



November 2016

Dear Fellow Employee:

Attached is your 2017 Open Enrollment information for health insurance. Open Enrollment is your once-a-year opportunity to make changes to your benefit elections. **The deadline to make changes is November 30, 2016.**

2017 Benefits

In this packet, we have summarized the benefits offered and the new costs for 2017. It should be no surprise to anyone that the cost of healthcare continues to increase and our company is no exception. Nationally, employer sponsored health plans are seeing increases that average approximately 6.5%. For our Enhanced PPO the cost increase is about 7.5% for both employees and the company. However, we are pleased to announce that the increase for both the Value PPO Plan and the Health Savings Account PPO Plan is just 2% for 2017.

In addition, the health plans will no longer be considered “grandfathered” under the provisions of the Affordable Care Act. As a result, beginning January 1, 2017, our plans are improved in several ways:

- Preventive care will be covered at 100% with no cost sharing (deductible, co-payment, or co-insurance) provided the service are received by in-network providers;
- Women’s Preventive Care service will also be covered at 100% with no cost sharing (deductible, co-payment, or co-insurance) provided the services are received by in-network providers. Details of what services are included can be found on the Women’s Preventive Care Services supplement included in this packet;
- Certain tobacco cessation drugs will be covered with no-copayment. Details are in the Tobacco Cessation supplement;
- Maximum out-of-pocket limits now include the dollars spent on copays, deductibles and prescription costs.

Healthy Directions

In addition, we are continuing the *Healthy Directions Wellness Program* for 2017. By participating in this program, you will receive a discount on your health insurance of approximately 17%. There are two ways you can participate:

- **Fitbit Program:** You qualify for the quarterly discount by averaging 6,000 steps per day.
- **Biggest Loser Program:** You qualify for the quarterly discount by meeting the weight loss goals of the program.

Retiree Medical Plan Discontinued

The company has recently completed a review of our benefits programs, which including retiree medical benefits. The results of this review, combined with the overall increasing cost of healthcare and the availability of individual coverage options created by the Affordable Care Act have all impacted our decision to make some critical changes.

The Affordable Care Act, or Health Care Reform, made Public Healthcare Exchanges available to all United States residents, and many employers have recently reduced or eliminated retiree medical benefits altogether. Decreasing enrollment in the company plan and the steadily

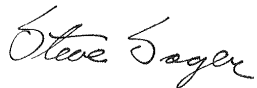
increasing cost of providing coverage have both contributed to company's decision to make that change as well.

A thorough comparison of the company's retiree medical plan with other available options uncovered a variety of health plans, available through outside sources, many of which offer coverage that is more flexible than the plan offered by the company. Some of these plans are also available at a lower cost than the coverage offered by company. Based on these findings, the company will not be offering company provided retiree medical benefits to former employees going forward.

Questions

If you have any questions about your benefits, please feel free to contact Vickie Hurt (Ext. 62531) or Tina Reed (Ext. 63033) in your Human Resources Department.

Sincerely,



Steve Sager
Director, Human Resources

Your 2017 Open Enrollment Guide

Open Enrollment is your once-a-year opportunity to enroll or re-enroll for your benefits for benefit year 2017. This informational guide is being provided to you to help you elect your 2017 benefits. All changes are effective January 1, 2017. Please carefully review the information provided and follow the three (3) easy steps to complete your enrollment.

The deadline to complete your enrollment is November 30, 2016.

Note: If you are currently enrolled in benefits and are not making changes to your benefits for 2017, you do not need to complete the online elections unless you want to continue or enroll in flexible spending account (FSA) or health savings account (HSA).

What's New for 2017?

Medical Plans (see pages 15-18 for more details)

Beginning January 1, 2017, both plans will cover:

- Preventive care will be covered at 100% with no cost sharing (deductible, co-payment, or co-insurance) provided the services are received by in-network providers;
- Women's Preventive Care service will also be covered at 100% (deductible, co-payment, or co-insurance) provided the services are received by in-network providers. Details of what services are included can be found on the Women's Preventive Care Services supplement included in this packet;
- Certain tobacco cessation drugs will be covered with no-copayment. Details are in the Tobacco cessation supplement;
- Maximum out-of-pocket limits now include the dollars spent on copays, deductibles and prescription costs.
- There are new employee contributions for 2017.

Health Savings Account (See page 6 for details)

The amount you can contribute to a Health Savings Account increased \$50 to \$2,900 for Single coverage. Family coverage did not increase.

Dental and Vision Benefits

There are new contributions in 2017.

Retiree Medical Plan

The retiree medical plan is being discontinued effective December 31, 2016.

1. Review your choices

Medical Insurance

These medical options are administered by United HealthCare.

You have 2 or 3 choices:

1. Enhanced PPO – Available only to employees hired (or rehired) on or before December 31, 2015.
2. Value PPO
3. Health Savings Account PPO

Enhanced PPO

This plan option offers affordable co-payments for in-network doctor office visits and prescription medications. Most other in-network medical services are covered at 100% after the annual deductible. The annual in-network deductible is \$450 per covered individual and \$900 for families. The plan has an annual out-of-pocket maximum of \$1,800 for individuals and \$3,600 for families. Out-of-network services have lesser coverage.

Highlights of In-Network Coverage:

- The primary care office visit co-payment is \$25, and the specialist co-payment is \$35 with no deductible.
- The deductible is \$450 for individuals and \$900 for families.
- Coverage for hospital stays, x-rays, laboratory services, surgeries, and most other services are covered at 100% after satisfying your annual deductible.
- Prescription drugs are covered with a co-payment as described on page 18 with no deductible.

