Security benefits paid. You can choose an option to replace 50% or 60% of your annual base salary.	You, with after-tax contributions
Supplemental Life Insurance*	Pays one to 10 times your base annual salary (depending on the option you select) to your beneficiary(ies) if you die while covered under this plan. If you enroll, you may also purchase coverage for your spouse/domestic partner (up to $250,000) and your eligible child(ren) ($5,000 or $10,000).	You, with after-tax contributions
Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance*	Pays a benefit if the covered person becomes seriously injured or dies. If you enroll, you may also purchase coverage for your spouse/domestic partner (in an amount equal to 50 % or 60% of the coverage amount you select for yourself) and your eligible child(ren) (in an amount equal to 10% or 20% of the coverage amount you select for yourself).	You, with after-tax contributions
Wellness	Provides a variety of programs/services including Nurseline, Health Advocate, Employee Assistance & Work/Life Program (EAP), Maternity Program, and Wellness Portal, as well as the opportunity to earn Healthy Rewards Cash Reward Incentives.	ADT

*Evidence of Insurability (EOI) may be required before this insurance becomes effective if you are enrolling for the first time or increasing coverage.

Where to Find Other Important Information

Keeping in mind that this ADT Health and Welfare Benefits Plan SPD and the HMSA documents listed at the beginning of this section together are your health and welfare SPD if you reside in Hawaii, the following guides you to other important information.

Information	ADT Health and Welfare Benefits Plan SPD	HMSA Document
Eligibility	X	
Enrollment	X	X (HMSA Guide to Benefits)
Life Events	X	X (HMSA Guide to Benefits)
Medical Coverage		X (HMSA Guide to Benefits)
Prescription Drug Coverage		X (HMSA Guide to Benefits, Prescription Drug Certificate Rider)
Wellness	X	
Dental Coverage	X	
Vision Coverage	X	X (HMSA Guide to Benefits, Vision Care Certificate Rider)
Spending Accounts	X	
Short-Term Disability Coverage	X	
Long-Term Disability Coverage	X	
Life and AD&D Coverage	X	
Additional Benefits ▪ Healthy Rewards Incentive Program ▪ Legal Services Plan ▪ Tuition Reimbursement Program ▪ Adoption Assistance Program ▪ Auto and Home Insurance Program ▪ Employee Discount Program ▪ BlueCard Worldwide® Program	X	
Coordination of Benefits	X	X (HMSA Guide to Benefits)
Continuing Coverage under COBRA	X	X (HMSA Guide to Benefits)
Claim Review and Appeal Processes	X (Benefit plans other than the Health Plan Hawaii Plus Plan)	X (HMSA Guide to Benefits)
Special Notices	X	
Administrative Information	X	X

Information	ADT Health and Welfare Benefits Plan SPD	HMSA Document
Your Rights under ERISA	X	
Glossary	X (Benefit plans other Health Plan Hawaii Plus)	X (HMSA Guide to Benefits)

Special Notices

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Special Notices

The following are important, legally required notices. If you have any questions about the notices, contact EmployeeAccess or, if applicable, the contact listed within the notice.

Affordable Care Act of 2010

Under the federal law known as the Affordable Care Act ("ACA"), enacted in 2010 and as amended, employers are required to maintain their group health plans in accordance with certain minimum standards. ADT's plans generally conformed to these standards before the enactment of the ACA, and will continue to do so. However, under the ACA, practical aspects of certain of the new standards are yet to be defined in regulations and pronouncements still to be issued. While every attempt has been made to fully conform the applicable ADT plans to these standards, there is a possibility that future regulatory guidance will render certain of the descriptions of plan provisions contained within the SPD incomplete. Where this happens, ADT will issue interim guidance before the revision of the relevant SPD language.

Women's Health and Cancer Rights Act of 1998

The Medical Plan includes coverage for certain reconstructive procedures following a mastectomy covered under the Plan. Benefits for these services are available as long as you continue to be a covered participant under the Medical Plan.

If you, your spouse/domestic partner, or a child receives breast reconstruction services connected with a mastectomy while covered under the Medical Plan, the plan will cover the following services:

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

Coverage and benefits are subject to the same deductible, copay, and coinsurance provisions that apply for any other medical or surgical procedures under the Medical Plan.

Coverage will be provided in a manner determined in consultation with your attending physician.

If you need these services or if you have specific questions regarding the benefits available, call the toll-free Member Services number on the back of your current medical ID card.

Newborns' and Mothers' Health Protection Act of 1996

Under federal law, hospital stay benefits for childbirth generally may not be limited for the mother or the newborn to less than the following time periods:

- 48 hours following a vaginal delivery; or
- 96 hours following a cesarean section.

The mother's or newborn's attending provider (who may be a physician or nurse midwife) may discharge the mother or her newborn earlier than the time periods described above, after consulting with the mother. Federal law does not prohibit an early discharge in this situation.

Plans or insurers may not require pre-certification for a length of stay that is expected to be 48 (or 96) hours or less. However, if a hospital stay in connection with childbirth is expected to continue beyond the applicable number of hours, you or your doctor must notify your medical option's claims administrator before the end of your approved stay.

Continuation of Coverage under the FMLA

If you are eligible and approved for a leave under the Family and Medical Leave Act of 1993 ("FMLA"), your coverage may continue for an extended period agreed to by you and the Company.

While on an FMLA leave, you may be required to apply some of your accrued (or earned) unused vacation time to your leave. Your total vacation time and FMLA leave time will not exceed 12 weeks during a 12-month period. You are eligible for this type of leave if you need to provide care:

- After the birth of a child;
- After the legal adoption of a child;
- After the placement of a foster child in your home;
- To a spouse, child or parent due to his or her serious health condition; or
- For your own serious health condition.

In addition, in compliance with the National Defense Authorization Act of 2008, if you are an eligible employee, you can take up to 12 combined weeks of FMLA in a single 12-month period for a qualifying exigency to spend time with your spouse, child, or parent on active duty or notified of call to duty.

Also, if you are an eligible employee caring for your spouse, child, parent, or next of kin who is a recovering service member (meaning he/she has suffered a serious illness or injury sustained in the line of duty while on active duty), you can take up to 26 combined weeks of FMLA leave in a single 12-month period to care for the service member.

