American Traffic Solutions™

Making Life Safer and Easier on the Road Ahead™

2017 Benefits Enrollment Guide

Continuing on the road to wellness

Get Fit! Improve your health & your savings increase through lower healthcare costs.

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Summary of Benefits

MEDICAL & PRESCRIPTION CARE	DESCRIPTION
2 Consumer Plans with Health Savings Accounts	Choose a plan that best meets the needs for you and your family.
Prescription Drug Coverage	Included as part of your medical plan. Provides differing coverage levels for generic, formulary and non-formulary drugs.
Wellness Incentive Program	Earn additional dollars in 2017 by participating in annual wellness exam
DENTAL & VISION CARE	**DESCRIPTION**
3 Dental Plans	Choose a plan that best meets the needs of you and your family.
Vision Coverage	Provides routine vision care for yourself and your family.
OTHER PROGRAMS	**DESCRIPTION**
401(k) Retirement Plan	Give yourself a raise! Did you know that if you contribute 5%, we will give you 4%? That's an 80% return on your money!
Disability Programs	Provides salary continuation up to 60% if you are considered disabled under our program – FREE!
Employee Assistance Program	Provides sessions for behavioral health, substance abuse and other personal issues.
Dependent Care Flexible Spending Account	Allows employees to set aside pre-tax dollars to pay for eligible dependent care expenses.
Accidental Injury Insurance	Pays a lump sum cash benefit for a broad range of accident treatments and conditions based on a schedule.
Life & AD&D	Provides FREE basic life insurance and AD&D! ATS also offers its employees the option to purchase additional coverage.
Time Off	ATS believes in the restorative value of time off!
Tuition Reimbursement	$5,250 max per year

Quick Reference List

BENEFIT	PROVIDER / NETWORK	GROUP #	PHONE #
Medical & Prescription Care			
Medical Plans	Cigna	3332739	800.244.6224
Prescription Home Delivery Pharmacy	Cigna Home Delivery Pharmacy	NA	800.285.4812
Wellness Incentive Program	ATS	Human Resources	480.596.4614
Dental & Vision Care			
Dental Plans	Cigna	3332739	800.244.6224
Vision Plans	VSP	30017048	800.877.7195
Other Programs			
401(k) Retirement Plan	Mass Mutual	61479	800.743.5274
Health Savings Account (HSA)	Health Equity	53685	866-346-5800
Accidental Injury	Cigna	AT960060	800-754-3207
Disability Programs	Sun Life	246546	877.786.5433
Employee Assistance Program	Sun Life	ATS ID:EAPBusiness	877.595.5281
Flexible Spending Dependent Care	Health Equity	NA	866.346.5800

Wellness Facts:

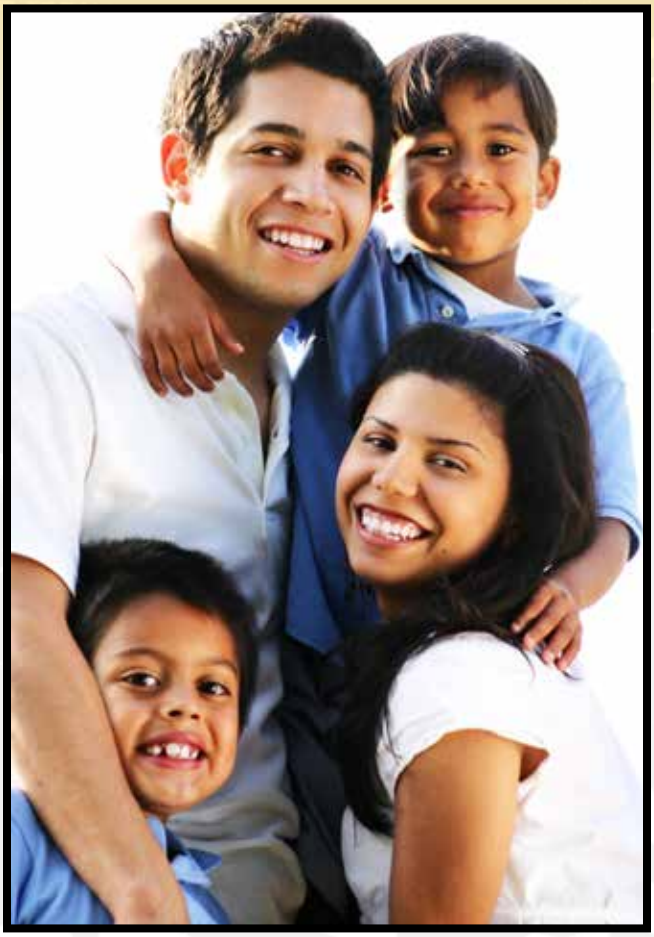
Remember to eat until you are satisfied, not full. Slow down and chew your meal, you might find you're satisfied with less than you thought!

Don't eat out of boredom! Instead of reaching for something to eat to pass the time, call a friend or go for a walk...you don't need those extra calories if you're not hungry. If you truly are hungry, plan ahead and have healthy snacks.

Instead of counting calories, eat the right kind. Consume calories with the most nutrients like whole grains, healthy proteins and fats, fruits and vegetables.