2017 Employee Contributions

	Bi-weekly Base	Bi-weekly Wellness
Employee Only	\$ 110.97	\$ 92.47
Employee & Spouse	\$ 233.47	\$ 194.55
Employee & Child (ren)	\$ 192.97	\$ 160.80
Employee, Spouse & Child (ren)	\$ 346.07	\$ 288.38

Value PPO Plan

This plan option offers affordable co-payments for in-network doctor office visits and prescription medications. Most other in-network medical services are covered at 80% after the annual deductible. The annual in-network deductible is \$725 per covered individual and \$1,450 for families. The plan has an annual out-of-pocket maximum of \$3,100 for individuals and \$6,200 for families. Out-of-network services have lesser coverage.

Highlights of In-Network Coverage:

- The primary care office visit co-payment is \$25, and the specialist co-payment is \$35 with no deductible.
- The deductible is \$725 for individuals and \$1,450 for families.
- Coverage for hospital stays, x-rays, laboratory services, surgeries, and most other services are covered at 80% after satisfying your annual deductible.
- Prescription drugs are covered with a co-payment as described on page 18 with no deductible.

Value PPO Plan

2017 Employee Contributions

	Bi-weekly Base	Bi-weekly Wellness
Employee Only	\$ 77.81	\$ 64.84
Employee & Spouse	\$ 163.72	\$ 136.43
Employee & Child (ren)	\$ 135.32	\$ 112.76
Employee, Spouse & Child (ren)	\$ 242.70	\$ 202.24

Health Savings Account PPO

This plan uses a Health Savings Account (HSA) to help pay for your medical expenses and puts you in control of your health care cost. A Health Savings Account allows you to save money for medical expenses on a pre-tax basis, reducing your taxable income. If you don't spend the money, it remains in your account for next year.

To help fund your HSA, the company will contribute \$500 (single coverage) or \$1,000 (family coverage) into your account. Contributions are prorated and paid on a bi-weekly basis throughout the year. You can also contribute to your HSA on a pre-tax basis up to \$2,850 annually (for single) and \$5,750 (family). Your account comes with a debit card that you can use to pay for doctor visits, prescriptions, and other medical expenses not covered by the insurance. You also earn interest on your money in the account from the bank.

Along with your HSA, this option includes a catastrophic insurance plan to pay for "big ticket" medical expenses. The plan has a deductible of \$1,550 per person or \$3,100 for families¹ and provides 80% coverage for in-network services.

Highlights of In-Network Coverage:

- Health Savings Account includes annual company contributions of \$500 (single) or \$1,000 (family). You can contribute up to \$2,850 annually for individuals and \$5,750 for families. If you are age 55 or older, you can contribute an additional \$1,000.
- Deductible is \$1,550 per person or \$3,100 for families (see footnote 1).
- Coverage for hospital stays, doctor visits, x-rays, laboratory services, surgeries, and most other services are covered at 80% after satisfying your annual deductible.
- Out-of-pocket maximum is \$4,300 for individuals and \$8,600 for families.
- Prescription drugs are covered with a co-payment as described on page 18 after the deductible is met.

2017 Employee Contributions

	Bi-weekly Base	Bi-weekly Wellness
Employee Only	\$ 43.87	\$ 36.56
Employee & Spouse	\$ 101.48	\$ 84.56
Employee & Child (ren)	\$ 83.88	\$ 69.89
Employee, Spouse & Child (ren)	\$ 150.44	\$ 125.36

¹ Unlike the Enhanced & Value PPO plans, if you elect the family plan you must reach the \$3,100 deductible before the plan will pay any benefit.

Dental Insurance

Both dental options are administered by MetLife.

YOU HAVE TWO PLANS TO CHOOSE FROM:

Enhanced Dental

This option provides coverage for preventive care, dental treatment, and orthodontia.

2017 Employee Contributions

(Includes Vision Benefit)

	Bi-weekly
Employee Only	\$ 9.41
Employee & Spouse	\$ 18.36
Employee & Child (ren)	\$ 21.98
Employee, Spouse & Child (ren)	\$ 30.93

Basic Dental

This option provides coverage for preventive care and dental treatment. There is no coverage for orthodontia.

2017 Employee Contributions

(Includes Vision Benefit)

	Bi-weekly
Employee Only	\$ 7.82
Employee & Spouse	\$ 15.18
Employee & Child (ren)	\$ 18.18
Employee, Spouse & Child (ren)	\$ 25.53

Vision Benefits

Vision benefits are administered by EyeMed.

If you elect one of the Dental options, vision benefits are included.

Vision Plan

The cost of the vision benefits is included in the cost of the dental plans. The plan pays up to \$50 for one eye exam per year per covered person and up to \$100 per year per covered person toward the purchase of glasses or contacts.

Flexible Spending Account (FSA)

This plan is administered by United HealthCare.

Medical FSA

The Medical FSA allows you to contribute pre-tax dollars to an account that you can then use to pay for medical, dental, and vision expenses that are not covered by insurance. Examples include: deductibles, co-insurance, co-payments, and other out-of-pocket expenses. For a complete list of eligible expenses see IRS publication 502 at www.irs.gov. By using a FSA, you reduce your taxable income for the year by the amount you contribute to the program which saves you money. As a result of Affordable Care Act the annual contribution limit for flexible spending accounts is \$2,500.

Due to federal rules, if you elected the Health Savings Account PPO, you are not eligible for the Medical FSA.

Use it or lose it!

You need to carefully budget for 2017. Any leftover 2016 money that is not used by March 15, 2017, will be forfeited to the Company.

Health Savings Accounts (HSA)

This plan is administered by United HealthCare.