During the single 12-month period, you are entitled to a combined total of 26 workweeks of leave for (1) leaves relating to birth, adoption or foster care, care of a family member or employee with a serious health condition, or because of a qualifying exigency, and (2) to care for a service member, however, no more than 12 of the weeks can be used for a reason other than service member leave.

ADT continues your coverage under the applicable health care plans during your period of leave under the FMLA just as if you were still employed. Continued coverage ends on the earliest of the date you:

- Terminate employment;
- Do not make required contributions; or
- Exhaust your approved period of FMLA leave and do not return to work from your FMLA leave.

If your employment does not terminate during your leave, but you do not return to work once your leave ends, you can choose to continue health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") continuation rules. See the **Continuing Coverage under COBRA** section of this SPD. Your COBRA continuation period begins on the last day of your FMLA leave.

If you do not return to covered employment following your leave, the Company may recover the value of benefits or premiums paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the FMLA.

Refer to ADT's FMLA policy, which can be found at **InsideADT.com > Human Resources > Policies and Procedures.**

Continuation of Health Coverage under USERRA

If you are absent from work because of your service in the uniformed services (including Reserve and National Guard duty), you may choose to continue health coverage (that is, medical, dental, and vision) for yourself and your covered spouse/domestic partner, and child(ren) under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA)." The period of coverage for you, your spouse/domestic partner, and your child(ren) ends on the earlier of:

- The end of the 24-month period starting on the day your military leave of absence begins (except for Long-Term Disability which ends at nine months).
- The day after the day on which you are required, but do not apply to, return to work. Under USERRA, you must apply to return to work within different time periods—depending on the duration of your uniformed service:
  - **If your uniformed service is one through 30 calendar days:** You are generally required to apply to return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service. (Your period of uniformed service ends after you return from your place of service to your residence.)
  - **If your uniformed service is 31 through 180 calendar days:** You are generally required to apply to return to work within 14 calendar days of your discharge.
  - **If your uniformed service is 181 or more calendar days:** You are generally required to apply to return to work within 90 calendar days of your discharge.

You will be required to pay the employee cost of your coverage and if you receive a pay differential, your employee contribution will be deducted from this amount. For more information, see the ADT Military Leave Policy found at **InsideADT > Human Resources Home > Policies & Procedures**.

You also must notify your human resources representative that you will be absent from employment due to military service and provide a copy of your orders (unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable). If an employee on an Active Military Duty Leave of Absence wishes to suspend his or her ADT medical and dental benefits during this period, the employee must notify ADT Health and Group Benefits in writing within 31 calendar days of the commencement of the Active Military Duty Leave of Absence.

Regular Mail:

ADT Health and Group Benefits
Attention: Appeals
P.O. Box 199575
Dallas, Texas 75219-9575

Or

Overnight Mail:

ADT Health and Group Benefits
Attention: Appeals
Building 5 / Floor 1
2828 N. Haskell Ave
Dallas, TX 75204-2909

Release of Medical Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the medical, dental, prescription drug, vision, mental health, employee assistance program, and flexible spending account (FSA) portions of the Plan are subject to HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, plan administration, or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Plan's HIPAA Privacy Notice, which is furnished to all plan participants.

You can obtain a copy of the HIPAA Privacy Notice by calling **Employee Access** at **1-888-833-1839** or by going online to **InsideADT.com > Human Resources**.

Administrative Information

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Administrative Information

Once you've reviewed all of your coverage options, be sure you understand how to receive your benefits. This section addresses additional information you should be familiar with regarding the benefit plans provided under ADT Health and Welfare Benefits Plan (the "Plan").

Payment Rights

Right of Recovery

If the claims administrator pays more than it should under the Plan, it has the right to recover any excess amount paid. The Plan may recover this amount from one or more of the following sources:

- The person(s) it has paid or for whom it has paid (this can be you or a provider)
- Insurance companies
- Any other organization

The amount recovered may include the reasonable cash value of any benefits provided in the form of services.

If a Third Party Is Liable

As discussed further below, the Plan has certain rights if you, your spouse/domestic partner, or your eligible child(ren) receive benefits from the Plan and you also receive or are entitled to receive benefits from a third party for the same injury or illness whether through legal action, settlement, Workers' Compensation, or for any other reason. These rights are called the right to subrogation and reimbursement. The Plan has these rights regardless of the manner in which the recovery is structured or worded, and even if you or your dependent has not been paid or fully reimbursed for all of your damages or expenses.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees, in writing, to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, "fund" doctrine, "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence, or any other equitable defenses that may affect the plan's right to subrogation or reimbursement.

If the Plan is required to take action, including legal action, to seek reimbursement of amounts otherwise due to the Plan under its subrogation or reimbursement rights, the Plan may ask you to pay the costs of collection, including reasonable attorney's fees. The Plan will also have the right to offset future benefit payments from the Plan until the amount otherwise due the Plan as a result of its subrogation or reimbursement rights has been received by the Plan.

Right of Subrogation

You, your spouse/domestic partner, your eligible child(ren), or your legal representative may have a claim to recover money from a third party (such as an automobile insurer) relating to an injury for which the Plan has the right to step into your shoes and take action to recover any claim payments made from that third party. This is called the “right of subrogation.”

To secure the Plan’s right of subrogation, you agree to:

- Provide the Plan with proof that a proceeding against a third party has not been and will not be discharged or released without the written consent of the Plan Administrator or Claim Administrator;
- Assign to the Plan all rights, claims, interests, and causes of action that you, your spouse/domestic partner, or dependent child has against a third party in connection with the expenses paid by the Plan;
- Authorize the Plan to sue, compromise, or settle all claims related to benefits paid by the Plan; and
- Agree, in writing, to assist the Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Plan.

If ADT or the Plan is not allowed to exercise its right of subrogation or chooses not to do so, the Company or the Plan may still, at its discretion, choose to pay benefits under the Plan. In addition, ADT or the Plan, at its discretion, may choose to exercise only the right of reimbursement under the Plan as discussed below.

