ATI PHYSICAL THERAPY

2016 EMPLOYEE BENEFITS GUIDE

Your Benefits

We offer a comprehensive benefits program consisting of:

- **Medical—PPO and HSA Plans**
- **Dental**
- **Vision**
- **Basic Life**
- **Voluntary Life for employees, spouses and child(ren)**
- **Short-Term Disability**
- **Long-Term Disability**
- **Flexible Spending Account—Healthcare and Dependent Care**
- **Employee Assistance Program (EAP)**

2016 EMPLOYEE BENEFITS GUIDE

CONTENTS

WHAT'S NEW FOR 2016

New Forms for Your 2015 Federal Income Tax Filing

Around the time you receive your Form W-2, you will receive one or more new tax forms related to health insurance you may have had or were offered in 2015.

Please keep in mind that while we know what form we will be sending, you may receive others if you worked for another employer earlier in the year.

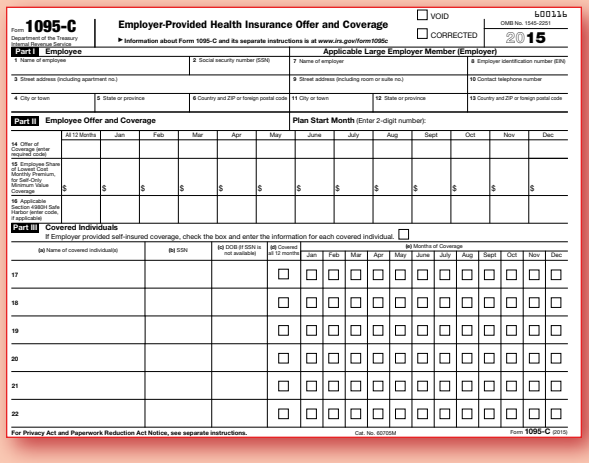
Form 1095-C

You will receive this form because you:

Were considered "full time" for ACA purposes for at least part of 2015.

or

Were covered for at least a day in 2015 under an employer-provided self-insured plan.



Form **1095-C** Department of the Treasury Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

☐ VOID ☐ CORRECTED

OMB No. 1545-2251

2015

Part I Employee

1 Name of employee | 2 Social security number (SSN)

3 Street address (including apartment no.)

4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer | 8 Employer identification number (EIN)

9 Street address (including room or suite no.)

10 Contact telephone number

11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage		$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2015)

How Will I Use This Information?

You or your tax preparer will enter information contained on this form on your federal tax return for 2015 to demonstrate that you satisfied the ACA's obligation to have health insurance.

Payroll Deduction Changes

Beginning in 2016, payroll deductions for your benefits will be taken from each bi-weekly paycheck. This means that instead of breaking up your annual contributions over 24 deductions per year, they will be broken up over 26 deductions.

MDLIVE Telemedicine Service

For employees and dependents who participate in the HSA plan, you will have access to MDLIVE. This program connects you to a doctor live and from anywhere using the web, a mobile app or phone 24/7/365, for much less than the cost of a regular doctor's visit. MDLIVE can be used when your primary care physician isn't convenient or available, for common low-level conditions, including some prescriptions.

BlueCross BlueShield of Illinois

Online Tools

Prescription Drug Information... Whenever You Want It

Your prescription drug coverage through Blue Cross and Blue Shield of Illinois (BCBSIL) offers many options, resources and advantages:

- Cost savings
- Time savings
- Convenience
- Safety programs

To get started, just follow these steps:

1. Go to bcbsil.com.
2. Log in to **Blue Access for MembersSM**.
3. Click **Prescription Drugs** in the Quick Links box on the right. This will take you to MyPrime.com, the member site of BCBSIL's pharmacy benefit manager. From there, you can:
   1. Find Medicine
   2. Prescription History
   3. Find Pharmacies
   4. And More

MyPrime.com is also Mobile Friendly!

A New BenefitWallet® Member Portal

BenefitWallet has redesigned our member portal to offer a more efficient and friendly user experience.

New Features

- Streamlined navigation
- More features and more control of health plan claims
- Improved claims processing
- HSA Save-IT! recordkeeping tool
- Additional member communications

Visit https://mybenefitwallet.com/members.html for more info

HEALTH CARE REFORM

What Do I Need to Think About for My Health Care in 2016?

In compliance with the law, ATI Physical Therapy intends to continue offering coverage to all full-time employees working 30 or more hours per week. Of course, ATI Physical Therapy retains the right to modify its benefit offerings at any time.

People without health insurance can shop for coverage through an online public health insurance marketplace/exchange and compare available plan options based on price, benefits, and quality. We encourage you to review the exchanges when reviewing your ATI Benefit options as an additional comparison.

Potential Financial Assistance in the Marketplace

Financial assistance in the form of advance tax credits may be available to you (to purchase a health plan), under certain circumstances.

- If your household income is greater than 100 percent but less than 400 percent of the federal poverty level and you meet other requirements, you might be eligible for a tax credit. Tax credit amounts vary based on household income.
- If your income is at or below 133 percent of the federal poverty level, you might be eligible for Medicaid.

Cost-sharing subsidies may also be available to you (financial assistance in paying out-of-pocket plan costs like deductibles, co-payments, etc.).

For more information about tax credits and subsidies and to determine your potential eligibility, please visit www.healthcare.gov.

No Coverage, Pay Penalty

If you do not enroll in and maintain health insurance for yourself and your dependents, you may be required to pay an annual penalty (prorated for the number of months you and/or they don't have coverage).

- In 2016, the penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater.

Penalties may increase in future years.

Exceptions From Penalties

You may be exempt from a penalty if any of the following apply:

- You cannot afford coverage (i.e., would have to pay more than eight percent of annual household income to purchase health insurance after taking into account any employer contributions and subsidies).
- Your income is below the tax filing threshold
- You qualify for a hardship exemption
- You experience a gap in coverage of less than three consecutive months in one calendar year.
- You are a member of a religious group that objects to coverage on religious principles.
- You are a member of a nonprofit religious organization that shares medical costs.
- You are in prison
- You are a non-U.S. citizen.
- You are a Native American tribe member

If you think you qualify for an exemption, please visit www.healthcare.gov for more information.

Being compliant with health reform and providing you with the most up-to-date information are top priorities for ATI Physical Therapy. As information changes, please be on the lookout for more details regarding health care reform through ATI and the Marketplace.

If you have questions about new regulations, please visit www.healthcare.gov or contact human resources for any information about your state exchange.

BENEFIT WEBSITE

The website can be accessed at https://atibenefits.hrintouch.com. In addition, we have a benefits help line at 855-222-1884 or atibenefits@benefitfocus.com. Responses via email are expected within 48 hours.

What Will Be My Username and Password?

As a reminder, your username is your legal first name, first initial of last name, and last 4 digits of your SSN. Your initial password is your SSN. You will be required to change your password upon logging in.

What Will I Be Able to Do on the Website?

The website will allow you to have 24 hour a day access to your personal benefits information as well as access to a wealth of benefits information that will be useful to you and your family. You will be able to:

- Participate in Open Enrollment for 2016
- Enroll in benefits for the first time if you have recently been changed to full time status
- Make changes to your benefits due to a qualifying event (including marriage, divorce, birth or adoption of child, loss of spousal coverage, spousal open enrollment, etc.)
- Add dependents to your insurance plans
- Update your beneficiaries

What Do I Need to Do During Open Enrollment?

- Make any necessary changes to your health & welfare benefits—change plans, add or drop covered dependents, verify your life insurance beneficiaries. Any unchanged elections will carry over to 2016 (except FSA or HSA).
- Enroll in the Health Care or Dependent Care FSA plans. Remember these are "use it or lose it" plans, and your current election will not carry over to next year. These plans must be re-elected each year.
- Enroll in the Health Savings Account plan (only for High Deductible Medical plan participants only). If you currently have an HSA, your balance will carry over to 2016, but your election will not. You must verify your annual HSA election if you would like to continue contributing to your account.