If you elected the HSA PPO for your medical insurance, the company will contribute \$500 per year for single coverage or \$1,000 per year for family coverage to help offset the cost of the high deductible. The contribution is 1/26th of the \$500 or \$1,000 over each pay period of the year. You also may contribute up to \$2,900 for single or \$5,750 for families to the Health Savings Account each year.

IMPORTANT: If you elect this option, you must open a Health Savings Account with Optum Health Bank. If you are electing this benefit for the first time or if you are already enrolled in this option and have not yet opened an Optum Health Bank Health Savings Account, please visit www.optumhealthbank.com to open your account. Once your account is opened, you will receive a debit card to pay for medical expenses that are subject to the deductible or not covered by insurance, such as orthodontia, hearing aids, Lasik surgery, co-payments, etc.

The Money is Yours to Keep

NO "Use it or lose it"

Unlike the Flexible Spending Account, any leftover money at year-end is never forfeited but remains in your account until you need to use it. The money earns interest while it is in your account.

You must elect the HSA PPO as your medical insurance to be eligible for the Health Savings Account. If you elected the Enhanced or Value PPO plans you are not eligible for the Health Savings Account.

Life Insurance, AD&D, STD, & LTD

These plans are insured by The Hartford.

For Full-time Employees Only:

Company-paid Life Insurance and Accidental Death & Dismemberment (AD&D) coverage is paid by the Company. Your benefit is 1.5 times your base annual pay for life insurance and an additional 1.5 times base annual pay for AD&D coverage (up to certain limits).

The Company shares the cost of Short Term Disability with you. Long Term Disability is automatically provided to full time employees with one year of full-time service. If you have not previously elected Short Term Disability, and wish to do so at this time, you will be subject to Evidence of Insurability. Please contact Human Resources for more information.

Voluntary Accident Insurance

This plan is insured by CIGNA.

This plan allows employees to purchase accidental death and dismemberment insurance. This plan pays a benefit if you die, lose a limb or eye sight in an accident (on or off the job). You may purchase from \$25,000 up to \$500,000 in coverage but not more than 10 times your annual salary for amounts over \$250,000. You also may purchase family coverage for your spouse and dependent children.

RATES FOR 2017:

Bi-weekly cost:

Employee Principal Amount	Single	Family
\$ 25,000	\$0.35	\$0.64
\$ 50,000	\$0.69	\$1.27
\$ 75,000	\$1.04	\$1.91
\$ 100,000	\$1.38	\$2.54
\$ 125,000	\$1.73	\$3.18
\$ 150,000	\$2.08	\$3.81
\$ 175,000	\$2.42	\$4.44
\$ 200,000	\$2.77	\$5.08
\$ 225,000	\$3.12	\$5.71
\$ 250,000	\$3.46	\$6.35
\$ 275,000	\$3.81	\$6.98
\$ 300,000	\$4.15	\$7.62
\$ 325,000	\$4.50	\$8.25
\$ 350,000	\$4.85	\$8.88
\$ 375,000	\$5.19	\$9.53
\$ 400,000	\$5.54	\$10.15
\$ 425,000	\$5.88	\$10.79
\$ 450,000	\$6.23	\$11.42
\$ 475,000	\$6.58	\$12.06
\$ 500,000	\$6.92	\$12.69

Family members are covered at these levels of the principal sum if you elect the family coverage:

Spouse	50%
Spouse (if no children)	60%
Children	10%
Children (if no spouse)	15%

Group Universal Life Insurance

This plan is insured by Prudential Life and administered by Marsh @ Work Solutions.

ABX Air offers a Group Universal Life (GUL) Insurance program that allows you to purchase up to six times your annual salary in life insurance. This benefit is not subject to Open Enrollment. Evidence of Insurability maybe required for new enrollment. For more information visit www.personal-plans.com/abxair.com/ or call (800) 441-5581 to speak with a customer service representative.

Capital Accumulation Plan / 401(k)

Fidelity Investments is the record keeper and trustee of the 401(k) plan.

Visit www.401k.com or call (800) 835-5095 to enroll, make changes, or request more information. This benefit is not subject to Open Enrollment.

2. Deciding on your choices

You need to decide which coverage you want for 2017.

- A number of resources are available to help you make your choices
- Read pages 15-19 of this brochure for summaries of your options.
- Review the Summary of Benefits and Coverage and a Glossary of Health Coverage and Medical Terms, which is available on Employee Self Service website.
- Call the Human Resources Department at 937-382-5591 ext.# 62531 or ext.# 63033.

Web Resources to check-out:

- CAP/401(k) Plan www.401k.com
- Dental Insurance www.metlife.com/mybenefits
- EyeMed Vision Care www.eyemedvisioncare.com
- Group Universal Life Insurance www.personal-plans.com/abx
- Medical Insurance www.myuhc.com

How does the Deductible Work?

The deductible is the amount you pay before the insurance will pay any benefit. For example, the Value PPO Plan has an individual in-network deductible of \$725. Once the deductible has been satisfied for the calendar year, the plan pays the scheduled benefit. You have to satisfy the deductible only once per calendar year.

To help protect families, each plan has a family deductible. For example, the Value PPO Plan has a family deductible of \$1,450. Once the family as a whole reaches \$1,450 the plan will pay the scheduled benefit. This way each family member does not have to reach the individual deductible.

The Health Savings Account PPO deductible works differently from the Value PPO Plan deductible. Under this plan, if you elect family coverage, the entire family must reach the \$3,100 deductible before the plan pays anything. The \$1,550 individual deductible applies only to people electing single coverage. Remember that the Company contributes to your Health Savings Account to help offset the cost of the deductible.

Certain benefits are not subject to the deductible. Doctor office visits and prescription drug co-payments are not subject to the deductible (except in the Health Savings Account PPO where it is required by law).

