2018 New Hire Benefit EnrollmentGuide

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2018 New Hire Enrollment

You have 30 days from your date of hire to enroll in your benefits.

Please carefully review this guide it its entirety. It is your source of information for your benefit elections.

Dear Fellow Employee:
Welcome to ABX AIR! This is your opportunity to review your benefit options and select the coverages that will work best for you and your family. Consider all of your benefit options, and your financial and health care needs. You have only 30 days from your hire date to enroll in your benefits. You will be unable to enroll in your benefits after that date unless you have a qualified event.

Your Health , Your Money , Your Choice

Health care costs are on the rise and everyone is looking for ways to make health care more affordable. There ARE steps you can take to control your medical costs. The following tools and programs are available to employees enrolled in the company medical plan. These services can improve your health and help you make the right decisions for you, your family and your pocketbook.

To find out more about the programs below, log on to www.MYUHC.com.

Real Appeal and Rally:

Real Appeal is a simple, step-by-step program designed to introduce small changes over time that lead to healthier habits and long-lasting weight loss results. With Real Appeal you will work with a Personal Transformation Coach who leads weekly online group sessions and is available to you for a full year of guidance and support. Rally is an online experience that makes it easier for you to eat better, move more, and complete activities that help improve your health. Both programs are available to you and your covered dependents age 18 and over, free of charge.

Virtual Visits:

Seeing a doctor just got easier and cheaper. You can see and talk to a doctor virtually, using your computer, tablet or smartphone, without an appointment. Most visits take 10-15 minutes and doctors can write a prescription if needed. There is no cost for the Virtual Doctor visits for the Value PPO medical plans. Employees enrolled in the HSA PPO medical plan will pay zero coinsurance after the deductible has been met.

myHealthcare Cost Estimator:

The Healthcare Cost Estimator will compare the quality and costs of facilities, services and doctors so you can make the right decision for your health and pocketbook. You can then use this information to help you decide where to get care, or to have a cost conversation with your doctor.

Rx Home Delivery:

Home delivery is a safe and reliable way to get your prescriptions. With Rx Home Delivery you will pay less for a 90-day prescription than at retail and the medications are mailed to your home, free of charge. You will also have 24/7 access to a pharmacist who can answer your questions any time, any day.

Livongo Diabetes Management:

Livongo has developed a completely new approach for diabetes management that combines the latest in meter technology and coaching. The program provides meters, unlimited test strips and lancets, and anytime/anywhere coaching—all free of charge.

Take Charge

These tools and services are available to employees and family members enrolled in the company medical plan. They will enable you to make informed decisions resulting in better health, and make smarter purchasing decisions resulting in reduced costs. If you have any questions about these programs or your benefits, please feel free to contact Laurie Wells (62150) or Angie Hurst (62157) in the Human Resources Department.

Sincerely,

Jeff Walling

Jeff Walling
Director, Human Resources

New in 2018

Your Health
Your Money
Your Choice

Employee Discount MarketPlace

Our Employee Discount MarketPlace helps you save on products and services you use every day. Administered by Beneplace, this discount website gives you access to deals on consumer products, dining, automotive services, health and wellness products, travel and so much more! Beneplace is a program that provides savings on a variety of items and services you use on a daily basis. Go to https://www.beneplace.com/ATSG Code: ATSGSAVES
This program is open to every employee.

Spine and Joint Center of Excellence

The UnitedHealthcare Spine and Joint Center of Excellence program is available to members enrolled in the company medical plan who are looking for access to a Center of Excellence network that has an eye on quality and costs. The Spine and Joint Centers of Excellence have 30% fewer costly complications and readmissions, and have 25% lower costs when compared with area median costs. Standard PPO and Consumer Driven HSA PPO members who use the Spine and Joint Centers of Excellence for spine and joint surgeries will have their coinsurance reduced to 0% after their deductible. For more information go to https://www.cx.uhc.com/sjsnurse.