REMEMBER

If you are adding new dependents to your medical, dental or vision coverage, you must be sure to send over any documents confirming dependent status, such as a marriage certificate, birth certificate, etc.

WHAT PLAN SHOULD YOU CHOOSE?

As you review the information regarding your health coverage, you may ask yourself, "What plan should I choose?"

You may want to consider the following questions:

- Are your health risks low?
- Do you have alternative coverage options for your family?
- Have you considered the State Healthcare Marketplace?

If you answered yes to any of the above questions, you may be able to lower your health coverage costs.

Did you know, the high deductible plan has the lowest contribution structure? This means that you will only pay for the coverage you use throughout the year.

Did you know, if your spouse has coverage available through his/her employer, and you choose to add them to your plan, you will pay an additional $200 per month in ATI's medical plan?

Additionally, as part of our contribution structure, you will pay an additional $2.25 per person per month for any dependents added to your policy. Electing your spouse's plan and/or adding your dependents to a spouse's plan may reduce your coverage costs.

Did you know, if you elect to waive out of the medical coverage in the company-sponsored plan, you will receive a credit of $100 per month ($46.15 per biweekly paycheck)?

MEDICAL PLAN OPTIONS

Provider: BlueCross BlueShield of Illinois

ATI offers three medical plans, all Preferred Provider Organization (PPO) plans with access to the BlueCross BlueShield PPO network. Each plan pays benefits for in-network and out-of-network services. Here is a snapshot of each plan (details are found in the chart on the following pages):

- The **High Deductible Medical Plan** combines a high-deductible PPO plan with Health Savings Account (HSA). You may contribute to your HSA, tax-free. Services other than routine physicals and preventive care are subject to a high deductible—$2,500 per person or $5,000 per family—but you may use your HSA funds to pay for them. Please note for the family deductible, one family member can satisfy the deductible. If you do not use the money in your HSA during the year, it will carry over to the next year, tax-free and with earnings. Unused HSA funds may be accumulated until retirement to help pay your retiree medical expenses.
- The **Standard Option PPO Plan** has a $1,000 deductible per person/$2,000 deductible per family. Family deductible must be met by at least 2 family members. Most in network preventive care is covered at 100%. In network physician and specialist services other than routine physicals are subject to a $20 or $40 copay. The plan pays 80% for most other in-network services after you meet the deductible. Out-of-network care is covered at 60%.

- The **Premium Option PPO Plan** has a $600 deductible per person/$1,200 deductible per family. Family deductible must be met by at least 2 family members. Most in network preventive care is covered at 100%. In network physician and specialist services other than routine physicals are subject to a $20 or $40 copay. The plan pays 90% for most other in-network services after you meet the deductible. Out-of-network care is covered at 60%.

Fertility and Major Surgical Procedures: You are advised to contact the insurance company on fertility and surgical procedures in order to verify the level of coverage for such procedures. there is a maximum of 3 cycles per lifetime. Please do so prior to scheduling and/or having any major surgery or procedure as 2016 plan guidelines will apply.

WAIVING THE MEDICAL HEALTH COVERAGE

You have been given the opportunity to enroll in the medical health coverage issued by the Company. If you elect not to participate and waive out of the medical coverage in the company-sponsored plan, you will receive, in lieu of this benefit, $100 per month (which will occur as a credit of $46.15 per bi-weekly paycheck). Please note that you will receive this waiver credit as long as you are not enrolled in the medical plan as a dependent on our Company-sponsored plan and you have health insurance coverage elsewhere. You are still eligible for the waiver credit if you elect dental coverage and/or vision coverage.

SPOUSAL VERIFICATION OF NO INSURANCE

If your spouse is offered coverage elsewhere, and you choose to cover your spouse under your ATI medical plan, then you will pay an additional $200 per month for your benefits. If your spouse does not have access to other coverage, then you will not be assessed this fee. You must submit the 2016 Spousal Verification of Insurance Eligibility form electronically via the benefits website to apply for the spousal eligibility waiver; otherwise you will be charged the higher rate on your employee/spouse or family coverage. You must complete a Spousal Verification of No Insurance affidavit on the benefits enrollment site every year in order to apply for the waiver of the fee.

COST COMPARISON ANALYSIS

For simplicity, each of the examples below assumes you have selected individual non-smoking, no-wellness coverage and have used in-network providers.

Example #1:

You incur only **$300** of in-network eligible health care expenses during the year.

	High Deductible Medical Plan	Standard PPO Plan	Premium PPO Plan
Your Eligible Medical Expenses	$300	$300	$300
Your Share (Deductible Expenses)	$300	$300	$300
Remaining Expenses	$0	$0	$0
Coinsurance Paid by ATI	$0	$0	$0
Coinsurance You Paid	$0	$0	$0
Summary:			
Your Deductible & Coinsurance	$300	$300	$300
Your annual premium for single coverage (non-smoker)	$16.73 x 26 Deduction + $2.25x12 = $462	$52.58 x 26 Deduction + $2.25 x 12 = $1,394	$93.41 x 26 Deduction + $2.25 x 12 = $2,456
Your annual cost	**$762**	**$1,694**	**$2,756**

Example #2

You incur **$2,500** of in-network eligible health care expenses during the plan year.

	High Deductible Medical Plan	Standard PPO Plan	Premium PPO Plan
Your Eligible Medical Expenses	$2,500	$2,500	$2,500
Your Share (Deductible Expenses)	$2,500	$1,000	$600
Remaining Expenses	$0	$1,500	$1,900
Coinsurance Paid by ATI	$0	$1,200	$1,710
Coinsurance You Paid	$0	$300	$190
Summary:			
Your Deductible & Coinsurance	$2,500	$1,300	$790
Your annual premium for single coverage (non-smoker)	$16.73 x 26 Deduction + $2.25x12 = $462	$52.58 x 26 Deduction + $2.25 x 12 = $1,394	$93.41 x 26 Deduction + $2.25 x 12 = $2,456
Your annual cost	**$2,962**	**$2,694**	**$3,246**

Example #3

You incur **$15,000** of in-network eligible healthcare expenses during the plan year.

	High Deductible Medical Plan	Standard PPO Plan	Premium PPO Plan
Your Eligible Medical Expenses	$15,000	$15,000	$15,000
Your Share (Deductible Expenses)	$2,500	$1,000	$600
Remaining Expenses	$12,500	$14,000	$14,400
Coinsurance Paid by ATI	$11,250	$11,200	$12,960
Coinsurance You Paid	$1,250	$2,000 (out-of-pocket max)	$1,440
Summary:			
Your Deductible & Coinsurance	$3,750	$3,000	$2,040
Your annual premium for single coverage (non-smoker)	$16.73 x 26 Deduction + $2.25x12 = $462	$52.58 x 26 Deduction + $2.25 x 12 = $1,394	$93.41 x 26 Deduction + $2.25 x 12 = $2,456
Your Annual Cost	**$4,212**	**$4,394**	**$4,496**