Proper diet and exercise are the mainstays of a healthy lifestyle, although many Americans turn to costly fad diets and exercise programs that fail to provide a healthy lifestyle. The basic tenets of gradual weight loss and good health include developing healthy eating habits and increasing daily physical activity.

Eligibility



You are eligible to participate in our benefits plans if you are scheduled to work at least 30 hours per week.

Our benefits programs are also open to your eligible dependents:

1. A covered employee's spouse or domestic partner
2. A covered employee's child(ren) or domestic partner's child(ren) under age 26

Benefits coverage is effective the date of hire for eligible employees. Employees have 30 days from date of hire to enroll.

Please note that employees may only enroll in our plans during Annual Open Enrollment, within 30 days of their date of hire or within 30 days of their benefits eligibility date. There are a few exceptions for qualifying events during the plan year. If you experience a qualifying event, you may elect to make changes to your coverage within 30 days of the qualifying event, and unfortunately, we cannot make any enrollment exceptions if you miss the 30 day window.

Qualifying events include:

1. The gain or loss of coverage through a spouse or domestic partner's plan
2. The loss of eligibility of a covered dependent
3. The death of a covered dependent
4. The birth or adoption of a child
5. A marriage, qualified domestic partnership, divorce or legal separation
6. An employment status change from part-time to full-time
7. The receipt of a Qualified Medical Child Support Order

How to Enroll

Enrollment will occur via ADP WorkforceNow. To sign up, navigate to the Myself > Benefits > Enrollments

Please ensure you print and save your enrollment confirmation after enrolling. Although we certainly do not foresee any issues, should the system fail to show you enrolled in a plan that you believe you enrolled in, you will be asked to provide your enrollment confirmation to confirm the elections.

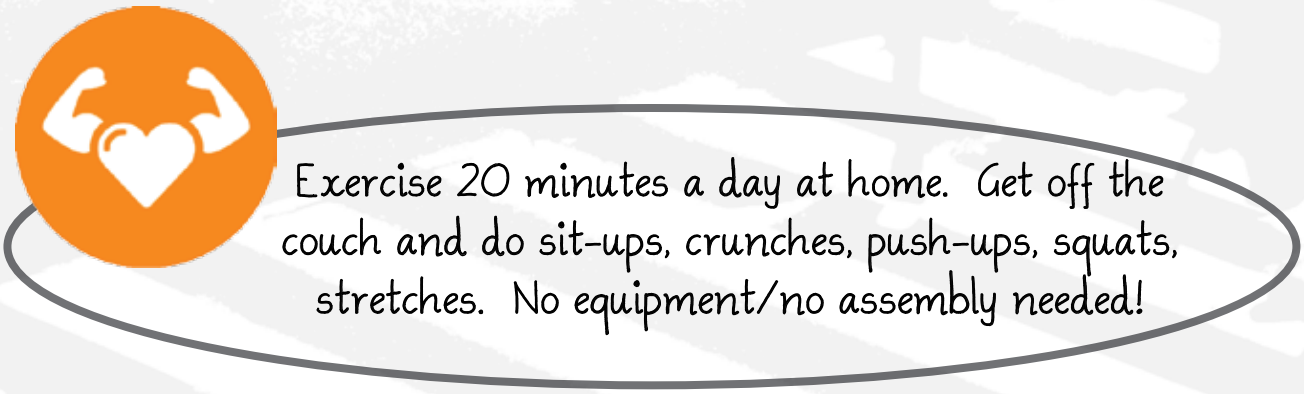
Wellness Incentive

Annual Wellness Exam Incentive

ATS realizes the importance of preventative care as a means of maintaining health and heading off a potential health problem before it develops into something more serious.

In 2017, ATS will make a one time, lump sum $500 contribution to the HSAs of employees who are enrolled in the Cigna medical plan and who complete their annual wellness exam in 2017. ATS will provide employees with an instruction sheet for them to give to their provider requesting that the exam be billed properly using ICD code V700. The annual preventive exam is 100% covered in-network by the plan with no cost to the employee.

Once this is processed through Cigna claims, and the completion of the wellness exam confirmed, Cigna will notify ATS. The deposit will then be made to the HSA account on the next scheduled deposit date. Employees not enrolled in the Cigna medical plan who have no HSA are not eligible for the incentive.



Medical & Prescription Care

Plan Designs

ATS understands how important health care is to you and your family, which is why we offer two comprehensive health plans, designed to meet the needs of all of our employees:

$2,500/$1,750 Consumer Plans: 80% co-insurance medical plans with $2,500 or $1,750 (Employee only coverage) deductibles

As always, our plans are designed to encourage all employees to seek in-network care to keep our medical care spending under control. We have negotiated deeper discounts with in-network providers, and the network is vast, so finding quality care in-network will not be an issue.

