



January 29, 2010

Dear Retiree:

Recently you received notice from us that the retiree medical insurance would be transitioned to the Ohio Conference of Teamsters later this year as a result of the new Collective Bargaining Agreement between ABX Air and the Airline Professionals Association–Teamsters Local 1224.

This letter is to notify you that this change will occur on March 1, 2010. The last day of coverage under the ABX program will be February, 28, 2010. The Ohio Conference of Teamsters is offering the same coverage and a new option for retirees under the age of 65 through United Healthcare. The United Healthcare network is the same network as today meaning that you do not need to change doctors or hospitals.

The new collective bargaining agreement provides for new cost sharing between the Company and the retiree. In addition, coverage will end when you turn 65 and coverage for your spouse (if applicable) will end when she/he turns 65.

Attached are the coverage options available to you and the new monthly cost. In order to enroll in the new coverage you will need to complete the enclosed enrollment form and return to the ABX Benefits Dept. preferable by no later than February 10, 2010.

You may return the form via:

Fax: (937) 366-3145

E-mail: abx.benefits@abxair.com

U.S. Mail: ABX Air
M/S 2061B
145 Hunter Drive
Wilmington, OH 45177

If you have any questions, please contact Kathy Eversman at ext. 62463 (Tuesdays through Thursday only) or me at ext. 62230.

Sincerely,

Jeffrey S. Walling
Manager, Benefits

Ohio Conference of Teamsters Health & Industry Fund
 March 1, 2010 thru December 31, 2010

Both Retiree and Spouse Under 65 Years of Age

Enhanced PPO	Premium	ABX Pays	Retiree Pays
Retiree Only	\$ 486.54	\$ 310.00	\$ 176.54
Retiree & Spouse	\$ 1,023.66	\$ 620.00	\$ 403.66
Retiree & Children	\$ 846.09	\$ 620.00	\$ 226.09
Retiree, Spouse, & Children	\$ 1,517.49	\$ 930.00	\$ 587.49

Traditional Plan	Premium	ABX Pays	Retiree Pays
Retiree Only	\$ 536.19	\$ 310.00	\$ 226.19
Retiree & Spouse	\$ 1,228.41	\$ 620.00	\$ 608.41
Retiree & Children	\$ 1,232.41	\$ 620.00	\$ 612.41
Retiree, Spouse, & Children	\$ 1,924.55	\$ 930.00	\$ 994.55

Value Plan	Premium	ABX Pays	Retiree Pays
Retiree Only	\$ 436.82	\$ 310.00	\$ 126.82
Retiree & Spouse	\$ 919.05	\$ 620.00	\$ 299.05
Retiree & Children	\$ 759.62	\$ 620.00	\$ 139.62
Retiree, Spouse, & Children	\$ 1,362.42	\$ 930.00	\$ 432.42

Retiree Over 65 and Spouse under 65 or Dependent Children

Enhanced PPO	Premium	ABX Pays	Retiree Pays
Retiree & Spouse	\$ 1,023.66	\$ 310.00	\$ 713.66
Retiree & Children	\$ 846.09	\$ 310.00	\$ 536.09
Retiree, Spouse, & Children	\$ 1,517.49	\$ 620.00	\$ 897.49

Traditional Plan	Premium	ABX Pays	Retiree Pays
Retiree & Spouse	\$ 1,228.41	\$ 310.00	\$ 918.41
Retiree & Children	\$ 1,232.41	\$ 310.00	\$ 922.41
Retiree, Spouse, & Children	\$ 1,924.55	\$ 620.00	\$ 1,304.55

Value Plan	Premium	ABX Pays	Retiree Pays
Retiree & Spouse	\$ 919.05	\$ 310.00	\$ 609.05
Retiree & Children	\$ 759.62	\$ 310.00	\$ 449.62
Retiree, Spouse, & Children	\$ 1,362.42	\$ 620.00	\$ 742.42