Right of Reimbursement

As a condition of receiving plan benefits, you must reimburse ADT or the Plan for payments made to you or on your behalf under the Plan from any claim payments for which you or your legal representative is paid by a third party or its insurer because of the third party’s liability for an injury or illness for which you received benefits under the Plan. With respect to the Plan’s right of reimbursement, the term “third party” includes any form of first party coverage (i.e., medical payment coverage, personal injury protection coverage, uninsured motorist coverage, and underinsured motorist coverage). You are expected to reimburse the Plan up to the amount paid by the Plan on the claim. This is called the “right of reimbursement.” “Right to reimbursement” includes:

- Payments from your automobile insurance for an uninsured motorist, underinsured motorist coverage, medical payment or reimbursement coverage, or personal injury protection coverage; or
- Payments from any other individual, entity, or source intended to compensate the covered person for injuries caused by an act of the third party.
- To secure the Plan’s right of reimbursement, you agree to:
- Place the proceeds of any settlement, verdict, and/or other amounts you receive in an amount equal to related expenses paid by the Plan plus interest at 5% per year or, if less, the full third-party payment amount in a separate identifiable account (the “Reimbursement Amount”);
- Act as the constructive trustee over the Reimbursement Amount until the time the Reimbursement amount is paid to the Plan; and

- Grant the Plan a first priority lien against the proceeds of any settlement, verdict, and/or other amount you receive.

ADT or the Plan has the right to recover 100% of the value of services paid for or provided under the Plan from a recovery you receive from a third party. ADT or the plan is not subject to reduction for a pro rata share of any attorney's fees you incur in seeking recovery from other persons or entities. This right to recovery applies even if the recovery you received is designated or described as being for illness or injury other than health care expenses.

ADT or the Plan's right to recovery applies whether or not the Plan participant recovering money is a minor.

What You Need to Do

You must cooperate fully with ADT and the applicable Plan when the Plan exercises its subrogation and reimbursement rights. You must do nothing to prejudice those rights. In addition, when making or filing a claim, you or your legal representative must give the Plan Administrator written notice about whether or not you were injured by a third party. You also must provide the following information in a timely manner:

- The name, address, and telephone number of the:
  - Third party that in any way caused the injury, as well as those of the attorney representing the third party;
  - Third party's insurer; and
  - Attorney who represents you with respect to the third party's act.
- Before any meeting, the date, time, and location of the meeting between the third party or his or her attorney and yourself or your attorney.
- All terms of any settlement offer made by the third party or his or her insurer.
- All information discovered by yourself or your attorney concerning the insurance coverage of the third party.
- The amount and location of any funds you recover from the third party or his or her insurer and the dates on which these funds were received.
- All information related to any verbal or written settlement agreement between you and the third party or his or her insurer.
- All information regarding any legal action that has been brought on your behalf against the third party or his or her insurer.
- All other information requested by the Plan Administrator.

To be eligible to receive benefits under the Plan, you or your legal representative must sign and return a written agreement to subrogate or reimburse ADT and/or the Plan and comply with the subrogation and reimbursement terms of the Plan. The Plan has the right to discontinue payments and to bring legal action against you or your heirs, guardians, executors, or other representatives to recover benefits already paid.

Other Requirements

As a condition of receiving benefits under the Plan, each covered person and that person's legal representative must waive attorney/client privilege with regard to the third party. In other words, you must comply with any requests for information regarding this situation.

In addition, you are responsible for any expenses or fees you or your legal representative incurs while recovering any sums from the third party. Neither ADT nor the Plan will be responsible for those expenses.

Recovery of Payment Made by Mistake

If, under any of the benefit plans, you receive any benefits or portion of benefits by mistake of fact or law, you'll be required to return any of these benefits or portion of these benefits to ADT or the applicable claims administrator or insurer.

No Alienation, Sale, or Assignment

To the extent permitted by law, and except as specified under the terms of the benefit plans, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution, or encumbrance of any kind. Any attempt to do so will be void. However, benefits under certain plans (e.g., the Medical Plan) may be subject to a Qualified Medical Child Support Order (QMCSO). For general information regarding QMCSOs, contact **EmployeeAccess** at **1-888-833-1839**.

QMCSO's should be sent to:

ADT LLC
Attn: Legal Department
RE: QMSCO / Subpoena
1501 Yamato Road
Boca Raton, FL 33431

Representations Contrary to the Plans

No employee, director, or officer of ADT has the authority to alter, vary, or modify the terms of any plan under the Plan except by means of a duly authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the plans are binding upon the Plan, the Plan Administrator, or ADT.

Administrative Information about the Plans

Plan Name	
ADT Health and Welfare Benefits Plan	
Plan Administrator and Plan Sponsor	**Agent for Service of Legal Process**
ADT LLC 1501 Yamato Road Boca Raton, FL 33431 Attn: Plan Administrator—Health and Welfare Benefits Plan Direct confidential correspondence to: ADT LLC HIPAA Correspondences 1501 Yamato Road Boca Raton, FL 33431 Attn: HIPAA Privacy Officer You can also call **EmployeeAccess** at **1-888-833-1839**.	Chief Labor and Employment Counsel ADT LLC 1501 Yamato Road Boca Raton, FL 33431 Service of legal process may also be made to the Plan Administrator.

Employer Identification Number (EIN)	Plan Year
The Internal Revenue Service has assigned the Plan Sponsor of the Plan in this SPD the following tax identification number: 45-4343781	The calendar year: January 1 to December 31

The following chart shows the plan number, type of funding (who pays for the cost of the plan, including premiums and administrative fees) and type of each ERISA benefit plan in the Plan. **Please note:** The Plan Number for all of the benefit plans listed is 501.

ERISA Benefit Plan	Funding	Plan Type
Medical Plan/ Prescription Drug Plan	Self-funded through contributions from the employer, eligible employees, and qualified beneficiaries who elect COBRA continuation coverage.	Employee welfare plan and group health plan providing medical and prescription drug benefits.
Dental Plan	Self-funded through contributions from the employer, eligible employees, and qualified beneficiaries who elect COBRA continuation coverage.	Employee welfare plan and group health plan providing limited scope dental benefits.
Vision Care Plan	Self-funded through contributions from the employer, eligible employees, and qualified beneficiaries who elect COBRA continuation coverage.	Employee welfare plan and group health plan providing vision care benefits.
Short-Term Disability (STD) Plan	Self-funded by ADT. The full cost is paid by the company.	Payroll practice providing income replacement.