Livongo Diabetes Management

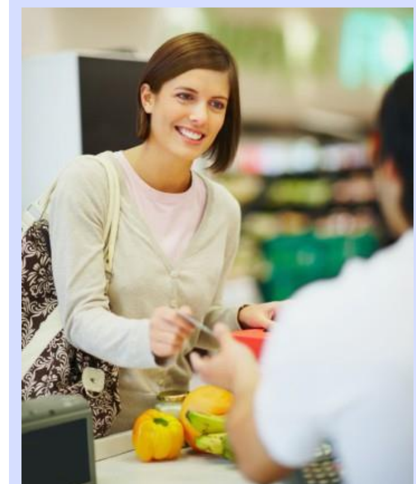
The Livongo Diabetes Program is a health benefit that makes living with diabetes easier by providing you with a connected meter, unlimited test strips, and coaching to support you in managing your diabetes. This program is part of your medical benefit plan and is offered at no cost to you and your eligible family members.
To register for the program or to find out more go to https://welcome.livongo.com/ATSG .

Enrollment Eligibility Periods

30 Days: Medical, Dental, Vision, Health Savings Account

60 Days: Life Insurance, Business Travel Accident, Accidental Death & Dismemberment, Short Term Disability, Group Universal Life, Voluntary Accidental Death & Dismemberment, 401(k)

1 year: Long Term Disability, Flexible Spending Accounts, FMLA



New Hire Enrollment

STEP 1 Review Your Choices

Medical Insurance

These medical options are administered by United HealthCare.

You have 2 choices:

1. Value PPO
2. Health Savings Account (HSA) PPO

Important Note About Spouse Medical Coverage

You may not enroll your spouse in the company medical plan if they are working and have the opportunity to receive medical insurance through their employer.

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 $825 for employee only coverage and $1,650 for all other coverage tiers. The plan has an annual out-of-pocket maximum of $3,100 for employee coverage and $6,200 for all other coverage tiers. Out-of-network services are available but have lesser coverage.

Highlights of In-Network Coverage:

- Primary care office visit copayment is $25, and the specialist copayment is $45 with no deductible.
- Virtual doctor visit copayment is $0.
- The deductible is $825 for employee only coverage and $1,650 for all other coverage tiers.
- Coverage for hospital stays, x-rays, laboratory services, surgeries, and most other services are covered at 80% after satisfying the annual deductible.
- Emergency Room in-network co-pays are $150 for emergency services and $200 for non-emergency

2018 Employee Contributions:

	Bi-weekly Base	Bi-weekly Wellness
Employee Only	$ 80.15	$ 66.79
Employee & Spouse	$ 168.64	$ 140.52
Employee & Child (ren)	$ 139.38	$ 116.15
Employee, Spouse & Child (ren)	$ 249.98	$ 208.31

STEP 1 Review Your Choices - Medical Plans

Your Health
Your Money
Your Choice

Health Savings Account PPO Plan

This plan offers in-network medical services covered at 80% after the annual deductible. The annual in-network deductible is $1,550 for employee only coverage and $3,100 for all other coverage tiers. The plan has an annual out-of-pocket maximum of $4,000 for employee only coverage and $7,350 for all other coverage tiers. Once you have met your in-network out-of-pocket maximum, most in-network covered expenses are paid at 100% of the allowable amount for the rest of the year. Out-of-network services have lesser coverage.

This plan provides you with a Health Savings Account (HSA) through Optum Bank. 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. If you leave the company, your account moves with you. Your account comes with a debit card that you can use to pay for doctor visits, prescriptions, and other eligible medical expenses.

You can contribute to your HSA on a pre-tax basis up to $2,950 annually for employee only coverage and $5,900 for all other coverage tiers. You can change your contributions any time throughout the year. *The company will help fund your HSA by depositing $500 into your account for employee only coverage or $1,000 for all other coverage tiers.* The entire company prorated contribution will be deposited in to your account as soon as administratively possible. **In order to get the company contribution you must open a Health Savings Account.** Go to www.OptumBank.com and click on "Open an HSA" located in the upper right hand corner ASAP!!

Highlights of In-Network Coverage:

- The plan has a Health Savings Account that includes an annual company contribution of $500 for employee only coverage or $1,000 for all other coverage tiers. The entire prorated company contribution will be deposited after your first paycheck. You must have an Optum HSA account set up to receive the company contribution.
- You can contribute to your HSA up to $2,950 annually for employee only coverage and $5,900 for all other coverage tiers.
- If you are age 55 or older, you can contribute an additional $1,000.
- HSA contribution **elections** do not carry over from one year to the next. You must re-enroll every year.
- The deductible is $1,550 for employee only coverage or $3,100 for all other coverage tiers. The full deductible must be met before the Plan will apply the 80% coinsurance.
- 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 $4,000 for employee only coverage and $7,350 for all other coverage tiers.