Each plan we offer has a different deductible, so you should carefully review your options before enrolling.

How does the Out-of-Pocket Maximum Work?

The out-of-pocket maximum is designed to protect you and your family from catastrophic claims. For example, in the Value PPO Plan, the in-network out-of-pocket maximum is \$3,100. This means the most you would pay is \$3,100 plus the deductible and any co-payments.

An illustration may help. Suppose you had a catastrophic claim and the hospital bill was \$100,000. You are enrolled in the Value PPO plan and you used an in-network hospital. Here's what you would have to pay and what the plan would pay:

Hospital Claim	\$100,000
Deductible	\$ 725 (you pay)
Remaining	\$ 99,275
Plan Pays @ 80%	\$79,480
20% remaining is	\$19,795; out-of-pocket max is \$3,100
Because out-of-pocket maximum reached at \$3,100	
Plan pays 100%	\$16,695 (\$19,795 - \$3,100)
Total you pay	\$ 3,825
Total plan pays	\$96,075

Social Security Numbers for Dependents-

The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires that health plans such as our company's health plan report the social security number of all covered dependents to the Centers for Medicare & Medicaid Services (CMS). This reporting is to allow the CMS to detect potential fraud and cases where a person with Medicare or Medicaid benefits has benefits through an employer.

In order to enroll your dependents in the company's health plan, you will need to provide us with your dependents identification number (social security number). The number will only be used to report to the CMS. If you do not provide your dependents social security number, you cannot cover your dependent under our plan.

You can determine if you have provided us with social security number by clicking on **DEPENDENTS** under **BENEFITS** in Employee Self Service. Click on your dependent's name and click on **CHANGE** to see if the social security number is entered.

Spouse eligibility-

With the passage of the Affordable Care Act, employers have been forced to explore new ways of controlling costs. Implementing a spousal eligibility provision can help by making sure that each employer is responsible for the health coverage of their own employees.

Spouses of employees who are eligible for medical coverage through their employer's health plan will not be eligible to enroll in the company medical plan. If you enroll your spouse in the ABX medical plan you must certify that he or she does not have access to employer-sponsored medical coverage through their job.

If you elect to enroll your spouse in your 2017 benefits, you need to certify enrollment for your spouse before the end of our Open Enrollment period (11/30/16). If your spouse doesn't have an Open Enrollment Period until mid-year 2017, simply fill out the 2017 Spousal Affidavit stating your benefit election for your spouse and list when his/her Open Enrollment period is. **Failure to disclose other coverage will subject you to possible disciplinary action.** 2017 Spousal Affidavit – Medical Coverage is required to be filled out and returned to HR no later than 12/31/16.

IF YOU ELECT DENTAL/VISION COVERAGE FOR YOUR SPOUSE NO AFFIDAVIT IS REQUIRED.

3. Enrolling for 2017

The deadline to enroll or make changes for 2017 benefits is November 30, 2016!

1. Making changes to your enrollment is easy! Go on-line to **EMPLOYEE SELF SERVICE**.
2. After logging in click on **BENEFITS**.
3. Check your **DEPENDENTS** and enter any eligible dependents.
 - Remember that spouses are not eligible for the company medical plan if they are eligible for health insurance through their employer.
 - Refer to pages 12- 13 for more information.
4. Click on **OPEN ENROLLMENT** and make your elections. All changes are effective January 1, 2016. ***Please note that only base prices will be shown.***
 - ***Wellness prices will apply if you complete the quarterly requirements, but will not show up on Self Service.***
5. Click **SUBMIT**.
 - Once you submit your form, the file is forwarded to the Benefits Administrator for approval or rejection.
 - Enrollment with errors will be rejected.
 - It your responsibility to check on the status of your enrollment and make any corrections. **Do not click on “Save as Draft”, as this will NOT submit your election.**
6. Check your enrollment to make sure it has been approved. The Benefits Administrator is committed to processing all enrollments within three (3) business days of submission.

Helpful Hints

- If you would like Self Service to send you an e-mail when your enrollment has been approved, enter your e-mail address under PERSONAL.
- If you elect more than \$250,000 in Voluntary Accident Insurance, be sure you do not elect more than 10 times your annual base salary.
- If you want to know what your current benefits are, click on MY BENEFITS.
- Make sure you enter any dependents before making other changes.
- Make sure you send proof of dependents to the Human Resources Dept. for any dependents not currently enrolled.

2017 Employee Contributions

All amounts are bi-weekly.

Base Medical Premiums			
<u>PPO</u>	<u>Enhanced PPO</u>	<u>Value PPO Plan</u>	<u>HSA</u>
Employee Only	\$110.97	\$ 77.81	\$ 43.87
Employee and Spouse	\$233.47	\$163.72	\$101.48
Employee and Child (ren)	\$192.97	\$135.32	\$ 83.88
Employee, Spouse and Child (ren)	\$346.07	\$242.70	\$150.44

Wellness Medical Discounted Premiums			
<u>PPO</u>	<u>Enhanced PPO</u>	<u>Value PPO Plan</u>	<u>HSA</u>
Employee Only	\$ 92.47	\$ 64.84	\$ 36.56
Employee and Spouse	\$194.55	\$136.43	\$ 84.56
Employee and Child (ren)	\$160.80	\$112.76	\$ 69.89
Employee, Spouse and Child (ren)	\$288.38	\$202.24	\$125.36

*NOTE: The wellness prices will not show up on Self Service.
You will automatically get the discounted prices if you complete the quarterly requirements.*

Dental & Vision Premiums		
	<u>Enhanced Dental & Vision</u>	<u>Basic Dental & Vision</u>
Employee Only	\$ 9.41	\$ 7.82
Employee and Spouse	\$18.36	\$ 15.18
Employee and Child (ren)	\$21.98	\$ 18.18
Employee, Spouse and Child (ren)	\$30.93	\$ 25.53