PLAN ELEMENT	$2,500 CONSUMER PLAN		$1,750 CONSUMER PLAN	
	In Network	Out of Network	In Network	Out of Network
Co-Insurance	80% - plan 20% - member	60% - plan 40% - member	80% - plan 20% - member	60% - plan 40% - member
Deductible* Individual Family	 $2,500 $5,000**	 $5,000 $10,000	 $1,750 $3,500**	 $4,000 $8,000
Out of Pocket Max* Individual Family	 $3,600 $6,550**	 $10,000 $21,400	 $3,000 $6,000**	 $10,000 $20,000
Office Visit Co-Pay Primary Specialist	 20% after deductible	 40% after deductible	 20% after deductible	 40% after deductible
Preventative Care Preventative Drugs	100% - plan 100% - plan	40% after deductible	100% - plan 100% - plan	40% after deductible
Hospital Stay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Lab & X-Ray Diagnostics Complex Imaging	 20% after deductible	 40% after deductible	 20% after deductible	 40% after deductible
Emergency Room	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent Care Co-Pay	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drugs* Generic Formulary Non-Formulary	After deductible: $10 $35 $50/$75	No Benefit	After deductible: $10 $35 $50/$75	No Benefit
Mail Order	2 retail co-pays for a 90-day supply		2 retail co-pays for a 90-day supply	

**Prescription drug co-pays are included in the out-of-pocket maximum figure.*

***Individual deductible and out-of-pocket maximum is not applicable if enrolled in family coverage (for example, "Mom" is in the $1,750 Consumer Plan and seeks a lot of care in 2017 and hits $1,750 of health care expenses. She will continue to pay until she hits the family in-network deductible of $3,500 since she is enrolled as a family unit).*

PLEASE NOTE: *Our plans do offer coverage for chiropractic care, mental health and physical therapy. For more details, refer to Summary Plan Descriptions*

Medical & Prescription Care

Premium Costs

Premium costs per paycheck are listed below. We are deducting premiums over 24 paychecks. In months where employees receive 3 paychecks, there will only be 2 paychecks worth of benefits deductions.

PER PAYCHECK PAYROLL RATES		
	$2,500 Consumer Plan	$1,750 Consumer Plan
EMPLOYEE ONLY	$23.35	$51.77
EMPLOYEE & SPOUSE	$100.50	$157.33
EMPLOYEE & CHILD(REN)*	$82.22	$139.06
EMPLOYEE & FAMILY*	$159.36	$215.18

** Children can be covered on our plans up to age 26, regardless of student status or marital status.*

Medical ID Cards

Your ID cards will be mailed to you directly from Cigna. Your ID cards will be universal cards, to be used for both medical care and when purchasing prescriptions. Do not discard your current ID cards until your ATS benefits are effective. You may also login at MyCigna and print temporary cards or order new permanent cards.

For Open Enrollment, you will receive your ID cards prior to January 1st.

1-2, 1-2:
Find a Fitness Friend
to keep you motivated
to exercise!

Medical & Prescription Care

How do the Consumer Plans with HSA work?

The Consumer Plan requires the member to meet his/her deductible fully before the co-insurance applies. This means that office visits and non-preventative prescription drugs are paid for fully by the member until the deductible is reached.

For more information on Cigna Consumer driven Health Care Plans and HSA Accounts, please click here.

For example: *Jane Smith has a cold and makes an appointment with her physician. If the physician's office visit costs $68 (after Cigna's in-network discount), Jane will pay $68. She will not pay a co-pay.*

This plan also requires that the full family deductible (e.g. $3,500 for in-network care) be met if you have enrolled any dependents at all. In other words, all members claims accumulate towards the family deductible before the plan begins to share in your eligible medical expenses. There is no "Individual" deductible or out of pocket maximum unless you are enrolled in the employee only tier.

For example: *Sally John covers her entire family on the ATS medical plan. No one in the family unit has used any medical care during the year. In March, she has to undergo surgery and it costs $3,500 (after Cigna's in-network discount). She will pay the full $3,500 because that's the deductible level for a family unit. Once the deductible level is met on the Consumer Plan, co-insurance will apply for all family members.*

Health Savings Account (HSA) Funding

Please be advised that if you choose to enroll in either Consumer Plan, our system will automatically initiate a personal HSA for you (*see page 17 for details*). To activate your account, you will need to call the number on the back of your HSA debit card. The bank may require additional information from you as proof of identity. Once the account is set-up, ATS will fund your account as follows:

Calculate your maximum HSA Contribution with this tool from Health Equity

Please Note: Employees age 65 or older and enrolled in Medicare Part A and/or B are not eligible to open a new HSA or contribute to their existing HSAs.

ATS Contributions to HSAs:

In the table below are the HSA employer contribution dates and lump sum amounts for enrolled eligible employees and newly eligible employees in 2017. The base HSA contributions are prorated based on eligibility date. All eligible employees as of 1/1/2017 will be funded on 1/13/2017. Newly benefit eligible employees' HSAs will be funded according to the scheduled dates throughout 2017.

Remember, you also have the opportunity to increase your HSA employer contribution by $500 by completing an annual wellness exam in 2017. This deposit will be made into your HSA account on the next regular deposit date following confirmation of completion of your wellness exam.

BENEFITS EFFECTIVE DATE *(Date of Hire)*	**EMPLOYEE ONLY**	**ALL OTHER CLASSIFICATIONS** *(ES, EC & EF)*
January 1-31 ***(*fully funded 1/13/2017)***	$500 annual funding	$1,000 annual funding
February 1 - March 31 ***(*fully funded 3/24/2017)***	$500 annual funding	$1,000 annual funding
April 1 - June 30 ***(*fully funded 6/16/2017)***	$375 annual funding	$750 annual funding
July 1 - September 30 ***(*fully funded 9/22/2017)***	$250 annual funding	$500 annual funding
October 1 - December 31 ***(*fully funded 12/15/2017)***	$125 annual funding	$250 annual funding

**Funding takes 3-5 business days from the account funding to show up in your account.*

Medical & Prescription Care

Employee Only Coverage - Comparing Plan Costs

(Assume the following are all in-network services. OOP = Out of Pocket.)