2018 Employee Contributions:

	Bi-weekly Base	Bi-weekly Wellness
Employee Only	$ 45.19	$ 37.66
Employee & Spouse	$ 104.52	$ 87.10
Employee & Child (ren)	$ 86.39	$ 71.99
Employee, Spouse & Child (ren)	$ 154.95	$ 129.12

STEP 1 Review Your Choices - Premium Comparisons

Your Health
Your Money
Your Choice

2018 Employee Bi-Weekly Contributions

Base Medical Premiums

	Value PPO Plan	HSA PPO
Employee Only	$ 80.15	$ 45.19
Employee and Spouse	$168.64	$104.52
Employee and Child (ren)	$139.38	$ 86.39
Employee, Spouse and Child (ren)	$249.98	$154.95

Wellness Medical Discounted Premiums

	Value PPO Plan	HSA PPO
Employee Only	$ 66.79	$ 37.66
Employee and Spouse	$140.52	$ 87.10
Employee and Child (ren)	$116.15	$ 71.99
Employee, Spouse and Child (ren)	$208.31	$129.12

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

	Enhanced Dental & Vision	Basic Dental & Vision
Employee Only	$ 8.64	$ 7.17
Employee and Spouse	$16.86	$ 13.94
Employee and Child (ren)	$20.19	$ 16.69
Employee, Spouse and Child (ren)	$28.41	$ 23.43

2018 Schedule of Medical Benefits

Medical Plan Features	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. . .
Care 24 - Call **888-887-4114, Option #2**. A nurse is available to provide immediate medical info and support 24 hrs/day; 100% covered. **Virtual Visits** (on-line doctor visits) - access through the **Health4Me** app on your mobile device or myuhc.com on your computer.				
Preventive Care Routine physical, Immunization, Pap test, Mammogram	100% (deductible and co-payment do not apply)	Not covered	100% (deductible and co-insurance do not apply)	Not covered
Well Baby Care (Preventative)	100% up to 2nd birthday (deductible does not apply)	Not covered	Covered under Preventive Care	Not covered
Chiropractic	$45 copay Limit 12 visits/cal year	50% of MNRP[1] Limit 6 visits/cal year (deductible applies)	80% Limit 12 visits/cal year	60% of MNRP[1] Limit 6 visits/cal year
Physician Services Office Visits	100% after $25 copay/office visit $45 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	80% hospital visits and surgery (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)

Medical Plan Features	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. . .
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 and board up to semi-private 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)	80% (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
X-Ray and Lab **Anesthesiology**	80% (deductible applies)	80% when ordered by network provider (deductible applies) 50% of MNRP[1] when ordered by non-network provider (deductible applies)	80% (deductible applies)	80% when ordered by network provider (deductible applies) 60% of MNRP[1] when ordered by non-network provider (deductible applies)
Hospital Emergency Room	80% after $150 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 80% after $200 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	80% of MNRP[1] after $150 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 50% of MNRP[1] after $200 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	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. . .
Urgent Care Centers	100% after $35 copayment/visit (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Virtual Doctors	0% copayment/visit (deductible does not apply)	N/A	0% coinsurance after the deductible	N/A
Other Covered Health Services Ambulance Service (emergencies)	80% (deductible applies)	80% of MNRP[1] (deductible applies)	80% (deductible applies)	80% of MNRP[1] (deductible applies)
Rehabilitation Therapy: Physical, Speech, Occupational and Respiratory Therapy	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)	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 maximum 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 maximum do not apply)	Not Covered

Medical Plan Features	Value: For NETWORK providers the plan pays. . .	Value: For NON-NETWORK providers the plan pays. . .	HSA: For NETWORK providers the plan pays. . .	HSA: For NON-NETWORK providers the plan pays. . .
Mental Health and Substance Abuse[3]				
Inpatient Care[3] (maximum apply; see Mental Health and Substance Abuse section)	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] (maximum apply; see Mental Health and Substance Abuse section)	80% after $25 copayment (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)
Intermediate Care[3]	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[4]	$825/person; $1,650/family (applies except where specified)	$1,325/person; $2,650/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 Maximums[5]	$3,100/person; $6,200/family (except where specified)	$6,200/person; $12,400/family (except where specified)	$4,000/person; $7,350/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.
[4]NOTE: Copayments do not apply towards deductible for the Value PPO. [5]The Out-of-Pocket Maximum includes the annual deductible, co-payments, and coinsurance. 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.