MEDICAL PLAN COMPARISON

Medical Benefits Summary	HSA		STANDARD	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$2,500 Individual or $5,000 Family —Applies to out-of-pocket maximum	$5,000 Individual or $10,000 Family —Applies to out-of-pocket maximum	$1,000 Individual/ $2,000 Family —Applies to out-of-pocket maximum	$2,500 Individual/ $5,000 Family —Applies to out-of-pocket maximum
Medical Out-of-Pocket Maximum	$4,000 Individual/ $6,850 Family	$8,000 Individual/ $16,000 Family	$3,000 Individual/ $6,000 Family	$6,500 Individual/ $13,000 Family
Rx Out-of-Pocket Maximum	Included in Medical Out-of-Pocket Maximum		$3,600 Individual/$7,200 Family	
Coinsurance Level	90%	60%	80%	60%
Lifetime Maximum	Unlimited		Unlimited	
Physician Services				
Office Visit	$20 copay after deductible	deductible then 40% coinsurance	$20 copay	deductible then 40% coinsurance
Specialist Visit	$40 copay after deductible	deductible then 40% coinsurance	$40 copay	deductible then 40% coinsurance
Well Adult Visit	100%	40% coinsurance	100%	deductible then 40% coinsurance
Well Child Visit	100%	40% coinsurance	100%	deductible then 40% coinsurance
Hospitalization Admission				
Inpatient	deductible then 10% coinsurance	$300 hosp. ded then regular ded & 40% coinsurance	$300 hosp. ded then regular ded & 20% coinsurance	$300 hosp. ded then regular ded. & 40% coinsurance
Outpatient	deductible then 10% coinsurance	deductible then 40% coinsurance	deductible then 20% coinsurance	deductible then 40% coinsurance
Diagnostic Testing	deductible then 10% coinsurance	deductible then 40% coinsurance	deductible then 20% coinsurance	deductible then 40% coinsurance
Pregnancy & Maternity	deductible then 10% coinsurance	deductible then 40% coinsurance	deductible then 20% coinsurance	deductible then 40% coinsurance
Emergency Services	Deductible, then $300 copay (waived if admitted)		$300 copay (waived if admitted)	
Prescription Drugs	Generic: $15	Generic: $15	Generic: $15	Generic: $15
	Formulary Brand: 35%	Formulary Brand: 35%	Formulary Brand: 35%	Formulary Brand: 35%
	Non-Formulary Brand: 35%	Non-Formulary Brand: 35%	Non-Formulary Brand: 35%	Non-Formulary Brand: 35%
	(after deductible is met)	(after deductible is met)	(after $250 deductible—brand only, per person covered on the plan)	(after $250 deductible—brand only, per person covered on the plan)
	Mail Order 3 x Retail	Mail Order 3 x Retail	Mail Order 3 x Retail	Mail Order 3 x Retail
Outpatient Physical Therapy	$40 copay after deductible 110 visits per calendar year	deductible then 40% coinsurance	$40 copay 110 visits per calendar year	deductible then 40% coinsurance
Outpatient Occupational & Speech Therapies	deductible then 10% coins OT: 70 visits per calendar year Speech Therapy: 50 visits per calendar year	deductible then 40% coinsurance	deductible then 20% coins OT: 70 visits per calendar year Speech Therapy: 50 visits per calendar year	deductible then 40% coinsurance
Chiropractic Manipulations	Excluded		Excluded	
Mental Health & Substance Abuse				
Inpatient	deductible then 10% coinsurance	$300 hosp. ded. then regular ded. & 40% coinsurance	$300 hosp. ded. then regular ded. & 20% coinsurance	$300 hosp. ded. then regular ded. & 40% coinsurance
Outpatient	$40 copay (after deductible)	deductible then 40% coinsurance	$40 copay (after ded.) then 20% coinsurance	deductible then 40% coinsurance

New Benefit for the HSA Plan—MDLIVE

Beginning in 2016, HSA plan members will have access to MDLIVE. The MDLIVE benefit gives you access to physicians and allows you to request prescriptions during or after normal business hours - including nights, weekends and holidays. You can also use MDLIVE for non-emergency medical issues and when you need medical care while traveling.

The virtual visit will cost you less than a regular doctor's visit. Plus, it allows you to connect with a doctor in the comfort of your home or office without needing a pre-scheduled appointment. Most visits take around 10-15 minutes and if needed a doctor can write a prescription for you (some states have limitations) that you can pick up at your local pharmacy.

MEDICAL PLAN COMPARISON (CONTINUED)

Premium		Medical Benefits Summary
In-Network	**Out-of-Network**	
$600 Individual/ $1,200 Family —Applies to out-of-pocket maximum	$1,200 Individual/ $2,400 Family —Applies to out-of-pocket maximum	Deductible
$2,100 Individual/ $4,200 Family	$4,200 Individual/ $8,400 Family	Medical Out-of-Pocket Maximum
$4,500 Individual/$9,000 Family		Rx Out-of-Pocket Maximum
90%	60%	Coinsurance Level
Unlimited		Lifetime Maximum
Physician Services		
$20 copay	deductible then 40% coinsurance	Office Visit
$40 copay	deductible then 40% coinsurance	Specialist Visit
100%	deductible then 40% coinsurance	Well Adult Visit
100%	deductible then 40% coinsurance	Well Child Visit
Hospitalization Admission		
$300 hosp. ded. then regular ded. & 10% coinsurance	$300 hosp. ded. then regular ded. & 40% coinsurance	Inpatient
deductible then 10% coinsurance	deductible then 40% coinsurance	Outpatient
deductible then 10% coinsurance	deductible then 40% coinsurance	Diagnostic Testing
deductible then 10% coinsurance	deductible then 40% coinsurance	Pregnancy & Maternity
$300 copay (waived if admitted)		Emergency Services
Generic: $15	Generic: $15	Prescription Drugs
Formulary Brand: 35%	Formulary Brand: 35%	
Non-Formulary Brand: 35%	Non-Formulary Brand: 35%	
(after $250 deductible—brand only, per person covered on the plan)	(after $250 deductible—brand only, per person covered on the plan)	
Mail Order 3 x Retail	Mail Order 3 x Retail	
$40 copay 110 visits per calendar year	deductible then 40% coinsurance	Outpatient Physical Therapy
deductible then 20% coins OT: 70 visits per calendar year Speech Therapy: 50 visits per calendar year	deductible then 40% coinsurance	Outpatient Occupational & Speech Therapies
Excluded		Chiropractic Manipulations
Mental Health & Substance Abuse		
$300 hosp. ded. then regular ded. & 10% coinsurance	$300 hosp. ded. then regular ded. & 40% coinsurance	Inpatient
$40 copay (after deductible)	deductible then 40% coinsurance	Outpatient

DID YOU KNOW?

Healthcare Reform mandated that all medical expenses (deductibles, copays and coinsurance) go towards your medical out-of-pocket maximum. Your out-of-pocket maximum has been adjusted to account for this change.

NEW FOR 2016

Benefit Deductions

- All benefit deductions will be taken on a bi-weekly basis. That means that you will have a deduction for your benefits on every paycheck.
- There is no increase to the Wellness contributions for the High Deductible Medical Plan in 2016!

MONTHLY MEDICAL EMPLOYEE CONTRIBUTION CHART

Benefit	Non-Tobacco User Rates		
	HSA	Standard PPO	Premium PPO
Single	$36.24	$113.92	$202.40
EE + Spouse	$242.48	$473.32	$631.61
EE + Children (2 or less)	$38.74	$281.34	$459.30
EE + Children (3 or more)	$41.23	$309.28	$507.00
Family with 2 children or less	$251.84	$647.32	$962.71
Family with 3 children or more	$254.96	$692.44	$1,042.93

Wellness Incentive (only available during open enrollment)	$30/month subtracted from above rates
Spousal Verification of No Insurance	$200/month subtracted from above Spouse and Family rates
Tobacco Surcharge	$115/month added to above rates
Additional Monthly Contribution	$2.25 per person on plan/month

	Coverage Level	You May Contribute (Pre-Tax) in 2016
2016 HSA Annual Contribution Maximums	Employee	$3,350
	Employee + Child Employee + Spouse Family	$6,750