2017	DEDUCTIBLE	OOP MAX
CDHP 2500	$2,500	$3,600
CDHP 1750	$1,750	$3,000
Difference	$750	$600

2017 PREMIUMS	2500 CDHP	1750 CDHP	DIFFERENCE
BiWeekly	$23.35	$51.77	$28.42
Annual	$560.40	$1,242.48	$682.08

NO MEDICAL EXPENSES IN 2017

Annual Amts	2500 CDHP	1750 CDHP	Difference
Premiums	$560.40	$1,242.48	$682.08
Deductible	$0	$0	$0
OOP Expense	$0	$0	$0
OOP Max	$0	$0	$0
ATS HSA Cont	($500)	($500)	$0
Net Cost	$60.40	$742.48	$682.08

OUT OF POCKET MAX HIT IN 2017

Annual Amts	2500 CDHP	1750 CDHP	Difference
Premiums	$560.40	$1,242.48	$682.08
Deductible	$2,500	$1,750	$750
OOP Expense	$1,100	$1,250	$150
OOP Max	$3,600	$3,000	$600
ATS HSA Cont	($500)	($500)	$0
Net Cost	$3,660.40	$3,742.48	$82.08

In the illustrations above, you can see that there is a $682.08 annual difference between the two plans in a year where there are no medical expenses incurred. If you have a year where you would need to use the maximum amount of health insurance benefits in either plan, the difference is $82.08. Because of the relative equivalency of the plans' ultimate cost in using healthcare services at the maximum, the decision of which plan to choose comes to the following: do you want pay the higher premiums for a reduction in the amount you would be ultimately responsible for paying in a high utilization year or do you want to pay the lower premium and manage the risk of the additional amount of out-of-pocket expenses you would ultimately be responsible for paying in a high utilization year?

KNOW YOUR BODY MASS INDEX (BMI)!

BMI Chart

	21	22	23	24	25	26	27	28	29	30	31
4'10"	100	105	110	115	119	124	129	134	138	143	148
5'0"	107	112	118	123	128	133	138	143	148	153	158
5'1"	111	116	122	127	132	137	143	148	153	158	164
5'3"	118	124	130	135	141	146	152	158	163	169	175
5'5"	126	132	138	144	150	156	162	168	174	180	186
5'7"	134	140	146	153	159	166	172	178	185	191	198
5'9"	142	149	155	162	169	176	182	189	196	203	209
6'0"	150	157	165	172	179	186	193	200	208	215	222
6'1"	159	166	174	182	189	197	204	212	219	227	235
6'3"	168	176	184	192	200	208	216	224	232	240	248

BMI Key

CLASSIFICATION	BMI	NOTE
Normal Weight	18.5 - 24.9	Good for you. Maintain your healthy weight.
Overweight	25 - 29.9	Do not gain any weight. You need to lose weight if you have 2 or more risk factors for heart disease, or have high waist circumference.
Obese	30+	You need to lose weight. Consult a physician or nutritionist.

Medical & Prescription Care

Family Coverage - Comparing Plan Costs

(Assume the following are all in-network services. OOP = Out of Pocket.)

2017	DEDUCTIBLE	OOP MAX
CDHP 2500	$5,000	$6,500
CDHP 1750	$3,500	$6,000
Difference	$1,500	$1,200

2017 PREMIUMS	2500 CDHP	1750 CDHP	DIFFERENCE
BiWeekly	$159.36	$215.18	$55.82
Annual	$3,824.64	$5,164.32	$1,339.68

NO MEDICAL EXPENSES IN 2017

Annual Amts	2500 CDHP	1750 CDHP	Difference
Premiums	$3,824.64	$5,164.32	$1,339.68
Deductible	$0	$0	$0
OOP Expense	$0	$0	$0
OOP Max	$0	$0	$0
ATS HSA Cont	($1,000)	($1,000)	$0.00
Net Cost	$2,824.64	$4,164.32	$1,339.68

OUT OF POCKET MAX HIT IN 2017

Annual Amts	2500 CDHP	1750 CDHP	Difference
Premiums	$3,824.64	$5,164.32	$1,339.68
Deductible	$5,000	$3,500	$1,500
OOP Expense	$1,500	$2,500	$1,000
OOP Max	$6,550	$6,000	$550
ATS HSA Cont	($1,000)	($1,000)	$0
Net Cost	$9,374.64	$10,164.32	$789.68

In the illustrations above, you can see that there is a $1339.68 annual difference between the two plans in a year where there are no medical expenses incurred. If you have a year where you would need to use the maximum amount of health insurance benefits in either plan, the difference is $789.68. Because of the relative equivalency of the plans' ultimate cost in using healthcare services at the maximum, the decision of which plan to choose comes to the following: do you want pay the higher premiums for a reduction in the amount you would be ultimately responsible for paying in a high utilization year or do you want to pay the lower premium and manage the risk of the additional amount of out-of-pocket expenses you would ultimately be responsible for paying in a high utilization year?