ERISA Benefit Plan	Funding	Plan Type
Long-Term Disability (LTD) Plan	Insured under the group master policy for the plan (policy #VDT-980097). The full cost is paid by the employee.	Employee welfare plan providing disability benefits.
Basic Term Life Insurance Plan	Insured under the group master policy for the plan (policy #GL-402649). The full cost is paid by the Company.	Employee welfare plan providing basic term insurance benefits.
Supplemental Life Insurance Plan	Insured under the group master policy for the plan (policy #GL-402649). The full cost is paid by employee contributions.	Employee welfare plan providing supplemental life insurance benefits.
Accidental Death & Dismemberment (AD&D) Insurance Plan	Insured under the group master policy for the plan (policy #GL-402649). The full cost is paid by the Company.	Employee welfare plan providing accidental death and dismemberment insurance benefits.
Business Travel Accident (BTA) Insurance Plan	Insured under the group master policy for the plan (policy #ETB-153105). The full cost is paid by the Company.	Employee welfare plan providing insurance benefits while traveling on business for the Company.
BlueCard Worldwide Insurance Plan	Insured under the group master policy for the plan. The full cost is paid by the Company.	Employee welfare plan providing emergency and urgent medical insurance benefits.
Personal and Family Accidental Death & Dismemberment (P&F AD&D) Insurance Plan	Insured under the group master policy for the plan (policy #ADD-S07694). The full cost is paid by the employee.	Employee welfare plan providing accident insurance benefits.
Flexible Spending Account (FSA)	Self-funded through pre-tax contributions from eligible employees and qualified beneficiaries who elect COBRA continuation coverage for their FSA. The amount of the contribution is determined by the participant and federal limits.	Employee welfare plan providing reimbursement of eligible health care expenses.
Dependent Care Account (DCA)	Self-funded through pre-tax contributions from eligible employees. The amount of the contribution is determined by the participant and federal limits.	Employee welfare plan providing reimbursement of eligible dependent day care expenses.
Employee Assistance & Work/Life Program	Self-funded for active employees and dependents through contributions from the employer. Also self-funded for participants and their qualified beneficiaries who elect COBRA continuation coverage.	Employee welfare plan providing employee assistance and work/life benefits.
Triple-S Salud Plan (Puerto Rico)	Insured under the group master policy for the plan (policy # 8208415). Contributions from the employer, eligible employees, and qualified beneficiaries who elect COBRA continuation coverage.	Employee welfare plan and group health plan providing medical, prescription drug, dental, and vision care benefits.
Hawaii Medical Service Association (HMSA)	Insured under the group master policy for the plan (policy # 21574). Contributions from the employer, eligible employees, and qualified beneficiaries who elect COBRA continuation coverage.	Employee welfare plan and group health plan providing medical, prescription drug, and, and vision care benefits.

In addition to the ERISA benefit plans listed in the chart above, the Health and Welfare Benefits Plan also includes the following non-ERISA benefit plans, which are discussed in more detail in the **Additional Benefits** section of this SPD:

Non-ERISA Benefit Plan	Funding	Plan Type
Legal Services Plan	Funded solely through the contributions of eligible employees.	Benefit plan providing professional legal consultation and representation, and comprehensive legal insurance.
Tuition Reimbursement Plan	Self-funded through contributions from the employer.	Benefit plan providing tuition reimbursement to employees for eligible coursework based on grade.
Adoption Assistance Program	Self-funded through contributions from the employer.	Benefit plan assisting employees with covered expenses during the adoption process.
Auto and Home Insurance	Funded solely through the contributions of eligible employees.	Benefit plan providing employees with discounted group rates for Auto and Home Insurance.
Employee Discount Program	Funded solely through the contributions of eligible employees.	Benefit plan offering employees discounted corporate pricing on many items and service.

Claims Administrators

ADT has delegated claims administration authority to a number of entities or insurance companies that review the claims and administer them according to plan provisions. The claims administrators provide certain administration and claim services and do not guarantee plan benefits under an insurance contract.

Insurance Companies or Insurers

ADT has purchased certain benefits coverages through insurance contracts with certain insurance companies. These insurers not only review the claims and administer them according to plan provisions, but are fully responsible for the benefit payments under the insurance contract.

Plan Documents

If you wish to receive a copy of a plan document or need additional information about any specific Plan provision, contact the Plan Administrator. You also can contact the appropriate claims administrator for information about a benefit plan or for copies of contracts or certificates of coverage that may apply to that benefit plan.

For More Information

If you have questions about your benefits under an ADT-sponsored benefit plan which is part of the Plan or need information about how an underlying benefit plan works, contact **EmployeeAccess**.

Glossary

Table of Contents

Glossary

This section broadly defines many of the terms used in the 2014 ADT Health and Welfare Benefits Plan Summary Plan Description (the "SPD"). The definition specific to a benefit plan (e.g., the Medical Plan) can be found in the benefit plan's Plan document.

Accidental Injury

A traumatic injury caused solely by an accident.

Active Service

You are at your usual and customary place of business with the Company or at some location to which the Company's business requires you to travel, performing the duties of your occupation for wages or salary on your normal work schedule. Paid vacation days, holidays, and normal non-working days are considered days in active service, provided you were in active service on the last scheduled working day before that non-working day.

You are not considered in active service if you are absent from work due to accidental bodily injury, illness, pregnancy, mental illness, or substance abuse.

You are in active service on a day that is one of the Company's scheduled work days if any of the following conditions is met:

- You are performing your regular occupation for the Company on a full-time basis. You must be working at one of the Company's usual places of business.
- The day is a scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.
- You are in active service on a day that is not one of the Company's scheduled work days only if you were in active service on the preceding scheduled work day.

Active Treatment

Being physically examined by the treating physician at intervals recommended by the physician, or as otherwise prescribed in the Short-Term Disability Plan.

Affordable Care Act (ACA)

The Affordable Care Act encompasses the Patient Protection and Affordable Care Act enacted on March 23, 2010 and the Health Care and Education Reconciliation Act enacted on March 30, 2010.