HOW YOUR MEDICAL DEDUCTIBLE WORKS

	Premium PPO Plan		Standard PPO Plan		HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Admission Deductible:	$300 per admit	$300 per admit	$300 per admit	$300 per admit	Not applicable	$300 per admit
NOTE: The Hospital Admission Deductible is in addition to your Annual Deductible (explained in detail below)						
Annual Deductible—Individual:	$600	$1,200	$1,000	$2,500	$2,500	$5,000
Annual Deductible—Family	$1,200	$2,400	$2,000	$5,000	$5,000	$10,000
All Covered Services that do not have a copay are subject to the Deductible. Each plan year you must satisfy your deductible before benefits begin.						
All Preventive Care is covered at 100% and not subject to the deductible						
Family Deductible Coordination:	Each family member is responsible for their own Individual Deductible before benefits begin. Once the total Family Deductible has been met (see amount above) benefits begin. Note: The PPO plans have a family deductible that is 2 times the individual amount; therefore, one person is responsible for the individual deductible.				The Family Deductible may be reached by one or all family members. Once the total deductible has been met (see amount above) benefits begin. Note: One family member can meet this entire family deductible.	
NOTE: The Family Deductible Coordination works differently on the PPO plan versus the HSA Plan. See below examples for further clarification:						

Examples of How Your Medical Deductible Works

	Month	Service	Premium PPO Plan	Standard PPO Plan	HSA Plan
			In-Network Example		
Individual Person Example: (Matt is the Employee)	March	Matt has a broken leg totaling $500.	The full $500 bill is applied towards the deductible.	The full $500 bill is applied towards the deductible.	The full $500 bill is applied towards the deductible.
	August	Matt has outpatient surgery totaling $1,000.	$100 of the $1,000 bill is applied towards the deductible. Benefits apply on the remainder.	$500 of the $1,000 bill is applied towards the deductible. Benefits apply on the remainder.	The full $1,000 bill is applied towards the deductible.
2 Person Family Example: (Joe is the Employee and Mary is his Spouse)	March	Mary has an Appendicitis totaling $2,500 requiring an inpatient hospital stay.	$600 of the $2,500 bill is applied towards the deductible AND $300 of the bill is applied towards the hospital admission deductible. Benefits apply on the remainder.	$1,000 of the $2,500 bill is applied towards the deductible AND $300 of the bill is applied towards the hospital admission deductible. Benefits apply on the remainder.	The full $2,500 is applied towards the deductible.
	August	Joe has major surgery totaling $10,000 and is admitted to the hospital.	$600 of the $10,000 bill is applied towards the deductible AND $300 of the bill is applied towards the hospital admission deductible. Benefits apply on the remainder.	$1,000 of the $10,000 bill is applied towards the deductible AND $300 of the bill is applied towards the hospital admission deductible. Benefits apply on the remainder.	$2,500 is applied towards the deductible. Benefits apply on the remainder.
3 Person Family Example: (Christine is the Employee, Frank is her Spouse and Liz is their child)	March	Liz has a broken leg totaling $500.	The full $500 bill is applied towards the deductible.	The full $500 bill is applied towards the deductible.	The full $500 bill is applied towards the deductible.
	August	Christine has outpatient surgery totaling $5,000.	$600 of the $5,000 bill is applied towards the deductible. Benefits apply on the remainder.	$1,000 of the $5,000 bill is applied towards the deductible. Benefits apply on the remainder.	$4,500 of the $5,000 bill is applied towards the deductible. Benefits apply on the remainder.
	October	Frank has surgery totaling $10,000 and is NOT admitted to the hospital.	$100 of the $10,000 bill is applied towards the deductible. Benefits apply towards the remainder.	$500 of the $10,000 bill is applied towards the deductible. Benefits apply on the remainder.	Benefits apply immediately.

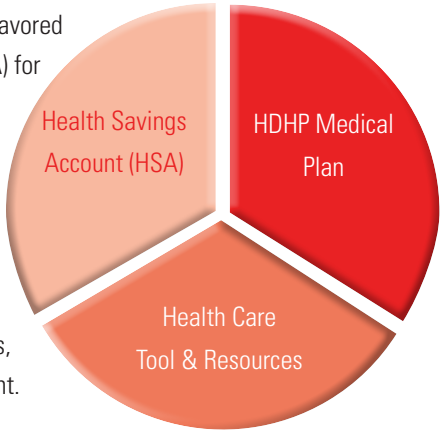
DID YOU KNOW?

Blue Cross offers members a Spending Summary on their website so you can see the current balance of your deductible and out-of-pocket maximum.

Go to http://www.bcbsil.com/member to log in.

HIGH DEDUCTIBLE MEDICAL PLAN

The High Deductible Medical Plan is a way of utilizing and paying for health care services, putting you, the consumer, at the center of your health care decisions. With the HSA plan, you have greater control over how your health dollars are spent. There are three components: (1) A tax-favored Health Savings Account (HSA) for current and future needs; (2) BCBS High Deductible Health Plan (HDHP) coverage; and (3) Tools and resources to help you learn about treatment options and costs, plan your health care services, and manage your HSA account.



Health Savings Account (HSA)—You Must Re-Enroll for 2016 Deductions!

The HSA is like a bank account you use to pay for health care—such as office visits, prescription drugs and lab tests. The money you put into your HSA will reduce your taxes for the year—similar to the money you save in a 401(k) or IRA plan. There are dollar limits on the amount that you can deposit into your HSA each year.

For 2016, the maximum you can contribute to your HSA account is $3,350 if you have individual coverage and $6,750 if you are also covering dependents. Whatever you do not spend from your HSA rolls over year-to-year for future health care needs. If you leave the Company for any reason, you can take the balance in your HSA with you. The key advantages to an HSA program are as follows:

- **Tax Savings:** Your contributions to the HSA are made with pre-tax dollars, so you'll pay less in income taxes.
- **Control:** You can use the HSA to pay for any qualified medical expenses, as defined by the IRS.
- **Savings and Investments:** Unlike premiums, unused HSA dollars remain in the account until you use them later. BenefitWallet provides investment alternatives.
- **Portability:** The account is yours; you can take your HSA with you if employment changes.
- **Contributions and Investments Earning:** They are tax free, as are disbursements from the account to pay for qualified expenses. Funds withdrawn for non-qualified expenses will be assessed a 10% penalty in addition to normal taxation. The penalty is waived in the event of death, disability or attainment of Medicare eligible age.

As mentioned above, the HSA is your own account. You can enroll in the High Deductible Medical Plan without setting up an HSA to pay for qualified medical expenses. However, since many of the advantages of this plan revolve around setting aside money in your HSA account, we certainly encourage you to set one up as quickly as possible. There are a few other items that you need to keep in mind when setting up your HSA:

- Additional rules apply if your spouse also has an HSA. Please contact BenefitWallet for specific information at 877-HSA-4200 or https://www.mybenefitwallet.com.
- Individuals age 55 and older can make additional catch-up contributions until they enroll in Medicare.
- In 2016, the amount of the catch-up contribution is $1,000.
- You are responsible for your HSA account. You are responsible for verifying your eligibility for an HSA. You are responsible for verifying that HSA funds are used for qualified expenses.
- You must also keep records to verify that distributions from your HSA are for qualified services.
- You will receive a debit payment card, similar to an FSA debit card, issued by BenefitWallet. Funds can be accessed from your HSA account by using the BenefitWallet debit card at point of service, setting up a direct bill or reimbursing yourself directly from the Health Savings Account via a Mellon Bank check book. Unlike an FSA account, you do not need to supply receipts to substantiate your expenses; however you must maintain good records.
- BenefitWallet charges a $2.25 monthly maintenance fee for balances under $3,000.
- In order for a dependent under age 26 to use HSA money, they must qualify as your Tax Code dependent.

PPO Coverage

The High Deductible Medical Plan includes a PPO (Preferred Provider Organization) plan, similar in many ways to the Premium and Standard Option PPO medical plans. Like the PPO plans, the High Deductible Medical Plan gives you access to a network of doctors, hospitals, and other facilities that charge agreed-upon rates. It covers the same medical services and supplies as the PPO plans, including preventive care. But there is an important difference. Under the High Deductible Medical Plan, you must meet a high deductible and out-of-pocket expenses for non-preventive care. To promote good health, preventive services are not subject to the deductible. Although your out-of-pocket expenses are higher with this plan, you can use your HSA to help pay them. After you meet the deductible, the plan will begin paying benefits.