Tips for Saving Money on Prescription Drugs

If you or a member of your family are on a maintenance drug that is required each month, consider participation in the Cigna Home Delivery Pharmacy; it's a mail order program that allows you to receive three months of prescription drugs at a lesser cost than accessing the pharmacy. Cigna Home Delivery Pharmacy can be set-up by contacting Cigna at 800.285.4812.

MEDICAL PLAN ELECTION	MAIL ORDER COST
Consumer Plans	Once deductible is met, 2 retail co-pays for 90 day supply

Medical & Prescription Care

Tips for Choosing a Plan

Why do you need health insurance?
As medical care advances and treatments increase, health care costs also increase. The purpose of health insurance is to help you pay for care. It protects you and your family financially in the event of an unexpected, serious illness or injury that could be very expensive. In addition, you are more likely to get routine and preventive care if you have health insurance.

You need health insurance because you cannot predict what your medical bills will be. In some years, your costs may be low. In other years, you may have very high medical expenses. If you have health insurance, you will have peace of mind in knowing that you are protected from most of these costs. You should not wait until you or a family member becomes seriously ill to try to purchase health insurance.

There is also a link between having health insurance and getting better health care. Research shows that people with health insurance are more likely to have a regular doctor and to get care when they need it.

There are some basic questions you may want to ask yourself as you select your health insurance plan:

QUESTIONS TO CONSIDER	
1. How affordable is the care? (cost of care)	• How much will premiums cost me on a monthly basis? • Do I need to cover any children up to age 26? • What are the deductibles I must pay before the insurance helps to cover my cost? • After I have met the deductible, what parts of the cost are paid by the plan? • If I plan to use doctors outside the plan network, how much more will I pay? • Are there any limits to how much I must pay in case of major illness?
2. Do the included services match my needs? (access of care)	• Are the primary care physicians, specialists, hospitals, and other medical providers that I typically use part of the plan? • Where will I go for care? Are these places near where I work or live? • Is the prescription medication that I need covered by the plan?
3. What is my family's recent healthcare use history?	Look at what you spent last year. If you notice you didn't go to the doctor very much, or didn't get a lot of prescriptions, and you have some savings, you might consider the plan with the less expensive premiums. The deductibles will likely be higher, but even if you have to visit your primary care physician once or twice, it'll probably still be cheaper. Conversely, if you have used a lot of healthcare services, you might consider a plan with a lower deductible and lower out-of-pocket maximum, even if the premiums are slightly higher.

Dental Care

ATS offers its employees three plan options.

Healthy teeth are an important part of your overall well-being! In 2017 we will offer 2 "PPO" Plans; the differences between these are shown below.

Note: *It will not be an option to switch between Dental Plans in 2017; the plan you sign up for at open enrollment will be your plan for the entire plan year unless you experience a qualifying life event.*

DENTAL PLAN ELEMENT	CIGNA – DENTAL HMO***	CIGNA - ENHANCED PPO	CIGNA - BASIC PPO	
	In Network Only	In and Out of Network (same coverage)	In Network	Out of Network
Deductible				
Individual	$0	$50	$50	$50
Family	$0	$150	$150	$150
Preventative Services	$0 co-pay	100%**	100%**	80%**
Basic Services+	$15 - $100	80%**	80%**	60%**
Major Services+	$50 - $675	50%**	50%**	30%
Orthodontia	Refer to charge schedule	Lifetime max of $1,000*	None	
Maximum Annual Benefit	Not applicable	$2,000 (separate from ortho)	$1,200	
Employee Per Paycheck Cost				
Employee Only	$7.47	$16.73	$12.18	
Employee & Spouse	$14.91	$33.44	$24.35	
Employee & Child(ren) (to age 26)	$16.04	$35.94	$26.16	
Employee & Family	$24.24	$54.33	$39.56	

**Only applies to dependents up to age 19*

***Of maximum allowable fee.*

**** A specific dentist must be designated for each covered participant. If you do not use your designated dentist for services, you will not have dental coverage for the procedure(s).*

+Estimates only, please refer to **patient charge schedule**.

Vision Care

ATS offers its employees a comprehensive vision plan through VSP. To use services, ID cards are not required. To find a provider, log on to vsp.com.

VISION PLAN ELEMENT		
Benefit Frequencies		
Exam and Lenses	Approved every 12 months	
Frames	Approved every 24 months	
Plan Benefits	**In Network**	**Out of Network**
Exam	$20 co-pay	Up to $34
Lenses		
Single	$10 co-pay	Up to $17
Bifocal	$10 co-pay	Up to $30
Trifocal	$10 co-pay	Up to $43
Lens Options	10 – 25% discount	No coverage
Frames	100% to $130 20% discount on balance over $130	Up to $38.25
Contacts		
In lieu of eyeglasses	100% up to $130	Up to $100
Medically necessary	Co-pay then 100%	Up to $210
Contact Lens fit	15% discount	No coverage
LASIK Surgery/PRK	15% discount off retail, or 5% off discount pricing	No coverage
Employee Per Paycheck Cost		
Employee Only	$4.37	
Employee & Spouse	$6.99	
Employee & Child(ren)	$7.13	
Employee & Family	$11.50	

Wellness Fact:

Annual eye exams not only help correct vision problems; comprehensive eye exams can also reveal the warning signs of more serious undiagnosed health problems such as hypertension, cardiovascular disease, and diabetes.