SCHEDULE OF MEDICAL BENEFITS 2010

Medical Plan Features	Enhanced PPO		Traditional Plan	Value	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	Network or Non-Network Providers the Plan pay . . .	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% after \$20 co-pay/office visit up to \$300/person maximum per cal year (deductible does not apply)	Not covered	Preventive Care not covered except: 80% for one Pap test/cal year, 80% for mammogram per age schedule. Office visit not covered. (deductible applies)	100% after \$20 co-pay/office visit up to \$300/person max/cal yr (deductible does not apply)	Not covered
Well Baby Care	100% after \$20 co-pay/office visit up to 2nd birthday (deductible does not apply)	Not covered	Not covered	100% after \$20 co-pay/office visit up to \$300/person max/cal yr (deductible does not apply) Co-pay/office visit up to 2nd birthday (deductible does not apply)	Not covered
Chiropractic • Spinal Adjustments	\$30 Co-pay Limit 6 visits/calendar yr	60% of MNRP ⁵ (deductible applies) Limit 6 visits per calendar year	80% of R&C ¹ (deductible applies) Up To 12 Visits per calendar year	\$30 co-pay Limit 6 visits/cal year	50% of MNRP ¹ Limit 6 visits / cal year (deductible applies)
Physician Services • Office Visits	100% after \$20 co-pay/office visit	60% of MNRP ⁵	80% of R&C ¹	100% after \$20 co-pay/office visit	50% of MNRP ¹

Medical Plan Features	Enhanced PPO		Traditional Plan	Value	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	Network or Non-Network Providers the Plan pay . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .
	\$30 co-pay specialist (deductible does not apply)	(deductible applies)	(deductible applies)	\$30 co-pay/ specialist visit (deductible does not apply)	(deductible applies)
Hospital Services					
<ul style="list-style-type: none"> • Hospital Visits • Inpatient Surgery • Outpatient Surgery • Hospital Newborn Care 	100% hospital visits and surgery (deductible applies)	60% of MNRP ⁵ (deductible applies)	80% of R&C ¹ (deductible applies)	80% hospital visits and surgery (deductible applies)	50% of MNRP ¹ (deductible applies)
Health Care Facility					
<ul style="list-style-type: none"> • Hospital Outpatient (minor surgery, radiation therapy) • Hospital Inpatient² (room and board, x-rays, intensive care, newborn routine nursery care) • Skilled Nursing Facility² (room & board up to semiprivate room rate, up to 120 days/cal yr) • Home Health Care² (up to 130 visits/cal year) • Hospice Care² (up to \$5,000 maximum) 	100% (deductible applies)	60% of MNRP ⁵ (deductible applies)	100% of R&C ¹	80% (deductible applies)	50% of MNRP ¹ (deductible applies)
X-Ray and Lab					
Anesthesiology	100% (deductible applies)	100% when ordered by a network provider (deductible applies)	80% of R&C ¹ (deductible applies)	80% (deductible applies)	80% when by a network provider (deductible applies)
		60% of MNRP ⁵ when ordered by a non-network provider (deductible applies)			50% of MNRP ¹ when ordered by a non-network provider (deductible applies)

Medical Plan Features	Enhanced PPO		Traditional Plan	Value	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	Network or Non-Network Providers the Plan pay . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .
Hospital	100% after \$75 co-pay for emergencies (deductible does not apply)	100% of MNRP ⁵ after \$75 co-pay for emergencies (deductible does not apply)	Facility Charges 100% for emergencies (deductible applies)	80% after \$75 co-pay for emergencies (deductible does not apply) (copayment is not waived even if admitted)	80% of MNRP ¹ after \$75 co-pay for emergencies (deductible does not apply) (copayment is not waived even if admitted)
Emergency Room	80% after \$125 co-pay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	60% of MNRP ⁵ after \$125 co-pay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	Physician and other charges 80% of R&C ¹ for emergencies (deductible applies)	80% after \$125 co-pay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	50% of MNRP ¹ after \$125 co-pay for non-emergencies (deductible applies) (copayment is not waived even if admitted)
Urgent Care Centers	100% after \$30 co-payment/visit (deductible does not apply)	60% of MNRP ⁵ (deductible applies)	80% of R&C ¹ (deductible applies)	100% after \$30 co-payment/visit (deductible does not apply)	50% of MNRP ¹ (deductible applies)
Other Covered Health					
Services:	80% (deductible applies)	80% of MNRP ⁵ (deductible applies)	80% of R&C ¹ (deductible applies)	80% (deductible applies)	80% of MNRP ¹ (deductible applies)
<ul style="list-style-type: none"> Equipment 					
<ul style="list-style-type: none"> Ambulance Service Durable Medical Rehabilitation Therapy: Physical, Speech, Occupational and Respiratory Infertility Treatment (maximums apply; see Covered Health services –Infertility section) 	80% (deductible applies)	60% of MNRP ⁵ (deductible applies)	80% of R&C ¹ (deductible applies)	80% (deductible applies)	50% of MNRP ¹ (deductible applies)
<ul style="list-style-type: none"> Bariatric Surgery² 	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)
Outpatient Prescription Drugs	Tier 1 – 90% (\$10 min/\$20 max) Tier 2 – 80% (\$25 min/\$45 max)	Not covered	80% (deductible applies)	Tier 1 - 90% (\$10 min/\$20 max) Tier 2 - 80% (\$25 min/\$45 max) Tier 3 - 60%	Not covered