PRESCRIPTION PROGRAM

High Deductible Medical Plan

Rx Out of Pocket Maximum

You must first satisfy the entire plan deductible on the High Deductible Medical Plan, before any prescription copays apply. Once you have satisfied the entire plan deductible, copays for generic drugs will be $15 per prescription. Additionally, the Company has a mandatory generic drug program. This means that if there is a generic drug available for your prescription, you must choose that generic drug. If you do not, you will be charged the difference between the brand name and the generic drug plus the copay.

This amount will be charged even after you have satisfied the entire plan deductible applicable.

If there is not a generic drug available, and you have satisfied the entire plan deductible, then 35% coinsurance for brands will apply.

Standard and Premium PPO

Generic drugs are not subject to a deductible; however, if there is not a generic drug available, you must first satisfy the $250 prescription deductible on the Standard and Premium PPO plans (per person covered on the plan), which is applicable to formulary and non-formulary brand name medications only. Once you have satisfied the $250 prescription deductible (per person covered on the plan), then 35% coinsurance for brands will apply.

Copays for generic drugs will be $15 per prescription. Additionally, the Company has a mandatory generic drug program. This means that if there is a generic drug available for your prescription, you must choose that generic drug. If you do not, you will be charged the difference between the brand name and the generic drug plus the copay.

Mail Order Rx

The Mail Order Prescription Drug program (offered through BCBSIL's PrimeMail®) conveniently provides you with a 90 day supply of maintenance medications at 3x the cost of your retail prescription.

There are two ways to order a maintenance medication for the first time. Online: visit bcbsil.com and log into BlueAccess® for Members. Transitioning your prescriptions from a retail pharmacy to mail is as easy as filling out the online form. Through the mail: you must request a new written prescription from your doctor. It is recommended that you request two prescriptions: one for a 14 day supply that can be filled immediately at your local pharmacy, and a second for the 90 day mail order supply. Complete the PrimeMail® order form, which can be found on bcbsil.com or by calling 877-357-7463. Mail your completed order form, prescription and payment to PrimeMail®. Expect your medication to arrive five to eight business days after your order is received.

Specialty Pharmacy

Specialty medicines are generally higher-cost medicines that require extra support to manage and administer. These medicines are used to treat chronic (long-term) and complex conditions.

Specialty medicines

- Are injected or infused (however, some may be taken by mouth)
- Have unique delivery, storage or shipment requirements
- Require additional patient education, training and safety monitoring
- May not be stocked at retail pharmacies

All specialty medications will now be administered by BCBS's Prime Specialty Pharmacy. This will give you access to the best case management through Prime Pharmacy to ensure you are receiving appropriate instructions, delivery, and dispensing procedures for your specialty medication.

FLEXIBLE SPENDING ACCOUNTS (FSA)

FSAs allow you to use pre-tax dollars to pay for many health care expenses and dependent care expenses. The Company's FSA program is a calendar year program and is administered by WageWorks.

How Does It Work?

You decide how much you would like to set aside for health care expenses and/or dependent care expenses in 2016. That amount will be deducted from your semi-monthly paycheck on a pre-tax basis and credited to an individual "account" for you. You submit claims and are reimbursed from the account for your eligible expenses. **You must enroll for the entire year—the FSA plan year runs from January 1 through December 31.** Your election (payroll deduction amount) may not be changed during the year unless you have a qualifying life event or change in status.

How Much Will Be Reimbursed?

You may be reimbursed up to your annual election amount, **not to exceed $2,500 for the Health Care Spending Account**. For the **Dependent Care Spending Account, $5,000 if you are filing your taxes jointly; $2,500 if you file individually.**

REMINDER

$500 rollover of FSA funds for 2016.

Health Care FSA

You can use the Health Care FSA for expenses incurred by you, your spouse or any of your dependents, even if not covered by one of the Company's medical plans. Procedures performed for cosmetic reasons do not qualify.

Eligible expenses include (but are not limited to):

- Deductibles, copays and coinsurance; over the counter medications (if prescribed by a physician); glasses and contact lenses not covered by a vision discount plan; laser eye surgery; hearing aids; and other expenses allowed by the IRS.

Dependent Care FSA

You can use your Dependent Care FSA to pay for daycare that allows you and/or your spouse to work outside the home. If you are married, you can use this account only if your spouse is employed or actively seeking work, is a full-time student for at least five months of the year, or is disabled. You can pay daycare expenses for children under age 13, disabled children, disabled parents, a disabled spouse, or relatives who qualify as dependents under the Internal Revenue Code. Educational expenses are not eligible. For your Dependent Care FSA contributions to be eligible for reimbursement, your provider must claim your payments as taxable income. Additional rules apply during leaves of absence for use.

Eligible daycare arrangements include (but not limited to):

- Licensed nursery school and daycare centers for preschool children; day camps, after school care or in-home daycare for children under age 13; daycare centers for other qualifying dependents (elder care centers, for instance); housekeepers, cooks or maids who provide dependent care in your home; and individuals other than your dependents who provide daycare for your qualifying dependents, either inside or outside your home.

If you enroll in the High Deductible Medical Plan, you cannot use a Health Care FSA. Instead, you may establish a Limited Use FSA for dental, vision and other flexible spending eligible items not covered by insurance. The Limited Use FSA can be used for medical and prescription expenses, only after you meet your HSA deductible.

Use It or Lose It

Health Care FSA and Dependent Care FSA participants are subject to the "use it or lose it" rule. At the end of the plan year, you will be allowed to roll over up to $500 to the next year's plan. Any leftover amount over $500 will be forfeited per IRS rules. Careful planning can help you reduce that risk. You will be given 90 days after the end of the plan year or 90 days after your last day of employment to submit claims incurred during that plan year. Your FSA accounts end on the last day of employment with ATI.

Changing Your FSA Benefit Selection

Generally, your FSA election is irrevocable and cannot be changed during the plan year. However, you may request to change your FSA election during the plan year only if you experience a qualifying life event or a change in status that affects you, your spouse or your dependent's eligibility for coverage under this plan or another employer's plan.

METHODS OF REIMBURSEMENT FOR YOUR FSA: VISA DEBIT CARD

You will be provided with a Visa Debit Card for easy access to your FSA funds. For a Health Care FSA, the card works at places where you usually purchase healthcare products or services such as pharmacies, doctor's offices and hospitals. Although the Debit Card eliminates the need to file paper requests for reimbursement, the IRS requires that your charges be verified. **Save your receipts in case WageWorks requests them later to confirm a purchase.**

In the event that your card is used for ineligible items or you neglect to send in required receipts, you will be asked to write a personal check back to the plan. If you do not reimburse the plan, your Debit Card will be deactivated and collection procedures will begin.

All employees that participate in the Health Care and/or Dependent Care Flexible Spending Account (FSA) benefit will receive a debit card to pay for qualified expenses. The debit card looks like a regular credit card, and is issued under the Visa system, but is only accepted at specific types of merchants or provider locations.

- Debit cards will be mailed to your home.
- If you lose your card, please contact WageWorks Benefits at 866.679.7649 to deactivate your card and order a new card. In addition, you can order cards for your family members. Please visit www.takecarewageworks.com to request a new card. There is no cost for additional cards.
- To activate your card, purchase an item where the card is swiped. An initial order online will not activate the card.
- It is called a debit card, but you use it just like a credit card. At the merchant point of service keypad, choose "credit" as there is no PIN assigned to the card. Any transaction over your account balance will be declined. There are transaction limits at certain merchants such as grocery stores ($200 transaction limit) and discount stores ($250 transaction limit).

How Do You Use Your Debit Card?

Use your card at any of the following vendors and you will not be asked for documentation. The card will only work for qualified expenses at these vendors. The following is a sample listing of some of the merchants that have implemented the IIAS inventory control system.