Accidental Injury Coverage

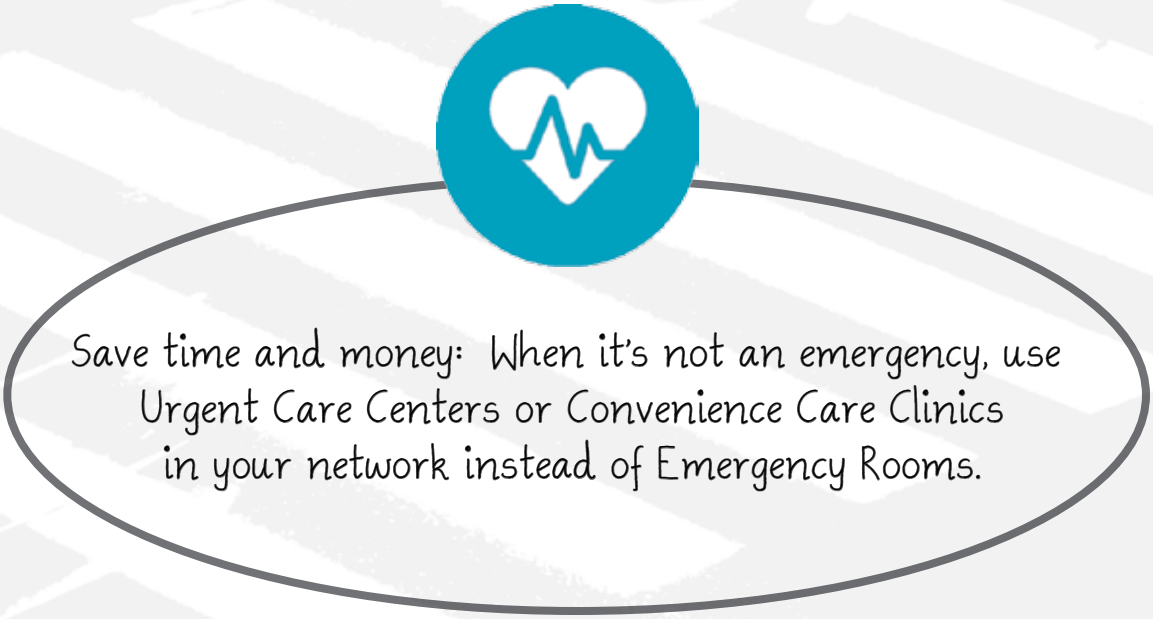
- Plan pays a scheduled lump sum cash benefit for a broad range of accident treatments and conditions **off-the-job**
- Benefits not intended to cover all medical expenses
- Not a substitute for comprehensive health insurance

Benefit Amounts and Coverages

- Three plan levels
- Initial care and emergency care
- Hospitalization
- Fractures
- Dislocations
- Follow-up care
- Portability
- Enhanced benefits

COVERAGE	PLAN 1	PLAN 2	PLAN 3
Employee	$3.90	$7.51	$10.96
EE + Spouse	$6.43	$12.42	$18.14
EE + Child(ren)	$8.94	$17.39	$25.44
EE + Family	$11.47	$22.31	$32.62

To learn more about Accidental Injury coverage and see a complete list of coverage, review the Summary Plan Document located **Here.** Document is also located on the Accidental Injury enrollment page in ADP. Enrollment in ATS medical insurance is *not* required for enrollment in Accidental Injury coverage. Refer to the Summary Plan Document to learn what exclusions exist in this plan.



Additional Programs

401(k) Retirement Plan

ATS offers an incredible 401(k) retirement plan through MassMutual.

If you are not enrolled, you are walking away from free money! Give yourself a raise today! Even better – the money ATS contributes is vested immediately, which means it is yours, no matter what!

IF YOU CONTRIBUTE…	ATS WILL CONTRIBUTE ANOTHER…	EXAMPLE: IF YOU EARN $30,000	EXAMPLE: IF YOU EARN $80,000
1%	1%	You contribute $300, ATS gives you $300	You contribute $800, ATS gives you $800
2%	2%	You contribute $600, ATS gives you $600	You contribute $1,600, ATS gives you $1,600
3%	3%	You contribute $900, ATS gives you $900	You contribute $2,400, ATS gives you $2,400
4%	3.5%	You contribute $1,200, ATS gives you $1,050	You contribute $3,200, ATS gives you $2,800
5%	4%	You contribute $1,500, ATS gives you $1,200	You contribute $4,000, ATS gives you $3,200

You are eligible to participate in the program the first day of the month following 30 days of your hire date, and if you are at least 21 years of age. All full-time and part-time employees who meet those requirements are eligible to participate. Temporary employees and interns are eligible if working more than 1,000 hours annually.

To enroll, CLICK HERE. You may change your election at any time during the year.

For further information, refer to the Summary Plan Description posted to myATS.

* **PLEASE NOTE:** *The 2017 annual 401(k) maximum is $18,000 (pre-tax). In other words, employees cannot contribute more than $18,000 (pre-tax) into their accounts unless they are eligible for catch-up contributions (employees over age 50 may contribute an additional $6,000). These maximums are not inclusive of the employer matching dollars.*

Disability Programs

The ATS short-term disability (STD) and long-term disability (LTD) benefits provide a weekly source of income if you have an illness or injury that keeps you out of work for an extended period of time.