The Affordable Care Act is designed to ensure that all Americans have access to quality, affordable health care and to create the transformation within the health care system necessary to contain costs. The Affordable Care Act contains nine titles, each addressing an essential component of reform:

- Quality, affordable health care for all Americans.
- The role of public programs.

- Improving the quality and efficiency of health care.
- Prevention of chronic disease and improving public health.
- Health care workforce.
- Transparency and program integrity.
- Improving access to innovative medical therapies.
- Community living assistance services and supports.
- Revenue provisions.

After-Tax Contributions

Deductions taken from your pay for your share of the cost of certain benefits **after** federal, state, and local income taxes have been deducted from your pay.

Appropriate Care

Being treated to achieve maximum medical improvement by a physician with medical training and clinical experience suitable to treat your disabling condition; and whose treatment is:

- Consistent with the diagnosis of the disabling condition;
- According to guidelines established by medical, research, and rehabilitative organizations; and
- Administered as often as needed to achieve maximum medical improvement.

Assisted Reproductive Technology (ART)

Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to:

- In vitro fertilization.
- Gamete intrafallopian transfer.
- Zygote intrafallopian transfer.
- Pronuclear stage tubal transfer.

Base Annual Salary/Pre-Disability Earnings

The amount of your regular annual pay. If you are paid on an hourly basis, your base annual salary is based on the product of your regularly scheduled hours immediately before the applicable event, multiplied by your hourly wage in effect immediately before the applicable event.

"Base annual salary" does not include any overtime pay, bonuses, commissions, tips and tokens, profit sharing, fringe benefit, or other extra compensation. If you have been assigned a target benefits salary, your base annual salary is your target benefits salary in effect immediately before the eligible event (e.g., your death while covered). If you are a commission-based employee, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** for the commission-based calculation.

Please note: Any increase in your base annual salary will not be effective if received during a period of continuous disability.

Beneficiary

The person or persons who would receive benefits under a plan upon your death. Generally, you are the beneficiary if you are severely injured or a covered family member dies or is injured in a covered accident.

Blue Cross Blue Shield

Blue Cross and Blue Shield of Alabama (BCBS), except where the context designates otherwise.

Certified Physician

A Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), or an Advanced Registered Nurse Practitioner (ARNP) in the Certified Physician's office. Pregnancies are certifiable by a licensed midwife for the normal time frames of six weeks (regular delivery) following a birth.

Claims Administrator

The entity to whom ADT has delegated the authority to decide claims and/or appeals. For some plans or options within a plan, ADT has delegated the responsibility to review and administer claims to an insurance company or carrier, who has final discretionary responsibility and authority for responding to claims appeals.

Cosmetic Surgery

Any surgery done primarily to improve or change the way an individual appears. Cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma, or birth defect.

Covered Accident

A sudden, unforeseeable, external event that occurs by chance at an identifiable time and place and results, directly and independently of all other causes, in an injury or loss, and meets all of the following conditions:

- Occurs while you (or your spouse/domestic partner, and or covered dependent child(ren)) are insured under the plan;
- Is not contributed to by disease, illness, or mental or bodily infirmity; and
- Is not otherwise excluded under the terms of the plan.

Covered Expense/Eligible Expense

The portion of the provider's bill which is payable by you and the ADT plan. The amount billed by the provider is reduced by any items not covered and any applicable discounts which have been negotiated with the provider. The remainder, the covered expense, includes amounts which may be owed by you to meet your deductible, coinsurance, or copay obligations and the amount which is to be paid by ADT.

Covered Person(s)/Plan Participant(s)

Eligible employees, spouses/domestic partners, or eligible dependent child(ren) of employees who are covered under the plan according to the terms and conditions of the plan. The term also refers to a person who has the rights to plan coverage after plan coverage ends.

Custodial Care

Care primarily to provide room and board for an individual who is mentally or physically disabled.

Dentist(s)

Includes Doctors of Dental Surgery (D.D.S.) or Doctors of Medical Dentistry (D.M.D.) who are licensed to practice in the state in which they are located and acting within the scope of their licenses.

Diagnostic

Services performed in response to signs or symptoms of illness, condition, or disease, or in some cases where there is family history of illness, condition, or disease.

Disability/Disabled

For Long-Term Disability purposes, you are prevented from performing one or more of the material duties of:

- Your occupation during the benefit waiting period;
- Your occupation for the 24 months following the benefit waiting period, and as a result, your current monthly earnings are less than 80% of your indexed pre-disability earnings (calculated based on your base annual salary); and
- After that, any occupation. “Any occupation” means any occupation for which you are qualified by education, training, or experience that has an earnings potential greater than the lesser of.
  - The product of your indexed pre-disability earnings and the benefit percentage; or
  - The maximum monthly benefit.

Disability Earnings

Any wage or salary for any work performed for any employer during your disability, including commissions, bonus, overtime pay, or other extra compensation.

Doctor/Physician

A person who is:

- A doctor of medicine, osteopathy, psychology, or other legally qualified practitioner of a healing art that the plan recognizes or is required by law to recognize;
- Licensed to practice in the jurisdiction where care is being given;
- Practicing within the scope of that license; and
- Not a member of the covered person’s immediate family.

Domestic Partner

Domestic partner coverage is available for domestic partners who meet the eligibility requirements as defined by the plan. For a complete definition of domestic partner, call **EmployeeAccess** at **1-888-833-1839** and select **Health and Group Benefits** or visit **MyADTHR.com > Health & Group Benefits > Forms**, for a copy of the Domestic Partner Enrollment Guide. See also "Spouse," later in this section and refer to the **Eligibility** section of this SPD.

Durable Medical Equipment (DME)

Equipment approved by Blue Cross Blue Shield (BCBS) as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment, an item must be:

- Made to withstand repeated use;
- For a medical purpose rather than for comfort or convenience;
- Useful only if the individual is sick or injured; and
- Related to the individual's condition and prescribed by his/her physician to use in the individual's home.

Emergency Care

Services and/or supplies provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of a person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee

An individual working for the Company who is covered under the ADT Health and Welfare Benefits Plan.

EmployeeAccess

A benefits service center which has been identified to assist you with your ADT benefits-related questions and issues and to support you during the Benefits Annual Enrollment process. The telephone number for **EmployeeAccess** is **1-888-833-1839**.