Use your card for copayments which WageWorks has loaded in our system and you will not be asked for documentation. If other non-copay transactions are included on the same card transaction you will be required to submit for all of the charges including the copay. Also, recurring transactions that have been reported to WageWorks will not require documentation after the initial submission. When you use your card for any other expense or vendor, use the personalized form for substantiating your claim. Complete a copy of your Debit Card Substantiation Form and send to WageWorks with a copy of the receipt. To avoid delay in clearing the transaction, send the form within 30 days of your purchase. WageWorks will send you a monthly statement if you have any pending transactions. You may also submit your receipts along with the monthly statement.

How Do You Get Reimbursed When You Do Not Use the Debit Card?

Simply complete a copy of the personalized claim form and send along with your receipts as instructed. You can also generate the claim online and submit it through the website (www.takecarewageworks.com). Please do not use the Debit Card Substantiation Form for these expenses. They will not be reimbursed if the incorrect form is used.

Reminders...Reminders...Reminders...

- Make copies of the personalized claim forms
- Credit card receipts/statements cannot be accepted as receipts
- Receipts from the provider must show description of the purchase and a date of service
- Do not use a highlighter on the submission (appears black on a fax)
- Do not send original receipts, copies of all receipts should be on 8.5"x11" paper
- Your dependent under age 26 can use your FSA account

Update: State laws addressing civil unions will not affect the use of Flex Plans since they are governed by Federal Regulations and supersede any State law. In order to use FSA money, the civil partner has to qualify as your Tax Code dependent.

MyFlex App

Download our New Smartphone App and you can:

- Take a picture of receipts and file claims on the go.
- See your elections.
- Check your balance.
- View our contact information.

MyFlex Mobile Alerts

- You can start receiving text or email notices when your claim is paid or we need a receipt.
- To sign up for notifications, go to our website, log into your account at takecareWageWorks.com and go to "Settings."

DENTAL PLAN

Provider: Delta Dental

Recognizing the need to provide employees with a dental plan, the Company offers dental insurance coverage through Delta Dental. Benefits are available for preventive, basic and major services. Please refer to the summary of benefits below.

Delta Dental provides you with two dental networks, Delta Dental Premier and Delta Dental PPO, instead of one and the opportunity to maximize savings should you choose to receive treatment from a Delta Dental PPO dentist. Please note, for non-network services you will be responsible for the difference between your dentist's charge and the covered percentage of the Usual and Customary fee for a given service. In some cases this will require you to pay up front for services.

Delta Dental Benefits Summary	What plan pays for in-network and out-of-network services
Annual Deductible applies to Types II & III	$50 Individual/$150 Family
Annual Maximum (Per Person)	$1,500
Preventive & Diagnostic Services (Type I)	
Cleanings/Bitewings (Not Limited)	100% (of allowed expenses)
Basic Services (Type II)	
Fillings/Simple Extractions (Not Limited)	80%
Major Services (Type III)	
Crowns/Dentures (Not Limited)	50%
Orthodontic Services (Type IV)	
Lifetime Maximum $1,500	50%

Dental Monthly Employee Contribution Chart

Benefit	Dental
Employee	$17.95
Employee/Spouse	$34.08
Employee + 2 Child(ren) or Less	$34.08
Employee + 3 Child(ren) or More	$37.48
Family with 2 Child(ren) or Less	$68.76
Family with 3 Child(ren) or More	$75.64

Mobile App

Delta Dental offers a comprehensive mobile application that makes getting information convenient! This app allows you to:

- Securely access your ID card, claims and benefit information,
- View your mobile ID card,
- View coverage and claims information,
- Search for a dentist and
- Brush with the toothbrush timer

DID YOU KNOW?

There is a positive relationship between periodontal diseases and psychological factors such as stress, distress, anxiety, depression, and loneliness (57 percent of the studies in a literary review published by the Journal of Periodontology revealed). Specifically, increased levels of the hormone cortisol can lead to more destruction of the gums and bone due to periodontal diseases. It is well known that periodontal diseases, left untreated, can ultimately lead to bone loss or tooth loss. Preston D. Miller, DDS and AAP President, advised "Patients should seek healthy ways to relieve stress through exercise, balanced eating, plenty of sleep, and maintaining a positive mental attitude."

VISION PLAN

Provider: VSP

Recognizing the need to provide employees with a vision plan, the Company offers a voluntary vision plan through VSP. The plan covers services from any licensed VSP provider, but benefits are paid at a higher level when you use an in-network provider. Please refer to the summary of benefits below:

VSP Vision Benefits Summary	
With a VSP Provider	
WellVision Exam® focuses on your eye health and overall wellness	$10 copay every 12 months
Prescription Glasses:	
• Lenses	$25 copay every 12 months
• Frames	$150 allowance every 24 months (20% discount after allowed)
OR (Glasses or Lenses can be chosen per year)	
Contact Lenses	Up to $60 copay for exam and fitting $150 allowance for contact lenses every 12 months
With Other Provider, VSP will Cover	
Exam	Up to $45
Frame	Up to $70
Contacts	Up to $105

Vision Monthly Employee Contribution Chart

Benefit	Vision
Employee	$7.32
Employee/Spouse	$11.71
Employee/Child(ren)	$11.96
Family	$19.28

DID YOU KNOW?

Children and adults are at risk for eye strain due to the growing use of digital devices. CVS, or digital eye strain, is a medical issue with serious symptoms that can affect learning and work productivity. It is now the number one computer-related complaint in the U.S.—ahead of carpal tunnel syndrome. To help protect individuals' eyes against overuse of digital devices, people should get eye exams regularly.

125C STATUS

If you participate in 125C (i.e., contribute on a before-tax basis), you cannot cancel or change medical, dental and vision coverage as well as flexible spending accounts and health savings accounts for you or your covered dependents for the full 2016 calendar year unless you have a qualifying life event or status change (for example, marriage, birth of a child) that affects you, your spouse, or dependent(s). If you choose after-tax payments, you can drop or change your coverage any time during 2016 even if you don't experience a qualifying life event or status change. If you experience a qualifying life event or status change, log into the ATI Benefits website to update your dependents and insurance elections.

LIFE INSURANCE

Basic Life Insurance

Basic Life is a Company paid benefit which provides a $50,000 life insurance policy for employees only. If you would like to designate or update your beneficiary, please go to the ATI Benefits website.

Optional Life Insurance

The Company gives you the opportunity to buy valuable optional life insurance coverage for yourself, your spouse and your dependent children—all at affordable group rates. If you would like to apply to purchase this additional life insurance, please see the on-line application instructions available on the ATI Benefits website.

In regard to civil unions, domestic partnerships, and same-sex marriage laws regarding estates and inheritance, rights are evolving both on a state and federal level. For this reason, we are strongly encouraged to ensure your insurance policy has a named beneficiary.