2017 SCHEDULE OF DENTAL BENEFITS

Plan Feature	Enhanced Dental Plan	Basic Dental Plan
Annual deductible	\$25/person	None
Lifetime deductible	None	\$50/person
Annual maximum benefit	\$2,000 (not including orthodontia)	\$1,500
Diagnostic/preventive services <ul style="list-style-type: none"> • Exams • Cleaning (including periodontal) • Application of fluoride • X-rays • Space maintainers 	100% of R&C* (deductible does not apply)	80% R&C* after deductible
Basic restorative services <ul style="list-style-type: none"> • Fillings/Extractions • Surgery • Endodontics • Periodontal procedures such as bone and gum (gingival) surgery 	80% R&C* after deductible	80% R&C* after deductible
Major restorative services <ul style="list-style-type: none"> • Onlays • Crowns • Bridges 	50% R&C* after deductible	50% R&C* after deductible
Orthodontia & treatment of Bruxism	50% R&C* up to \$1,000 lifetime maximum (deductible does not apply)	Not covered
Emergency treatment	Same as any other covered expense	Same as any other covered expense

* The plan pays benefits based on reasonable and customary (R&C) charges.

2016 SCHEDULE OF VISION BENEFITS

Plan Feature	In-Network	Out-of-Network
Eye Exam	Up to \$50	Up to \$50
Glasses and Frames or contacts	Up to \$100	Up to \$100

SCHEDULE OF MEDICAL BENEFITS – 2017

Medical Plan Features	<u>Enhanced</u>		<u>Value</u>		<u>HSA</u>	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .
NurseLine: Pin 185 1-888-609-5880 A Nurse is available to provide immediate medical info & support 24 hrs/day; 100% covered.						
Preventive Care Routine physical Immunization Pap test Mammogram	100% (deductible and co-payment do not apply)	Not covered	100% (deductible and co-payment do not apply)	Not covered	100% (deductible and co-payment do not apply)	Not covered
Well Baby Care	100% after \$25 copay/office visit up to 2 nd birthday (deductible does not apply)	Not covered	100% after \$25 copay/office visit up to 2 nd birthday (deductible does not apply)	Not covered	Covered under Preventive Care	Not covered
Chiropractic	\$35 copay Limit 12 visits/cal year	60% of MNRP ¹ Limit 6 visits/cal year (deductible applies)	\$35 copay Limit 12 visits/cal year	50% of MNRP ¹ Limit 6 visits/cal year (deductible applies)	80% Limit 12 visits/cal year (deductible applies)	60% of MNRP ¹ Limit 6 visits/cal year (deductible applies)
Physician Services Office Visits	100% after \$25 copay/office visit \$35 copay/specialist visit (deductible does not apply)	60% of MNRP ¹ (deductible applies)	100% after \$25 copay/office visit \$35 copay/specialist visit (deductible does not apply)	50% of MNRP ¹ (deductible applies)	80% (deductible applies)	60% of MNRP ¹ (deductible applies)
Hospital Services Hospital Visits Inpatient Surgery Outpatient Surgery Hospital Newborn Care	100% hospital visits and surgery (deductible applies)	60% of MNRP ¹ (deductible applies)	80% hospital visits and surgery (deductible applies)	50% of MNRP ¹ (deductible applies)	80% (deductible applies)	60% of MNRP ¹ (deductible applies)

The Enhanced PPO Plan is available only to employees hired or rehired on or before December 31, 2015.

Medical Plan Features	<u>Enhanced</u>		<u>Value</u>		<u>HSA</u>	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .
Health Care Facility Hospital Outpatient (minor surgery, radiation therapy) Hospital Inpatient ² (room and board, x-rays, intensive care, newborn routine nursery care) Skilled Nursing Facility ² (room & board up to semiprivate room rate, up to 120 days/cal year) Home Health Care ² (up to 130 visits/cal year) Hospice Care ² (up to \$5,000 max)	100% (deductible applies)	60% of MNRP ¹ (deductible applies)	80% (deductible applies)	50% of MNRP ¹ (deductible applies)	80% (deductible applies)	60% of MNRP ¹ (deductible applies)
X-Ray and Lab Anesthesiology	100% (deductible applies)	100% when ordered by network provider (deductible applies) 60% of MNRP ¹ when ordered by a non-network provider (deductible applies)	80% (deductible applies)	80% when ordered by a network provider (deductible applies) 50% of MNRP ¹ when ordered by a non-network provider (deductible applies)	80% (deductible applies)	80% when ordered by a network provider (deductible applies) 60% of MNRP ¹ when ordered by a non-network provider (deductible applies)
Hospital Emergency Room	100% after \$90 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 80% after \$140 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	100% of MNRP ¹ after \$90 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 60% of MNRP ¹ after \$140 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	80% after \$90 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 80% after \$140 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	80% of MNRP ¹ after \$90 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 50% of MNRP ¹ after \$140 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	80% for emergencies (deductible applies) 60% for non-emergencies (deductible applies)	80% of MNRP ¹ for emergencies (deductible applies) 60% of MNRP ¹ for non-emergencies (deductible applies)