Employee Retirement Income Security Act of 1974 (ERISA)

ERISA, as amended, which establishes certain rights and protections for plan participants, as well as rules for employers to qualify benefit plans for special tax considerations.

Employer

ADT and any affiliates or subsidiaries participating in the ADT Health and Welfare Benefits Plan.

Evidence of Insurability (EOI)/Proof of Good Health

Refers to medical information or other information that indicates health status used by an insurance company to determine whether your non-health plan coverage under the plan is to be limited or excluded. For proof of good health, the insurance company can request that you:

- Complete and sign an insurance company health and medical history form.
- Submit to a medical exam.
- Provide any additional information and attending physicians' statements.

The above evidence may be required to be provided at your expense.

Family and Medical Leave Act (FMLA)

Refers to the Family and Medical Leave Act of 1993, which requires employers with 50 or more employees to provide the employees with up to 12 weeks of unpaid leave per 12-month period for certain family and medical events. You may take up to 26 combined weeks of FMLA leave in a single 12-month period to care for certain service members.

Guaranteed Issue Amount(s)

The amount of coverage that an insurance company is willing to provide under the plan without your having to provide any Evidence of Insurability or proof of good health.

Health Advocate

A service administered by Health Advocate, a third-party administrator, designed to help you and your family with health care and insurance-related issues and to resolve problems you may encounter related to claims and billing issues.

Health Insurance Portability and Accountability Act (HIPAA)

Refers to the Health Insurance Portability and Accountability Act of 1996, as amended. This act is designed to make it easier for you and your family members to have continued medical coverage when you change from one employer to another. The act requires employers to provide certificates of creditable coverage to employees and their dependents who lose group medical plan coverage for any reason. The certificates may be used to reduce or eliminate the pre-existing condition limitation in a new employer's group medical plan. This act also provides for a number of other employee rights such as preventing discrimination because of health factors, special enrollment rights if you lose your group health plan coverage and privacy rights with respect to your personal health information.

Health Plans

The Flexible Spending Account (FSA), medical, prescription drug, dental, employee assistance plan, and vision care plans—whether or not you are enrolled in these plans through ADT.

Healthy Rewards Cash Reward Incentive

The Healthy Rewards program is an annual program designed to encourage you and your spouse/domestic partner who are covered by the Medical Plan to take steps to improve your health and earn cash rewards when you've completed qualified activities. The cash rewards can be used to help offset medical costs (co-pays, co-insurance, deductibles, etc.) not otherwise covered by the Medical Plan.

Home Health Care

Skilled nursing visits ordered by a physician, provided in a patient's home by a Registered Nurse or Licensed Practical Nurse and billed by a home health agency. Any pre-certification requirements and/or any specified benefit maximums are applicable to the skilled nursing visits only. Other services included are home infusion therapy and medications administered by a home health agency.

Hospice Care

Hospice care deals with the physical and psychological aspects of the illness. Hospice care includes supplies or drugs included in the daily fee for hospice care provided by a hospice provider to a covered terminally ill person when a physician cerifies the individual's life expectancy to be six months or less.

Hospital

Any institution that is classified by the applicable medical carrier as a "general" hospital, using generally available sources of information.

In-Network

Care provided by a provider who participates in the plan's network of approved providers. In-network care is generally covered at a higher level than out-of-network care.

In-Network Providers

Providers who are furnishing a service or supply that is specified as an in-network benefit under the plan. A provider will be considered an in-network provider only if the plan designates the provider as an in-network provider for the service or supply being furnished. If a covered person receives a service or supply from a provider who is not an in-network provider, the plan will pay applicable benefits on an out-of-network basis.

Indexed Earnings

For the first 12 months Monthly Benefits are payable, your Indexed Earnings are equal to your Covered Earnings. After 12 Monthly Benefits are payable, your Indexed Earnings are your Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

1. 10% of your Indexed Earnings during your preceding year of disability; or

2. The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Inpatient

A registered bed patient in a hospital, provided that Blue Cross Blue Shield (BCBS) reserves the right in appropriate cases to reclassify inpatient stays as outpatient services.

Investigational

Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either Blue Cross Blue Shield (BCBS) does not recognize as having scientifically established medical value or that does not meet generally accepted standards of medical practice.

When possible, BCBS develops written criteria (called “medical criteria”) concerning services and supplies that BCBS considers to be investigational. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies that BCBS makes available to the medical community and covered persons. BCBS does this so that the covered person and his/her providers will know in advance, when possible, what benefits, if any, BCBS will pay. If a service or supply is considered investigational according to one of BCBS’s published medical criteria policies, BCBS will not pay benefits for it.

If the investigational nature of a service or supply is not addressed by one of BCBS’s published medical criteria policies, BCBS will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside of the investigational setting.

Please note: BCBS makes determinations about the investigational nature of a service or supply solely for the purpose of determining whether to pay benefits for the service or supply. All decisions concerning a covered person’s treatment must be made solely by his/her attending physician and other medical providers.

Job Accommodation

An interactive process whereby the employee, the treating physician(s), supervisors, managers, and human resources work to determine workplace modifications or adjustments, that enable the employee with an impairment to perform the essential functions of his/her position, and that are reasonable, effective, and do not impose an undue hardship on the Company’s business operations. This may include a period of unpaid leave of absence from the Company.

Loss

For purposes of the Life and AD&D Plans:

- **For an eye:** An entire and permanent loss of sight that is irrecoverable by natural, surgical, or artificial means.
- **For a hand or a foot:** The actual severance of the limb at or above the wrist or ankle, respectively.
- **For speech or hearing:** The entire and permanent loss of either the covered person's speech or hearing that is irrecoverable by natural, surgical, or artificial means.
- **For thumb and index finger:** The finger and thumb on the same hand are actually severed at or above the metacarpophalangeal joints.

Please note: "Severance" means complete separation and dismemberment of the limb from the body.

Material Duties

Material duties means duties that are:

- Substantial, not incidental;
- Fundamental or inherent to the occupation; and
- Cannot be reasonably omitted or changed.

Your ability to work the number of hours in your regularly scheduled workweek is a material duty.

