

Employee Health And Welfare Plan (\$850 Deductible):

TTI, Incorporated

Coverage Period: 7/01/16-6/30/17

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 <u>deductible</u> ?	Per calendar year - PPO - \$850 Person/\$1,700 Family Non-PPO - \$1,700 Person/\$3,400 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 1 st). See chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	Yes per calendar year – PPO - \$2,850 Person/\$5,700 Family Non-PPO - \$6,700 Person/\$13,400 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 <u>out-of-pocket limit</u> ?	Premiums, balanced billed charges, non-covered health care, copays, 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 <u>network of providers</u> ?	Yes. See www.multiplan.com or call 1-800-922-4362 (PHCS) or 1-800-279-9776 (EOS); www.hps.com or call 1-888-477-7968 (HPS); www.faboh.com or call 1-800-594-2731. For out-of-area providers contact PHX at 888-621-7900.	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 providers.
Do I need a referral to see a <u>specialist</u> ?	No	You can see the specialist you choose without permission from the plan .
Are there services this	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy

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OMB Control Numbers 1545-2229

1210-0147, and 0938-1146

Corrected on May 11, 2012

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plan doesn't cover? or plan document for additional information about excluded services.

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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 <u>provider's</u> 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	
	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	

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<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.serve-you-rx.com</p>	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
	Specialty Medications	Mail – 20% of cost of drug, not to exceed \$200 copay	Not Covered	Mail order only – 30 day supply

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If you have outpatient surgery	Facility fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification required. \$500 reduction in covered expenses when determining benefits for noncompliance.
	<u>Physician</u> /surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	PPO deductible applies.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	PPO deductible applies.
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification required. \$500 reduction in covered expenses when determining benefits for noncompliance.
	<u>Physician</u> /surgeon fee	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification required. \$500 reduction in covered expenses when determining benefits for noncompliance.
	Substance abuse disorder outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Substance abuse disorder inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification required. \$500 reduction in covered expenses when determining benefits for noncompliance.

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If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Routine prenatal visits are covered as preventive care
	Delivery and all inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Covers up to 30 visits per calendar year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Covers up to 36 visits per calendar year for cardiac rehabilitation/20 visits per calendar year for pulmonary rehabilitation
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Covers up to 60 days per calendar year/30 days per confinement for extended care facility
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Covers up to 60 days per calendar year/30 days per confinement for extended care facility
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Hospice service</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Routine screenings covered as preventive care
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	Routine check-ups covered as preventive care

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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 | • Dental Care | • Private Duty Nursing |
| • Cochlear Implant | • Hearing Aids | • Refractive Eye Surgery |
| • Cosmetic Surgery | • Long Term Care | • 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 | • Medically Necessary Treatment of Sleep Disorders | • Some Routine Foot Care |
| • Chiropractic 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.

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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 \$4,670
- Patient pays \$2,870

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:

<u>Deductibles</u>	\$1,700
<u>Copays</u>	\$50
<u>Coinsurance</u>	\$1,120
Limits or exclusions	\$0
Total	\$2,870

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 \$3,680
- Patient pays \$1,720

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:

<u>Deductibles</u>	\$850
<u>Copays</u>	\$120
<u>Coinsurance</u>	\$750
Limits or exclusions	\$0
Total	\$1,720

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

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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?

- ✗ **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?

- ✗ **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?

- ✓ **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?

- ✓ **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.

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