Medical Plan Features	Enhanced		Value		HSA	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .
Urgent Care Centers	100% after \$35 copayment/visit (deductible does not apply)	60% of MNRP ¹ (deductible applies)	100% after \$35 copayment/visit (deductible does not apply)	50% of MNRP ¹ (deductible applies)	80% (deductible applies)	60% of MNRP ¹ (deductible applies)
Other Covered Health Services: Ambulance Service Durable Medical Equipment	80% (deductible applies)	80% of MNRP ¹ (deductible applies)	80% (deductible applies)	80% of MNRP ¹ (deductible applies)	80% (deductible applies)	60% of MNRP ¹ (deductible applies)
Rehabilitation Therapy: Physical, Speech, Occupational and Respiratory therapy Infertility Treatment (maximums apply; see Covered Health services –Infertility section)	80% (deductible applies)	60% of MNRP ¹ (deductible applies)	80% (deductible applies)	50% of MNRP ¹ (deductible applies)	80% (deductible applies)	60% of MNRP ¹ (deductible applies)
Bariatric Surgery ²	80% (deductible applies) (does not count against the out-of-pocket maximum)	60% of MNRP ¹ (deductible applies) (does not count against the out-of-pocket maximum)	80% (deductible applies) (does not count against the out-of-pocket maximum)	50% of MNRP ¹ (deductible applies) (does not count against the out-of-pocket maximum)	80% (deductible applies) (does not count against the out-of-pocket maximum)	60% of MNRP ¹ (deductible applies) (does not count against the out-of-pocket maximum)
Outpatient Prescription Drugs Tiers as determined by the United HealthCare Prescription Drug List (PDL). See www.myuhc.com for the most current list.	Tier 1 - 90% (\$15 min/\$25 max) Tier 2 - 80% (\$30 min/\$55 max) Tier 3 - 60% (\$60 min/\$85 max) Mail Order (90-day supply) Tier 1 - 90% (\$25 min/\$45 max) Tier 2 - 80% (\$60 min/\$110 max) Tier 3 - 60% (\$120 min/\$170 max) (deductible/out-of-pocket maximums do not apply)	Not covered	Tier 1 - 90% (\$15 min/\$25 max) Tier 2 - 80% (\$30 min/\$55 max) Tier 3 - 60% (\$60 min/\$85 max) Mail Order (90-day supply) Tier 1 - 90% (\$25 min/\$45 max) Tier 2 - 80% (\$60 min/\$110 max) Tier 3 - 60% (\$120 min/\$170 max) (deductible/out-of-pocket maximums do not apply)	Not covered	Tier 1 - 80% (\$25 min/\$45 max) Tier 2 - 60% (\$45 min/\$70 max) Tier 3 - 50% (\$70 min/\$95 max) Mail Order (90-day supply) Tier 1 - 80% (\$45 min/\$90 max) Tier 2 - 60% (\$90 min/\$140 max) Tier 3 - 50% (\$140 min/\$190 max) (deductibles/out-of-pocket maximums apply)	Not covered

Medical Plan Features	Enhanced		Value		HSA	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .
Mental Health and Substance Abuse³						
Inpatient Care ³ (maximums apply; see Mental Health and Substance Abuse section)	100% (deductible applies / out-of-pocket maximums do not apply)	60% of MNRP ¹ (deductible applies / out-of-pocket maximums do not apply)	80% (deductible applies / out-of-pocket maximums do not apply)	50% of MNRP ¹ (deductible applies / out-of-pocket maximums do not apply)	80% (deductible applies / out-of-pocket maximums do not apply)	60% of MNRP ¹ (deductible applies / out-of-pocket maximums do not apply)
Outpatient Care ³ (maximums apply; see Mental Health and Substance Abuse section)	100%, after \$25 copayment (deductible / out-of-pocket maximums do not apply)	60% of MNRP ¹ (deductible / out-of-pocket maximums do not apply)	80%, after \$25 copayment (deductible / out-of-pocket maximums do not apply)	50% of MNRP ¹ (deductible / out-of-pocket maximums do not apply)	80% (deductible applies/ out-of-pocket maximums do not apply)	60% of MNRP ¹ (deductible applies/ out-of-pocket maximums do not apply)
Intermediate Care ³	100% (deductible applies/out-of-pocket maximums do not apply)	60% of MNRP ¹ (deductible applies/ out-of-pocket maximums do not apply)	80% (deductible applies/out-of-pocket maximums do not apply)	50% of MNRP ¹ (deductible applies/ out-of-pocket maximums do not apply)	80% (deductible applies/ out-of-pocket maximums do not apply)	60% of MNRP ¹ (deductible applies/ out-of-pocket maximums do not apply)
Annual Deductible	\$450/person; \$900/family (applies except where specified)	\$600/person; \$1,200/family (applies except where specified)	\$725/person; \$1,450/family (applies except where specified)	\$1,225/person; \$2,450/family (applies except where specified)	\$1,550 individual plan; \$3,100 total for family plan	\$3,100 individual plan; \$6,200 total for family plan
Out-Of-Pocket Maximum	\$1,800/person; \$3,600/family (except where specified)	\$6,200/person; \$12,400/family (except where specified)	\$3,100/person; \$6,200/family (except where specified)	\$6,200/person; \$12,400/family (except where specified)	\$4,300/person; \$8,600/family	\$6,200/person; \$12,400/family
Non-Notification Penalty	\$200 penalty applies to health facility services requiring pre-notification with UHC \$300 penalty applies to Mental Health/Substance Abuse services requiring UBH pre-notification					
Maximum Lifetime Benefit	NONE					

¹ Maximum Non-Network Reimbursement Program

² Pre-notification with UHC is required to receive full plan benefit and avoid penalty.

³ Pre-notification with UBH is required to receive full plan benefits and avoid penalty.

NOTE: Copayments do not apply towards deductible or out-of-pocket maximum.

Go to www.myUHC.com to review your claims, check eligibility of your dependents, order an ID card, locate network providers, and research information on many health topics.

IMPORTANT NOTICES

The following notices are mandated by federal law.