Medical Judgment

Includes whether a treatment, drug, or other item is either:

- Experimental or investigational; or
- Not medically necessary or appropriate.

Medical Necessity/Medically Necessary

Terms Blue Cross Blue Shield (BCBS) uses to help determine whether a particular service or supply will be covered. When possible, BCBS develops written criteria (called "medical criteria") that BCBS uses to determine medical necessity. BCBS bases these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. BCBS puts these medical criteria in policies BCBS makes available to the medical community and covered persons so that the covered person and his/her providers will know in advance, when possible, what benefits, if any, BCBS will pay. If a service or supply is not medically necessary according to one of BCBS's published medical criteria policies, BCBS will not pay benefits for it.

If a service or supply is not addressed by one of BCBS's published medical criteria policies, BCBS will consider it to be medically necessary only if BCBS determines that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of the covered person's medical condition:
- Provided for the diagnosis or direct care and treatment of the covered person's medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of the covered person, the covered person's family, or another provider of service;
- Not "investigational"; and
- Performed in the least costly setting, method, or manner, or with the least costly supplies required for the covered person's medical condition. A "setting" may be the covered person's home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when the covered person is an inpatient, or another type of facility providing a lesser level of care. Only the covered person's condition is considered in deciding which setting is medically necessary. The covered person's financial or family situation, the distance he/she lives from a hospital or other facility, or any other non-medical factor is not considered. As the covered person's medical condition changes, the setting he/she needs may also change. The covered person should ask his/her physician if any of the services can be performed on an outpatient basis or in a less costly setting.

Mental Health Disorders/Substance Abuse

Mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. These disorders, illnesses, and conditions are considered mental health disorders and substance abuse whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders and substance abuse regardless of how they are caused, based, or brought on.

Mental health disorders and substance abuse include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by the nerves.

Please note: Mental health disorders and substance abuse generally are intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Mental Illness

In general, a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A mental illness may be caused by biological factors or result in physical symptoms or manifestations.

Mental illness does **not** include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

- Mental retardation;
- Pervasive developmental disorders;
- Motor skills disorder;
- Substance-related disorders;
- Delirium, dementia, and amnestic, and other cognitive disorders; and
- Narcolepsy and sleep disorders related to a general medical condition.

The definition specific to a benefit plan (e.g., the Medical Plan) can be found in the benefit plan's plan document.

Necessary

For Dental Plan purpose, the dental treatment must be:

- Ordered by a dentist or doctor;
- Recognized throughout the doctor's or dentist's profession as safe and effective;
- Required for the diagnosis or treatment of the particular condition;
- Employed appropriately in a manner and setting consistent with generally accepted dental standards; and
- Not educational, experimental, or investigational in nature.

Normal Retirement Age

For Life Insurance purposes, means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Out-of-Network Providers

A provider who is not an in-network provider.

Outpatient

Services and supplies for a patient who is not a registered bed patient of a hospital. For example, a patient receiving services in an outpatient department of a hospital or a physician's office is an outpatient, provided that Blue Cross Blue Shield (BCBS) reserves the right in appropriate cases to reclassify outpatient stays as inpatient stays.

Plan Administrator

Refers to the entity with the discretionary authority to control and manage the operation and administration of the plans described in this SPD and is the agent for service of legal process. ADT is the Plan Administrator for the plans described in this SPD.

Plan Sponsor

The entity who has established the plans. For the plans described in this SPD, the plan sponsor is ADT.

Pre-Certification

The procedures used to determine whether a covered person requires treatment as a hospital inpatient before a covered person's admission, based upon medically recognized criteria.

Pregnancy

The condition of and complications arising from a woman having a fertilized ovum, embryo, or fetus in her body—usually, but not always, in the uterus—and lasting from the time of conception to the time of childbirth, abortion, miscarriage, or other termination.

Pre-Tax Contributions

Deductions from your pay made through the ADT Code Section 125 Cafeteria Plan for your share of the cost of certain benefits before federal and, in most cases, state and local income taxes have been deducted from your pay.

Preventive/Routine

Services performed before the onset of signs or symptoms of illness, condition, or disease or services which are not diagnostic.

Preventive Care

Steps taken to prevent disease and injuries, rather than curing or treating them.

Private Duty Nursing

A session of four or more hours during which continuous skilled nursing care is furnished to the covered person alone.

Proof of Loss

A formal written statement (or proof by any other electronic/telephonic means) authorized by the insurance company to validate a loss for which the claim is made is required. This statement is reviewed by the insurance company in order to determine its liability under the insurance policy.

Provider(s)

Any person or facility that provides covered health care services under the plan. Providers may include hospitals, physicians, counselors, and technicians.

Qualifying Event(s)

Certain changes in status that allow you to enroll in or make a change to your pre-tax benefits. Qualifying events include qualifying status changes (such as marriage, divorce, the birth or adoption of a child, or a change in Medicare eligibility status), cost and coverage changes, special enrollment events, and other qualifying events.

Qualified Medical Child Support Order (QMCSO)

Refers to a Qualified Medical Child Support Order—a court order approved by the ADT Health and Welfare Benefits Plan that provides for health care coverage and allocation or responsibility for payments of costs for health care coverage for a dependent child.

Qualifying Exigency

Under the FMLA, includes the following:

- Short-notice deployment;
- Military events and related activities;
- Child care and school-related activities;
- Care of the military member's parent;
- Financial and legal arrangements;
- Counseling;
- Rest and recuperation;
- Post-deployment activities; and
- Additional activities related to the active duty or call to duty, and for which the leave is agreed to by the Company.

Serious Health Condition

Under the FMLA, an illness, injury, impairment, or physical or mental condition that involves **either** any period of incapacity or treatment connected with inpatient care in a hospital, hospice, or residential medical care facility, and any period of incapacity or subsequent treatment in connection with the inpatient care; **or** continuing treatment by a health care provider which includes any period of incapacity due to any of the following:

- A health condition (including prior treatment and recovery) lasting more than three consecutive calendar days, and any subsequent treatment or period of incapacity relating to the same condition that also includes:
  - Treatment of two or more times by or under the supervision of a health care provider (both visits must occur within 30 calendar days of the start of the incapacity, and the first visit must occur within seven calendar days of the first day of incapacity); or
  - One treatment by a health care provider with a continuing regimen of treatment (the first and only visit must occur within seven calendar days of the first day of incapacity).
- Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence.
- A chronic, serious health condition which continues over an extended period of time, requires periodic visits to a health care provider (at least two visits per year), and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence.
- A permanent or long-term condition for which treatment may not be effective (only supervision by a health care provider is required, rather than active treatment).
- Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three calendar days if not treated.