PROGRAM ELEMENT	STD	LTD
Benefit Amount	60% of weekly income*	60% of monthly income*
Maximum Benefit	$1,000 per week	$15,000 per month
Maximum Benefit Period	25 weeks	5 years
Waiting Period	7 days	180 days
Cost to Employee	FREE	FREE

**Calculated on base earnings only.*

Additional Programs

Employee Assistance Program

Sun Life is our vendor for the ATS Employee Assistance Program.

Sun Life provides 24/7 confidential counseling to help address behavioral health or other personal issues facing employees and their dependents (marriage and relationship issues, stress and anxiety, depression, addictionproblems, parenting, legal consultation, senior care, anger management, grief and loss). This service is available by calling a toll-free phone line operating 24 hours a day, 7 days a week. You may meet with a counselor for three face-to-face sessions per occurrence each year.

Company Web ID: EAPBusiness

- 24/7 Phone Line: **877.595.5281/** TDD:**800-697-0353**
- Web: **CLICK HERE**

Flexible Spending Program

ATS offers a Dependent Care Flexible Spending Account that allows you to set aside pre-tax dollars to pay for certain dependent care expenses.

FLEXIBLE SPENDING ACCOUNT	CONTRIBUTION LIMITS *(per paycheck)*	EXAMPLES OF COVERED EXPENSES
Dependent Care Reimbursement*	Up to $208 (up to $5,000 annually)	To view a list of typical dependent care expenses and eligibility for reimbursement, **CLICK HERE.**

**A dependent receiving day care or elder care must live in your home at least 8 hours each day.*

Health Savings Account

HSA ACCOUNT	CONTRIBUTION LIMITS *(per paycheck)*	EXAMPLES OF COVERED EXPENSES
Health Savings Account (HSA)* Employee Only Any other tier Cannot elect unless enrolled in Consumer Plan. **CLICK HERE** to view IRS guidelines for further HSA qualifications.	Up to $120.83* ($2,900/yr) Up to $239.58* ($5,750/yr) *Assuming no other HSA incentives are met for the year *ATS will make a contribution (see page 9).	Deductibles,Co-insurance, Dental, Vision care, etc. **Click here for IRS guidelines**
A Health Savings Account (HSA) is a pre-tax account that you can use to reimburse certain medical expenses and other health-related expenses you incur. **If you enroll in our Consumer Plan**, our system will automatically initiate a Health Savings Account for you. The bank may require additional information from you as proof of identity.		
Health Savings Account (HSA) Catch-Up (age 55+ by Dec. 31, 2017)		

**An employee owned account; per the IRS 2015 maximum account contributions are: Single: $3,400; Family: $6,750*

Life Insurance

Life & Accidental Death and Dismemberment (AD&D)

ATS provides basic life insurance and AD&D **FREE** to all employees. Enrollment is automatic as soon as an employee becomes eligible (first of the month following 30 days of employment or benefits eligibility date). **Be sure to designate your basic life insurance beneficiary.**

Please understand that you will be taxed on any benefit received above $50,000. The payroll taxation code is GTL – Group Term Life.

AMOUNT OF BENEFIT PROVIDED*
1x base earnings** up to $400,000

**Employee coverage automatically reduces to 50% at age 70. For example, if an employee has $50,000 of coverage and turns age 70, the coverage would drop to $25,000. Coverage for employees below 70 is rounded to the next highest $1,000 increment.*

*** Base salary is not inclusive of any bonus or commission income, if received.*

Life & AD&D – Voluntary

Employees also have the option to elect voluntary life and AD&D coverage.

Coverage is available for dependents as well. Any increase in coverage requires a physical exam/ evidence of insurability (EOI). New hires are not required to complete an EOI if the coverage level elected is $150k or less for employee and $30k or less for spousal coverage. Further, EOI is not required for child coverage. **Be sure to designate your voluntary life insurance beneficiary.**

PROGRAM ELEMENT	COVERAGE OPTIONS*	MONTHLY COST
EMPLOYEE	$10,000 increments, up to 5x annual earnings or $300,000 *(the lesser of)*	See age bands
SPOUSE/DOMESTIC PARTNER**	$5,000 increments, up to $150,000; cannot exceed 50% of employee's voluntary life	See age bands
DEPENDENT CHILD(REN)+ *(domestic partner children not eligible; married children not eligible)*	$10,000	$1.87

**Employee coverage automatically reduces to 50% at age 70. For example, if an employee has $50,000 of coverage and turns age 70, the coverage would drop to $25,000. In addition, spousal coverage is based on spouse's age. Coverage for employees and spouses below 70 is rounded to the next highest $1,000 increment. Dependent child coverage is eliminated when the child turns age 26.*

***To enroll in spouse coverage, employee must have voluntary employee coverage.*

+ Coverage for children is $0 if the child is < 14 days old, and $250 if the child is < 6 months old.

