Employee Health And Welfare Plan ($2,000 Deductible): TTI, Incorporated

Coverage Period: 7/01/15-6/30/16

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual/Family| Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or **plan** document by calling the Plan Administrator at 920-477-4364. (Note: the Uniform Glossary can be accessed at: www.dol.gov/ebsa/healthreform).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per calendar year - **PPO** - $2,000 Per-son/$4,000 Family **Non-PPO** - $4,000 Person/$8,000 Family - **Deductible** waived for: services with a **copay; PPO** preventive care; second opinions	You must pay all costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes per calendar year – **PPO** - $4,000 Person/$8,000 Family **Non-PPO** - $9,000 Person/$18,000 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums, balanced billed charges**, non-covered health care, co-pays, penalties for noncompliance.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the **plan** will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.multiplan.com or call 1-800-922-4362 (PHCS) or call 1-800-279-9776 (EOS); www.hps.com or call 1-888-477-7968 (HPS); www.faboh.com or	If you use a **PPO** doctor or other health care provider, this **plan** will pay some or all of the costs of covered services. Be aware, your **PPO** doctor or hospital may use a **Non-PPO** provider for some services. Plans use the term **in-network, preferred** or **participating providers** in their network. See the chart starting on page 2 for how this **plan** pays different

	call 1-800-594-2731. For out-of-area providers contact PHX at 888-621-7900.	providers.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from the **plan.**
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or **plan** document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This **plan** may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	**Primary care** visit to treat an injury or illness	20% **coinsurance**	50% **coinsurance**	
	Specialist visit	20% **coinsurance**	50% **coinsurance**	
	Other practitioner office visit	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Preventive care/screening/immunization	0% **coinsurance**	50% **coinsurance**	
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	50% **coinsurance**	
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.serve-you-rx.com	Contraceptives as mandated by Healthcare Reform	Retail - $0 **copay** Mail - $0 **copay**	Not Covered	Retail – 30 day supply Mail – 90 day supply
	Generic Drugs	Retail - $10 **copay** Mail - $10 **copay**	Not Covered Retail – 30 day supply	Mail – 90 day supply
	Single Source Brand Name Drugs	Retail – 20% of prescription cost **copay** Mail – 20% of prescription cost **copay**	Not Covered	Retail – 30 day supply Mail – 90 day supply If name brand drug is purchased when doctor indicates a generic can be dispensed, the covered person must pay the applicable copay plus the cost difference between generic and name brand
	Non-Formulary Brand Name Drugs	Retail – 50% of prescription cost **copay** Mail – 50% of prescription cost **copay**	Not Covered	Retail – 30 day supply Mail – 90 day supply If name brand drug is purchased when doctor indicates a generic can be dispensed, the covered person must pay the applicable copay plus the cost difference between generic and name brand

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Specialty Medications	Mail – 20% of cost of drug, not to exceed $200 **copay**	Not Covered	Mail order only – 30 day supply
If you have outpatient surgery	Facility fees	20% **coinsurance**	50% **coinsurance**	Precertification required. $500 reduction in covered expenses when determining benefits for noncompliance.
	Physician/surgeon fees	20% **coinsurance**	50% **coinsurance**	
If you need immediate medical attention	**Emergency room services**	20% **coinsurance**	20% **coinsurance**	PPO Deductible applies
	Emergency medical transportation	20% **coinsurance**	20% **coinsurance**	PPO Deductible applies
	Urgent care	20% **coinsurance**	50% **coinsurance**	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	50% **coinsurance**	Precertification required. $500 reduction in covered expenses when determining benefits for noncompliance.
	Physician/surgeon fee	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% **coinsurance**	50% **coinsurance**	
	Mental/Behavioral health inpatient services	20% **coinsurance**	50% **coinsurance**	Precertification required. $500 reduction in covered expenses when determining benefits for noncompliance.
	Substance abuse disorder outpatient services	20% **coinsurance**	50% **coinsurance**	
	Substance abuse disorder inpatient services	20% **coinsurance**	50% **coinsurance**	Precertification required. $500 reduction in covered expenses when determining benefits for noncompliance.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	20% **coinsurance**	50% **coinsurance**	Routine prenatal visits covered as preventive
	Delivery and all inpatient services	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	**Home health care**	20% **coinsurance**	50% **coinsurance**	Covers up to 30 visits per calendar year
	Rehabilitation services	20% **coinsurance**	50% **coinsurance**	Covers up to 36 visits per calendar year for cardiac rehabilitation/20 visits per calendar year for pulmonary rehabilitation
	Habilitation services	20% **coinsurance**	50% **coinsurance**	Covers up to 60 days per calendar year/30 days per confinement for extended care facility
	Skilled nursing care	20% **coinsurance**	50% **coinsurance**	Covers up to 60 days per calendar year/30 days per confinement for extended care facility
	Durable medical equipment	20% **coinsurance**	50% **coinsurance**	
	Hospice service	20% **coinsurance**	50% **coinsurance**	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Routine screenings covered as preventive
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	Routine check-ups covered as preventive

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery
- Cochlear Implant
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Long Term Care
- Private Duty Nursing
- Refractive Eye Surgery
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic Care
- Medically Necessary Treatment of Sleep Disorders
- Some Routine Foot Care
- TMJ

Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the **plan** at 920-477-4364. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 X 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: TTI, Inc.: (920) 477-4364 or the Department of Labor, Employee Benefit Security Administration at 1-866-444-EBSA or www.dol.ebsa/healthreform.

Does This Plan Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does This Coverage Meet The Minimum Value Standard?

The Affordable Care Act established a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum standard for the benefits it provides.**

––––––––––––––––––––*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*––––––––––––––––––––

About these Coverage Examples:

These examples show how this **plan** might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,728
- **Patient pays** $3,812

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,900
Copays	$50
Coinsurance	$862
Limits or exclusions	$0
Total	**$3,812**

Note: Assumes **PPO** **Providers** & Family Coverage - Assumes all charges are for the mother except routine nursery, vaccines and other preventive + 4 generic prescriptions

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400

- **Plan pays** $3,200
- **Patient pays** $2,200

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$120
Coinsurance	$80
Limits or exclusions	$0
Total	**$2,200**

Note: Assumes **PPO** **Providers** & Individual Coverage + 12 generic prescriptions; 4 office visits

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

Û **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

Û **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Ü **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Ü **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as

copayments, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.