Skilled Nursing Facility

Any Medicare participating skilled nursing facility which provides non-acute care for patients needing skilled nursing services 24 hours per day. This facility must be staffed and equipped to perform skilled nursing care and other related health care services. A skilled nursing facility does not provide custodial or part-time care.

Spouse

In general, the person to whom you are legally married.

For Life and AD&D Insurance, “spouse” means your legal spouse who:

- Is not legally separated or divorced from you; and
- Is not in active full-time military

“Spouse” will include your domestic partner provided you:

- Have executed a Domestic Partner Affidavit, satisfactory to ADT, that established that you and your partner are domestic partners for Life and AD&D coverage purposes; or
- Have registered as domestic partners with a government agency or office where such registration is available and you provide proof of such registration, unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided you continue to meet the requirements described in the Domestic Partner Affidavit or required by law.

For Business Travel Accident Insurance, "spouse" means the covered employee's husband or wife who is not legally separated or divorced from the employee on the date of the accident. "Spouse" will include the covered employee's domestic partner, provided you and your partner have executed a Domestic Partner affidavit acceptable to ADT, establishing that you and your partner are domestic partners for Business Travel Accident coverage. You will be considered domestic partners provided you continue to meet the requirements described in the Domestic Partner Affidavit. "Spouse," with respect to California and Oregon residents only, includes an individual who is in a registered domestic partnership with the covered employee in accordance with the state's law. Reference to the covered employee's marriage or divorce includes his or her registered domestic partnership or the dissolution of his/her registered domestic partnership.

See also "Domestic Partner" earlier in this section.

Substance Abuse

The uncontrollable or excessive abuse of addictive substances such as, but not limited to, alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use. In general, the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

- Impairments in social and/or occupational functioning;
- Debilitating physical condition;
- Inability to abstain from or reduce consumption of the substance; or
- The need for daily substance use to maintain adequate functioning.

The definition specific to a benefit plan (e.g., the Medical Plan) can be found in the benefit plan's plan document.

Target Benefit Basis

If you are a no base salary or a fixed-base salary employee, your Life and AD&D coverage is based on a Target Benefit Basis. This is an amount which is not a function of your current compensation. The Company periodically will advise you of this Target Benefit Basis during onboarding, the Benefits Annual Enrollment period, or at other times throughout the plan year.

Term Insurance

Life insurance payable to a beneficiary only when the insured dies while still covered under the plan. There are no permanent plan benefits, such as cash or loan value.

Uniformed Service

Refers to the performance of duty on a voluntary or involuntary basis under competent authority, including:

- Active duty;
- Inactive duty for training;
- Full-time National Guard duty; and
- A period during which you are absent from work with ADT for an examination to determine your fitness to perform any duty in the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the Commissioned Corps of the Public Health Service, and any other category of person designated by the President in time of war or emergency.

Competent authority includes the following organizations as defined by the Uniformed Services Employment and Reemployment Right Act of 1994, as amended (USERRA):

- The active and Reserve components of the Armed Forces;
- The Army and Air National Guard;
- The Commissioned Corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or emergency.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Refers to the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. This act allows eligible employees who are on uniformed service for more than 31 calendar days to continue health care coverage for themselves, their spouse/domestic partner, and their dependent child(ren) while performing uniformed service.

Whole Life (Cash Value) Policy

Life insurance payable to a beneficiary only when the insured dies while still covered under the policy. Unlike term insurance, there are permanent policy benefits, such as cash or loan value.

Your Occupation

Your occupation as it is recognized in the general workplace. Your occupation does not mean the specific job you are performing for a specific employer or at a specific location.

Your Rights under ERISA

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Your Rights under ERISA

As a participant in the ADT Health and Welfare Benefits Plan, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office or at other specified locations, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

This information may be provided in written or electronic form. Electronic communications will be provided in a form that complies with any applicable legal requirements.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Descriptions (SPDs). The Plan Administrator may charge a reasonable fee for the copies.
- Receive a summary of the Plan's annual financial reports each year. These summaries are prepared and distributed to Plan participants each year. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Care Plan Coverage

- Continue group health care coverage for yourself, your spouse, or your eligible child(ren) if there's a loss of coverage under the group health care plan as a result of a qualifying event. You or your spouse or eligible child(ren) may have to pay for such coverage. (See the **Continuing Coverage Under COBRA** section of this SPD for the rules governing your COBRA continuation rights.)
- Have reduced or no exclusionary periods of coverage for preexisting conditions under your group health care plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from ADT or your group health care plan when your COBRA continuation coverage ends or when you:
  - Lose coverage under the Plan;
  - Become entitled to elect COBRA continuation coverage;
  - Request a certificate of creditable coverage before losing coverage; or
  - Request a certificate of creditable coverage up to 24 months after losing coverage.

  Without evidence of creditable coverage, a preexisting condition exclusion may apply for 12 months after the date you enroll in your coverage (18 months if you enroll after first becoming eligible).

Prudent Actions of Plan Fiduciaries

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

Enforce Your Rights

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

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

If your claim for benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the appropriate claims administrator or insurance company review and reconsider your claim.

If you have a claim for benefits that's denied or ignored, in whole or in part, you may file suit in a state or federal court once you've exhausted the Plan's claims procedures. You may also file suit in a state or federal court if you disagree with the Plan's decision, or lack of a decision, concerning the qualified status of a Medical Child Support Order (QMCSO) and have exhausted the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the other party to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if the court finds your claim is frivolous).

Assistance with Your Questions

If you have general questions about the ADT Health and Welfare Benefits Plan, contact **EmployeeAccess**. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator:

- Contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory;
- Write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210; or
- Log on to **askebsa.dol.gov**.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-444-3272 or online at **dol.gov/ebsa**.