AGE*	MONTHLY COST PER $1,000
Under 20	$0.055
20 – 24	$0.055
25 – 29	$0.064
30 – 34	$0.081
35 – 39	$0.090
40 – 44	$0.116

AGE*	MONTHLY COST PER $1,000
45-49	$0.151
50 – 54	$0.211
55 – 59	$0.359
60 – 64	$0.489
65 – 69	$0.820
70+	$2.131

**Spousal optional life insurance cost is based on spouse's age.*

Time Off

ATS believes in the restorative benefit of time off so we encourage our employees to use their time off banks, and rejuvenate.

Paid Time Off (PTO) Bank

Our PTO policy provides a lump sum allotment per year, and offers a carryover provision. Unused PTO can be carried over at a maximum of 40 hours except where laws may differ. For information on your PTO balance, please refer to your paycheck. Part-time employees are eligble for **partial** PTO.

We will drop 100% of your PTO into your bank effective January 1. These hours will be allotted based on your tenure of one year or more with ATS or prorated based on your date of hire. Please remember that these banks of hours are to be used for any sick time you need as well.

TENURE WITH ATS	PTO BANK
Less than 3 years	136 hours
3-5 years	160 hours
6-8 years	176 hours
9+ years	200 hours

Holidays

ATS recognizes the following paid holidays in 2017:

HOLIDAY	DATE
New Year's Day	Monday*, January 2, 2017
Memorial Day	Monday, May 29, 2017
Independence Day	Tuesday, July 4, 2017
Labor Day	Monday, September 4, 2017
Thanksgiving Day	Thursday, November 23, 2017
Day after Thanksgiving	Friday, November 24, 2017
Christmas Day	Monday, December 25, 2017
	**Sunday holiday observed Monday*

Did you know?

Employees who use PTO are less likely to burn out and more likely to maintain productive levels.

Legal Disclaimer

The ATS Health and Welfare Plans (the "Plan(s)") are designed to provide Employees of ATS who have satisfied conditions of eligibility with certain health and welfare benefits. This Benefits Enrollment Guide ("Guide") is intended to highlight certain eligibility and enrollment information. Please be advised that this is NOT a Summary Plan Description ("SPD") for the Plans. The SPDs for the Plans can be found on *myATS.*

If you have questions after reviewing the content of the Guide, please contact Human Resources. In case of any conflicts between this Guide and the SPDs or Plan documents, the terms of the SPDs will override.

Health Plan Notices

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 30 days after 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 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact :

Matt Alessandri | HRIS Analyst
American Traffic Solutions, Inc.
1150 N. Alma School Road | Mesa, Arizona 85201
T 480 596 4614| F 480 967 7131
matt.alessandri@atsol.com

WOMEN'S HEALTH AND CANCER RIGHTS ACT DISCLOSURE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance shown in the Medical section of this guide apply. If you would like more information on WHCRA benefits, call your plan administrator at (480) 596-4614.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

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).

Health Plan Notices

IMPORTANT NOTICE FROM AMERICAN TRAFFIC SOLUTIONS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with American Traffic Solutions, Inc. 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. If you are considering joining, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about this plan's coverage and Medicare's prescription drug coverage:

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. American Traffic Solutions, Inc. has determined that the prescription drug coverage offered by the American Traffic Solutions, Inc.'s Consumer Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You 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 to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current American Traffic Solutions coverage will be affected. If you keep both your group coverage and also enroll in a Medicare Part D Plan, the group plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current American Traffic Solutions, Inc. group health plan coverage, be aware that you and your dependents may not be able to get this coverage back.

Health Plan Notices

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with American Traffic Solutions, Inc. 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 creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare 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 October to join.

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, therefore, whether or not you are required to pay a higher premium (a penalty).

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 American Traffic Solutions, Inc. changes. You also may request a copy of this notice at any time.

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 for personalized help
- Call 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048

Date: 10/14/2016
American Traffic Solutions, Inc.
1150 N Alma School Road, Mesa, Arizona 85201
Phone Number: (480) 596-4614

Health Plan Notices

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 July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS-Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO-Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

Health Plan Notices

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

Health Plan Notices

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
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	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, 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)

Health Plan Notices

Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by American Traffic Solutions health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the American Traffic Solutions Cigna Consumer Plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you
The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not American Traffic Solutions as an employer — that's the way the HIPAA rules work. Different policies may apply to other American Traffic Solutions programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information
The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with ATS
The Plan, or its health insurer, may disclose your health information without your written authorization to American Traffic Solutions for plan administration purposes. American Traffic Solutions may need your health information to administer benefits under the Plan. American Traffic Solutions agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The Benefits staff in Human Resources are the only American Traffic Solutions employees who will have access to your health information for plan administration functions.

Health Plan Notices

Here's how additional information may be shared between the Plan and American Traffic Solutions as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose "summary health information" to American Traffic Solutions if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer, may disclose to American Traffic Solutions information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.
- In addition, you should know that American Traffic Solutions cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by American Traffic Solutions from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information
In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)

Health Plan Notices

Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights
You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse
You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Health Plan Notices

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request
- You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete
With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Health Plan Notices

Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below. You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)
- In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on September 23, 2013. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice which will be provided to you electronically via E-Mail and on the company website.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact Matt Alessandri at matt.alessandri@atsol.com, (480) 596-4614 or 1150 N. Alma School Road, Mesa, Arizona 85201

Contact
For more information on the Plan's privacy policies or your rights under HIPAA, contact Matt Alessandri as well.