November 1, 2016

Women's Health and Cancer Rights Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator (937) 382-5591 for more information.

HIPAA Privacy Practices

The Health Plan Notice of Privacy Practices is included in the Benefits Handbook (Summary Plan Description). If you would like a copy of the Health Plan Notice of Privacy Practices, contact the Health Plan's Privacy Officer, 145 Hunter Drive, Wilmington OH, 45177

IMPORTANT NOTICES

The following notices are mandated by federal law.

November 1, 2016

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

<p align="center">ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p align="center">INDIANA – Medicaid</p> <p>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</p>
<p align="center">COLORADO – Medicaid</p> <p>Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943</p>	<p align="center">IOWA – Medicaid</p> <p>Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562</p>
<p align="center">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>
<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>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</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739</p>	<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>

<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>	<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462</p>
<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633</p>	<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>	<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p>
<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p align="center">WASHINGTON – Medicaid</p> <p>Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>	<p align="center">WEST VIRGINIA – Medicaid</p> <p>Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p align="center">UTAH – Medicaid and CHIP</p> <p>Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669</p>	<p align="center">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</p>
<p align="center">VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531</p>
<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>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</p>	

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

SUMMARY OF MATERIAL MODIFICATIONS

Enhanced PPO Plan Value PPO Plan Health Savings Account PPO Plan

Effective: January 1, 2017

The Enhanced PPO Plan, Value PPO Plan, and Health Savings Account PPO Plan will no longer be “grandfathered” under the Affordable Care Act (ACA). This means that:

- Preventive care including women’s care as defined by the ACA, will be covered at 100% with no copayment or deductible when services are provided by in-network providers.
- The maximum out-of-pocket limits will include deductibles, co-payments, and co-insurance including for prescription drugs.
- Routine care in clinical trials will be covered under the plan.

Please review the 2017 Summary of Benefits for full details.

Retiree Medical Plan

Effective December 31, 2016

The company provided Retiree Medical Plan is discontinued effective December 31, 2016.

Every effort has been made to provide clear and accurate information about the Plan. However, in the event of a discrepancy between this material and the official plan documents, the official plan documents will govern.

The Company reserves the right to change, suspend, or amend the information in this summary at any time, in whole or in part. Any such change shall be solely at the discretion of the Company. You will be notified if any such change occurs.



**2017 EMPLOYEE
HEALTH & WELLNESS PROGRAM**
Let's get Healthier in 2017 with *Healthy Directions!*

OVERVIEW

This is a voluntary program offering you incentives to improve your overall health and earn savings on your monthly health insurance premiums.

WHY SHOULD YOU JOIN?

Besides the out-of-pocket savings on your premiums, there are additional benefits to being part of a wellness program. First, it is important to your own well-being and achieving a *Better Lifestyle* for you and your family. Second, wellness impacts the company's bottom line, because focusing on wellness reduces long term claim costs. Join the employee health and wellness program and "*Point Yourself Toward a Better Lifestyle!*"

HOW CAN YOU PARTICPATE? Participation is voluntary.

Each quarter you will have the chance to participate in the wellness program requirements, for a "wellness" reduction from the base price of premiums for the next quarter.

If you fail to achieve the required activity in any quarter, the following quarter's premiums will be deducted at the "base" or full rate.

WHAT ARE THE QUARTERLY REQUIREMENTS?

Each quarter, you may choose to participate in one of the following:

- ❖ Fitbit pedometer program, averaging 6,000 steps per day.
- ❖ Complete the required number of coaching topics through the UHC Healthy Rewards program.
- ❖ Participate in the Quarterly 'Biggest Loser Program' and meet the established goals.



WIRELESS ACTIVITY TRACKER

Contact Tracey Dykes, Human Resources at 937.366.2134 or #62134 for more details

2017 Spousal Affidavit Medical Coverage

The Company adopted special eligibility rules for spouses to be covered under the company's medical plan. The Company is adhering to this for 2017. If your spouse is eligible for *employer-sponsored medical insurance* through their employer, your spouse is NOT eligible for medical coverage under the "Company" Medical Plan. **Employees enrolling their spouse in Medical Coverage must complete this form, sign, return to HR no later than 12/31/16.**

IF YOU ARE ONLY ELECTING DENTAL/VISION COVERAGE FOR YOUR SPOUSE NO AFFIDAVIT IS REQUIRED.

Section I - Spouse Complete Section I

- 1) Is your spouse employed? Yes No
 - 2) Is your spouse currently enrolled in any other medical plan? Yes No
 - 3) Is your spouse eligible for medical coverage through his/her employer? Yes No
- If No to question #3, please indicate why not: _____

I hereby authorize the release of my employer-sponsored medical insurance eligibility status and authorize its use in determining eligibility under the Medical Plan.

Name of spouse (printed): _____

Signature of spouse: _____ Date: _____, 2016

Employer: _____ Phone Number: (____) _____-

Section II – Employee Complete Section II

I certify that all information on this form is true, correct and current. I also understand that if the medical insurance eligibility status of my spouse changes at any time during the year, it is (my) the Employee's responsibility to immediately notify the Human Resources Department. I also understand that if my spouse is offered medical coverage during 2017, I (*Employee*) need to make a medical change (or any *Qualifying Event*) within 30 days from eligibility date.

By providing information above and by signing below, I (*Employee*) understand that falsification of this information is against company policy and is cause for discipline up to and including termination of employment.

Employee Printed Name: _____ Employee ID# _____

Employee Signature: _____ Date: _____, 2016

Please return this form to:

.....

Human Resources Dept.
145 Hunter Drive, Mail Code 2061-H
Attn: Vickie Hurt
Wilmington, OH 45177
Fax: 937.366.3116
Email: abx.benefits@abxair.com

.....