MID-YEAR ELECTION CHANGES

IMPORTANT: An Employee has 30 Days to Make a Change to their Benefits

Event	Allowable Changes
Marriage	Employee may add spouse and any newly acquired eligible children to medical and dental plans. Employee may switch from one medical plan to another when adding the new dependents. Employee may increase health care FSA and dependent care FSA contributions. Employee may not drop or reduce health, dental, or health care FSA elections unless employee is actually electing/gaining coverage at spouse's place of employment. Employee may drop dependent care FSA if the new spouse cares for the children, or if dependent care FSA is elected at the spouse's place of employment.
Death of spouse	Employee may cancel coverage for the ex-spouse but not for other dependents. If the family had coverage at the spouse's former place of employment, employee and dependents may enter any of ATI's medical and dental plan offerings. Employee may reduce health care FSA elections. Dependent care FSA cannot be dropped. Employee may only increase health care and dependent care FSA elections if there was a loss of health and/or dependent care FSA at the spouse's former place of employment.
Divorce, legal separation, annulment	Employee may cancel coverage for the ex-spouse but not for other dependents. If the family had coverage at the spouse's place of employment, employee and dependent children may enter any of ATI's medical and dental plan offerings. Employee may reduce or drop health care and dependent care FSA elections. Employee may only increase health care FSA elections if there was a loss of health care FSA at the spouse's place of employment. Employee may elect or increase dependent care FSA if employee now has custody of the children.
Birth, adoption, placement for adoption	Employee may make an entirely new election providing for coverage of the employee, spouse and newborn. For example, employee may move from employee + spouse coverage on one medical plan to full family coverage on a different health plan. Employee may either elect for the first time or increase-—but not decrease—health care FSA and dependent care FSA elections.
Death of a child, or birthday of child who reaches limiting age of 26	Employee may cancel coverage for the affected dependent but not for other dependents. Employee may reduce—but not increase—health FSA and dependent care FSA elections.
Significant change in benefits offered (as determined by Employer)	If the plan benefits are enhanced, employee may elect the new benefit plan. If the plan benefits are reduced, employee may switch into a different plan or drop coverage. Significant changes mean changes in copays, deductibles, coinsurance, annual benefit maximums and annual out-of-pocket maximums. Health care and dependent care FSA may not be changed.
Change in network	Employee may change medical and dental coverage if network access changes significantly (e.g., employee moves outside of an HMO area). Employee may not change health care or dependent care FSA.
Spouse now eligible for new coverage	Changes are only permissible if an employee and/or dependents enroll in the spouse's coverage. FSA changes are also allowed if the spouse enrolls in his/her employer's health FSA and/or dependent care FSA.
Spouse loses coverage	Employee may elect coverage for him/herself and add spouse and dependent children who were covered under the spouse's plan before the spouse lost coverage. May elect health care FSA and dependent care FSA if other coverage was lost.
ATI employee becomes benefit eligible (part time to full time status)	Employee may elect medical, dental, health care FSA and dependent care FSA coverage.
Significant change in cost of benefits (as determined by Employer)	If the increase in the cost of medical or dental plan coverage (employee contributions) is significant (generally 10% or greater), employee may reduce or drop coverage. If a significant decrease in the cost of medical or dental coverage occurs, employees may elect the reduced-cost benefits. No health care FSA changes are permitted. Employees may enroll in or increase dependent care FSA elections if day care rates increase. Employees may drop or decrease dependent care FSA if rates decrease.
Change in service area	Employee may change medical, dental and health care FSA coverage if network access changes significantly (e.g., employee moves outside of an HMO area). Employee may change dependent care FSA if the move causes a change in day care expenses.
Change in coverage under spouse's plan	Dropping ATI medical, dental, health care FSA and/or dependent FSA coverage is only permissible if an employee and/or dependents enroll in the spouse's coverage. Enrolling in ATI coverage is only permissible if an employee and/or dependents drop the spouse's medical, dental, health FSA and/or dependent care FSA coverage. Dependent care FSA may be dropped if spouse is newly employed.
Judgment, decree, or Qualified Medical Child Support Order	Employee may add/drop/change medical, dental and health care FSA elections as directed by the court. Employee may not change dependent care FSA elections.
Medicare or Medicaid entitlement (gaining or losing coverage)	Employee may drop medical and dental plan coverage for the covered member entitled to Medicare or Medicaid. Employee may decrease or drop health care FSA. No changes are permitted to dependent care FSA.
Official leave of absence due to military service	May make a commensurate election change upon commencement of and return from leave.
Spouse's open enrollment that does not coincide with ATI's open enrollment	Employee may make an election change corresponding with a change made under the spouse's plan. Employee may only decrease or cancel an election if the employee elects coverage under the spouse's plan.
Parent's open enrollment that does not coincide with ATI's open enrollment	Employee may make an election change corresponding with a change made under the parent's plan. Employee may only decrease or cancel an election if the employee elects coverage under the parent's plan.
Children's Health Insurance Program (CHIP) Eligibility. Employee/dependent gains or loses eligibility for state assisted health insurance.	Employee/dependents may enter or exit the medical plan within 60 days of qualifying event. No changes are permitted to dental or FSA plans.

MID-YEAR ELECTION CHANGES (cont.)

As you know, you may only make changes to your benefit elections during open enrollment unless you have a qualifying event (**must be made within 30 days of the event or you must wait until open enrollment**) or a status change. Although you must still experience a qualifying event (e.g., birth of a child, marriage, change in work status from part time to full time, etc.) to change your benefits mid-year, you will be able to make these additional changes at the time of the qualifying event:

- If you have a baby, you may either elect for the first time or increase (but not decrease) your health care Flexible Spending Account and dependent care Flexible Spending account elections.
- You may change your dependent care Flexible Spending Account election if you move to an area which causes you to change dependent day care providers who charge a different amount for services.
- If your spouse gains or loses his/her coverage at his/her place of employment, you may change your health care Flexible Spending Account and dependent care Flexible Spending account allocations accordingly.
- With a court order, you may change all of your benefit elections except dependent care Flexible Spending Account.
- You may decrease your health care Flexible Spending Account election if one of your family members becomes entitled to Medicare.
- If you are a military reservist called to active duty, you may make benefit election changes immediately prior to your departure and immediately after your return to work.
- You may drop ATI coverage to elect coverage under a spouse's plan during your spouse's open enrollment period. You must provide proof that you elected your spouse's coverage.

ANNUAL NOTICES

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act requires group health plans and their insurance companies to provide certain benefits for mastectomy patients who elect breast reconstruction.

In the case of a plan participant who is receiving benefits in connection with mastectomy, coverage will be provided in a manner determined in consultation with the attending physician for:

- 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; and
- Prosthesis and treatment of physical complications of the mastectomy, including lymphedema.

These breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirements for Protected Health Information (PHI) under HIPAA. A copy of the Notice of Privacy Practices is available from the Human Resources Department of ATI for medical coverage and the health care flexible spending account plan, and from the insurance carrier for dental and vision insurance.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility—

Medicaid/CHIP Resources

ALABAMA—Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA—Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

COLORADO—Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA—Medicaid
Website: https://www.flmedicaidplrecovery.com/
Phone: 1-877-357-3268

GEORGIA—Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

INDIANA—Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA—Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS—Medicaid
Website: www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY—Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA—Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE—Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS—Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA—Medicaid
Website: http://www.dhs.state.mn.us/id_006254
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

MISSOURI—Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA—Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA—Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA—Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE—Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY—Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK—Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA—Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 1-919-855-4100

NORTH DAKOTA—Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA—Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON—Medicaid and CHIP
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA—Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND—Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA—Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA—Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS—Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH—Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414

VERMONT—Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA—Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON—Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA—Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN—Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING—Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

The Illinois Religious Freedom Protection & Civil Union Act

The Illinois Religious Freedom Protection & Civil Union Act (Public Act 96-1513) took effect June 1, 2011. While this is not an insurance act, it does afford same sex and opposite sex couples entering into a civil union, the same obligations, responsibilities, protections and benefits afforded or recognized by the law of Illinois to spouses.

As this is not an insurance law, BCBSIL and Delta Dental, our medical and dental carriers, have determined the applicability to our current plan as follows:

- As our current plan is self-funded, the law does not apply to our plan and include coverage to same sex and opposite sex unmarried couples. As a result, our plan, which does not currently offer coverage to same sex and opposite sex unmarried couples, will continue without any changes or additions as a result of this law.
- Please see page 6 for discussion of same-sex marriage.