Medical Plan Features	Enhanced PPO		Traditional Plan	Value	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	Network or Non-Network Providers the Plan pay . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .
Tiers as determined by the United Health Care Prescription Drug List (PDL). See www.myuhc.com for the most current list.	Tier 3 –60% (\$50 min/\$70 max) Mail Order (90-day supply) Tier 1 – 90% (\$20 min/\$40 max) Tier 2 – 80% (\$50 min/\$90 max) Tier 3 - 60% (\$100 min/\$140 max) (deductible/out-of-pocket maximums do not apply)		No mail order	(\$50 min/\$70 max) Mail Order (90-day supply) Tier 1 - 90% (\$20 min/\$40 max) Tier 2 - 80% (\$50 min/\$90 max) Tier 3 - 60% (\$100 min/\$140 max) (deductible/out-of-pocket maximums do not apply)	
Mental Health and Substance Abuse³					
Inpatient Care³ (maximums apply; see Metal Health and Substance Abuse section)	100% (deductible applies) (out-of-pocket maximums do not apply)	50% of MNRP ⁵ (deductible applies) (out-of-pocket maximums do not apply)	100% of R&C ¹ (deductible / out-of-pocket maximum 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)
Outpatient Care³ (maximums apply; see Metal Health and Substance Abuse section)	100%, after after \$20 co-pay \$20 copayment (deductible / out-of-pocket maximum do not apply)	50% of MNRP ⁵ (deductible / out-of-pocket maximum do not apply)	Mental Health 50% of R&C ¹ 20 Visit limit (deductible / out-of-pocket maximum apply) Substance Abuse 80% R&C ¹ (deductible / out-of-pocket maximum apply)	80%, after \$20 co-pay (deductible / out-of-pocket maximums do not apply)	50% of MNRP ¹ (deductible / out-of-pocket maximums do not apply)
Intermediate Care³	100% (deductible applies/out-of-pocket maximums do not apply)	50% of MNRP ⁵ (deductible applies/ out-of-pocket maximums do not apply)	80% of R&C ¹ (deductible / out-of-pocket maximum apply)	80% (deductible applies/ out-of-pocket maximum do not apply)	50% of MNRP ¹ (deductible applies/ out-of-pocket maximum do not apply)

Medical Plan Features	Enhanced PPO		Traditional Plan	Value	
	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .	Network or Non-Network Providers the Plan pay . . .	For NETWORK providers the Plan pays . . .	For NON-NETWORK providers the Plan pays . . .
Annual Deductible	\$375/person; \$750/family (applies except where specified)	\$500/person; \$1,000/family (applies except where specified)	\$100/person; \$200/family (applies except where specified)	\$600/person; \$1,200/family (applies except where specified)	\$1,000/person; \$2,000/family (applies except where specified)
Out-Of-Pocket Maximum	\$1,500/person; \$3,000/family (except where specified)	\$5,000/person; \$10,000/family (except where specified)	\$750/person; \$1,500/family (except where specified)	\$2,500/person; \$5,000/family (except where specified)	\$5,000/person; \$10,000/family (except where specified)
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	\$2,000,000/person ⁴	\$2,000,000/person ⁴	1,000,000/person ⁴	\$2,000,000/person ⁴	\$2,000,000/person ⁴

¹ Reasonable & customary charges.

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

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

⁴ Maximum life time benefit under all plans is \$2,000,000 combined.

⁵ Maximum Non-Network Reimbursement Program.

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

Visit 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.