Women's Preventive Care Services

Effective January 1, 2017

Under the health reform law, fully insured and self-funded non-grandfathered health plans are required to cover preventive care services without cost-sharing (copayment, coinsurance or a deductible) as long as they are received in the health plan's network.

While grandfathered plans are not required to make these changes, some have chosen to offer preventive care services at no cost-share. United Healthcare small business plans (generally 2-99 employees) cover preventive care services without cost-sharing regardless of grandfathered status.

The new list of women's preventive care services is an extension of the existing **preventive care services provision** that went into effect under the health reform law Sept. 23, 2010. The following eight categories of women's preventive care services are covered without cost-share as of the health plan's first renewal date on or after Aug. 1, 2012. Many of the preventive care services covered by United Healthcare go beyond the health reform law's requirements:

1. **Breast-feeding support, supplies and counseling.** Lactation support and counseling and breast-feeding equipment are covered without cost-share for each birth. United Healthcare covers the purchase of a personal, double-electric breast pump when received through a network doctor or approved durable medical equipment suppliers. Lactation counseling is covered when performed by a network physician or health care professional and billed according to our **Preventive Care Services Coverage Determination Guideline**.
2. **Contraception methods and counseling.** Prescribed FDA-approved contraception methods, sterilization procedures and patient education and counseling for all women with reproductive capacity. All *methods* does not mean all contraceptives. Only those on our Preventive Care Medications List are covered without cost-sharing. Certain religious institutions may be exempt from covering contraception services.
3. **Domestic violence screening.** Annual screening and counseling for interpersonal and domestic violence.
4. **Gestational diabetes screening.** Required for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for women identified to be at high risk for diabetes. United Healthcare will cover gestational diabetes screening for all pregnant women, regardless of gestational week.
5. **Human immune-deficiency virus (HIV) counseling and screening.** Annual counseling and screening for all sexually active women.
6. **Human papillomavirus (HPV) testing.** Screening should begin at 30 years of age, and need not occur more than every three years.
7. **Sexually transmitted infections counseling.** Annual counseling for all sexually active women
8. **Well-woman visits.** Includes visits to obtain the recommended preventive services plus preconception counseling and prenatal care. Today, United Healthcare covers many women's preventive health care services, including mammograms, screenings for cervical cancer, and immunizations, without cost-sharing in qualifying health plans. Multiple preventive visits may be required in the same year to receive the preventive care services.

Review our **Preventive Care Services Coverage Determination Guideline** that assigns specific codes and identifies what services are covered without cost-share. Consult your United Healthcare representative if you have questions, or visit the United for Reform Resource Center at uhc.com/reform for more information

The content provided is for informational purposes only and does not constitute medical advice.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc., or its affiliates.

This communication is not intended, nor should it be construed, as legal or tax advice. Please contact a competent legal or tax professional for legal advice, tax treatment and restrictions. Federal and state laws and regulations are subject to change.




Tobacco cessation drugs covered at no cost to members

Good news for those looking to kick the habit. **Beginning in 2017**, United Healthcare members will have certain tobacco cessation drugs covered at no cost. These drugs may help people quit smoking or stop using tobacco.

What tobacco cessation drugs are covered at no cost?

Here are the prescription drugs and over-the-counter (OTC) drugs covered at no cost.

Over-the-counter Medications <i>Required Prior Authorization</i>	Nicotine Replacement Gum Nicotine Replacement Lozenge Nicotine Replacement Patch
Prescriptions <i>Required Prior Authorization</i>	Bupropion sustained-release (generic Zyban) Tablet Nicotrol Inhaler Nicotrol Nasal Spray Chantix Tablet



These three Prescription medications are covered with Prior Authorization after members have tried:

- 1) One over-the-counter nicotine product **and**
- 2) Bupropion sustained-release (generic Zyban) separately

Up to two 90-day treatment courses are covered at no cost each year. Prior authorization is required for each 90-day drug supply.

Who can get the tobacco cessation drugs?

These drugs are covered for those who:

- Are 18 years of age or older
- Have a doctor that has obtained prior authorization for the drugs. This means the doctor will let us know the member is also getting counseling to help them stop using tobacco products.
- Get a prescription for these products, even if they are sold over-the-counter
- Fill the prescription at a network pharmacy

How does prior authorization work?

Doctors or health care professionals request prior authorization by calling, faxing or logging in to **optumrx.com**. They let us know if the member meets the requirements to receive the drug. We'll send the member and doctor a letter to let them know if the member qualifies to get the drug at no cost.

- If approved, members may fill the prescription at a network pharmacy at no cost.
- If the request is not approved, members can still get the drug, but they may have to pay the full cost of the prescription.
- Members currently taking one of these tobacco cessation drugs must ask their doctor to submit a prior authorization or their next refill may be delayed.

What else do members need to know?

- Nicotrol® and Chantix® are covered at no cost when the criteria are met and after trying a course of OTC nicotine replacement therapy and a course of bupropion.
- Screening for tobacco use is covered at no cost during a standard wellness exam.
- These drugs do not count toward a member's pharmacy plan deductible.
- Members are encouraged to call the number on their health plan ID card to confirm when the tobacco cessation benefit is available to them.

For more information

Visit the member website **myuhc.com** to find resources and information to help manage your health and save money.

Chantix is a registered trademark of Pfizer Inc.

The content provided is for informational purposes only and does not constitute medical advice. Decisions about medical care should be made by the doctor and patient. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the health plan ID card.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.
Administrative services provided by United HealthCare Services, Inc., or its affiliates.



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Human Resources Dept.
Mail code 2061-H
145 Hunter Drive
Wilmington, OH 45177
www.myabx.com

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