However, as our vision plan is a fully insured plan, it has been determined by VSP that the applicability to our current plan is as follows:

- Spouses of civil unions will be eligible for coverage as our policy covers spouses in marriage.
- This law will extend this benefit regardless of what state the individual resides
- Coverage is offered and available to a civil union spouse and dependents upon the qualifying life event of the member entering into a civil union on or after June 1, 2011. If the member does not elect to change their coverage within 30 days of entering into a civil union, the next opportunity will be upon our open enrollment period in November.
- Employees who enroll in coverage will be required to pay taxes on the portion of the contribution and premium for any spouse enrolled. This is a taxable issue for mandated by the IRS as the law allowing health related benefits as a pre-tax item does not extend to spouses of civil unions.
- Employees who reside in a state that does not recognize civil unions, regardless of whether they entered a civil union, will be unable to elect spousal coverage.

Newborn Mother's Act Notice

Group health plans and health insurance issuers generally may not under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days of when your or your dependents" other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 855-222-1884.

Medicare and Prescription Drug Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ATI Holdings, LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get

help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. ATI Holdings, LLC has determined that the prescription drug coverage offered by the ATI Flexible Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your ATI Holdings, LLC coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your ATI Flexible Benefits Plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with ATI Holdings, LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ATI Holdings, LLC changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

- Visit: www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	October 15, 2015
Name of Entity/Sender:	ATI Holdings, LLC
Contact: Position/Offices:	Johanna Koehler Human Resources
Address:	790 Remington Blvd, Bolingbrook, IL 60440
Phone Number:	(630) 296-2222, ext. 7404

ADDITIONAL BENEFITS

Prenatal Program

Special Beginnings

A prenatal program is available to BlueCross BlueShield of Illinois members. If you or your spouse is expecting, the Special Beginnings program will help guide you through your pregnancy with access to a number of different resources.

Enrollment is easy and confidential. Just call the toll-free number on the back of your BCBS ID card.

Take good care of yourself and your baby—enroll in Special Beginnings today!

Onlife, BCBS of IL Wellness Vendor, also gives members access to the Liveon Portal an online resource to help you maintain your health. You can complete a health risk assessment, ask a trainer about an exercise plan and much more. Go to Blue Access® for Members at www.bcbsil.com and click on the Liveon Portal icon to start.

Nurseline

Call 24/7 at (800) 299-0274

It's hard to know what to do about certain illnesses or injuries, especially at night or on the weekends. Should you:

- Call your doctor?
- Go to the emergency room?
- Treat them yourself?

Now, with Blue Care® Connection, you can call the 24/7 Nurseline and get information when you need it, 24 hours a day, 7 days a week. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week. In a matter of minutes, they can help you identify some options. Plus, you have the option to learn about more than 1,200 health topics over the phone via an audio library system. **When should you call?** The 24/7 Nurseline can help when you or a family member has a health problem or question, such as:

- Asthma, Back Pain or Other Chronic Conditions
- Dizziness or Severe Headaches
- High Fever
- Constant Crying (infants)
- Cuts or Burns
- Sore Throat

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Call 800-767-5320

This program is designed to provide assistance with personal and work-related concerns no matter how large or small. This no-cost, confidential assistance is available for you and your immediate family members 24 hours a day, 7 days a week. An EAP counselor will help you assess your concerns and identify how to help. This may include meeting with a counselor for three face to face visits, or referring you to community resources. Articles, tools, tips & resources are also available online at www.my-life-resource.com (username: hmsa; password = myresource)

New Feature from ATI's EAP

HMSA's Work/Life website provides a host of services that augment the HMSA EAP as well as provide resources for individuals who do not require counseling but are looking for information and tools to achieve work life balance and general wellness.

HMSA's online resources include:

- Childcare providers
- Eldercare providers
- Health Risk Assessments (HRAs/Weight loss tools)
- Adoption agency resources
- Education resources from pre-k through college/university
- Legal and financial documents/resources
- Podcasts/Seminars
- 1,000 + articles

Online Work-Life EAP Resources

www.my-life-resource.com

Username: hmsa

Password: myresource

KEY CONTACTS AND ONLINE RESOURCES

To support your important health and wellness decisions, ATI offers a variety of online health resources and tools. They are all available through the Employee Self Service Portal, your primary source for benefits and health care information. There, you will find benefit summaries, links to carriers, and other valuable information.

Medical and Pharmacy		
BlueCross BlueShield of Illinois	800-828-3116	This site provides general health and wellness information including preventive care guidelines, disease management and lifestyle improvement programs, and an encyclopedia of medical conditions and treatments.
Website	www.bcbsil.com	
BlueCross BlueShield Website	www.bcbs.com	Use the BlueCard® Doctor and Hospital Locator to find network providers nationwide. When you enter the prefix "XOF" you will also have access to the Treatment Cost Estimator and Hospital Profile tools.
BlueCross BlueShield (Explanation of Benefits) EOBs	http://www.bcbsil.com/member	This site gives you access to current and past claims, deductible balance, eligibility, and explanation of benefits (EOB) statements.
Dental		
Delta Dental	800-323-1743	Use this site to manage your Dental account online.
Website	www.deltadentalil.com	
Vision		
VSP	800-877-7195	Use this site to find a VSP providers near you.
Website	www.vsp.com	
Life Insurance and Long Term Disability		
Reliance Standard	800-351-7500	Submit and check the status of claims, view and print benefit summaries, and tools to help determine your coverage needs.
Website	www.reliancestandard.com	
Employee Assistance Program		
Health Management Systems of America (HMSA)	800-847-7240	Use this site to navigate tools & resources on work/life topics.
Assoc. Website	www.my-life-resource.com (username: hmsa password = myresource)	
FSA Administration		
WageWorks	866-679-7649	Use this site to manage your FSA account online.
Website	www.takecarewageworks.com	
HSA Administration		
BenefitWallet	877-HSA-4200	Use this site to manage your HSA account online
Website	https://www.mybenefitwallet.com	
Company Intranet: Sharepoint (must be on the company server)		
	http://atisps001/index.html	Use this site to access all of your benefits information online.
Online Enrollment:		
	https://atibenefits.hrintouch.com	
HR		
For more information	ATIBenefits@Benefitfocus.com 855-222-1884	

INSTRUCTIONS HOW TO ENROLL ONLINE

Electing or Making Changes in Benefits

If you are eligible for health benefits, you will need to log in to enroll for the first time, make changes to your existing medical/dental plans or enroll in the FSA (Flexible Spending Account)/HSA (Health Savings Account) for 2016. Full Time Employees working 30 or more hours per week are eligible. The website can be accessed at https://atibenefits.hrintouch.com. In addition, we have a benefits help line at 855-222-1884 or atibenefits@benefitfocus.com.

- You will see an enrollment notice at the top of the page when you log in. Click on the "Enroll In Your Benefits" link and complete your benefit elections or changes.
- You will see the "Get Started" button, at which point you will be able to proceed to the dependents page.
- If you have no Dependent(s) or marital status changes, click "next" to proceed with your benefit elections or changes.
- Elect or change the benefit plans that you are choosing.
- After making your elections or changes, you will see a summary screen of your benefits. It is very important that you verify your elections or changes for accuracy. We would suggest printing this screen for your records.

Company Open Enrollment (Annually in November)

- If you currently have health benefits and if you do not make changes to your existing medical/dental plans, your current elections will carry over.
- Health Care FSA and Dependent Care FSA plans must be re-elected every year. If you do not elect an FSA, you will not have an FSA for the following calendar year. Your current FSA election will not carry over. You must enroll for the 2016 FSA plan year; otherwise you will not have a 2016 FSA. Existing participants will not receive a new FSA card as it does not expire for three years.

  \+ $500 will carry over from FSA
- HSA (Health Savings Account) plans must be re-elected every year. We encourage you to elect an HSA during open enrollment. If by chance you do not make your HSA bank account election during the open enrollment period, you will be able to open or fund your account throughout the year. Your HSA account balance will carry over but NOT the HSA election.

This summary of benefits is not intended to be a complete description of the terms and ATI Physical Therapy's insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan. In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although ATI Physical Therapy maintains its benefit plans on an ongoing basis, ATI Physical Therapy reserves the right to terminate or amend each plan, in its entirety or in any part at any time.