2018 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 • 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 • 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 • 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

2018 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

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.

These benefits are not subject to an enrollment period.

Voluntary Accident Insurance

This plan is insured by CIGNA

This plan allows employees to purchase Accidental Death & 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.

Voluntary Accident Rates for 2018:

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

If you elect the family coverage, your family members are covered at these levels of the principal amount:

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.

The company offers a Group Universal Life (GUL) Insurance program that allows you to purchase up to six times your annual salary in life insurance. Evidence of Insurability maybe required for new enrollment. For more information visit www.personal-plans.com/abxair/ or call (800) 441-5581 to speak with a customer service representative.

This benefit is not subject to an enrollment period.

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 an enrollment period.

STEP 2 Review Resources and Reminders

Your Health
Your Money
Your Choice

To help you decide which coverage is best for you for 2018, review the Summary of Benefits and Coverage (SBC) and the Glossary of Health Coverage and Medical Terms available on the Employee Self Service website. Select the "Benefits" tab, then " Enrollment Materials."

The Human Resources Department is available for assistance. They can be reached at 937-382-5591 ext. #62150 or ext. #62157.

Medical Plan FAQs

What is a deductible and how does it work?

The deductible is the amount you pay for covered health care services before your insurance plan starts to pay. For example, the Value PPO Plan has an individual in-network deductible (for employee only coverage) of $825. Once the deductible has been satisfied for the calendar year, the plan pays the scheduled in-network coinsurance benefit (80% of the eligible claims). You have to satisfy the deductible only once per calendar year.

To help protect families, each plan has a family deductible for employee & spouse, employee & child(ren) and employee, spouse & child(ren) coverage. The family deductible works differently for the Value PPO plans than it does for the HSA PPO plan.

The Value PPO plan has an "embedded" family deductible. Once the family reaches the in-network deductible of $1,650 the plan will pay the scheduled coinsurance benefit. BUT, if one person in the family reaches the individual deductible of $825 for that person, the coinsurance of 80% would apply. The rest of the family will continue to contribute to the deductible until the family has contributed $1,650.

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 www.personal-plans.com/abxair/

Medical Insurance www.myuhc.com

The Health Savings Account PPO family deductible works differently from the Value PPO family deductible. Under this plan, if you elect employee & spouse, employee & child(ren) or employee, spouse & child(ren) in-network coverage your deductible is $3,100. The family must reach the total $3,100 deductible before the plan will pay the scheduled coinsurance benefit. Remember that the Company contributes to your Health Savings Account to help offset the cost of the deductible.

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. The illustration below may help you understand how it works. For the Value PPO Plan employee only coverage, the in-network deductible is $825, the coinsurance is 20% and the out-of-pocket maximum is $3,100.

Example of out-of-pocket maximum with high medical costs:

Let's say you need surgery with allowable costs of $20,000. You are responsible for the deductible of $825, and 20% coinsurance of the remainder, up to a maximum of $3,100.

$20,000 surgery - $825 deductible = $19,175
$19,175 X 20% coinsurance= $3,835.

Your total costs *would* be $825 (your deductible) plus $3,835 (coinsurance) or $4,660. **But** your out-of-pocket maximum is $3,100. So the medical plan pays all in-network covered costs above $3,100 for this surgery and any covered care you get for the rest of the plan year.

How does a Flexible Spending Account (FSA) Work?

This plan is administered by UnitedHealthCare.

Medical FSA

The Medical FSA allows you to contribute pre-tax dollars to an account that you can then use to pay for eligible medical, dental, and vision expenses that are not covered by insurance. Examples include deductibles, coinsurance, co-payments, and other out-of-pocket expenses. For a complete list of eligible expenses see IRS publication 502 at www.irs.gov. By contributing to a FSA, you reduce your taxable income for the year by the amount you contribute to the program, which saves you money.

2018 Medical FSA Pretax Contribution Limits:
The 2018 annual contribution limit for a Medical FSA is $2,600.

If you elected the Health Savings Account PPO, you are not eligible for the Medical FSA.

Dependent Care FSA

A Dependent Care FSA is a pre-tax benefit account used to pay for dependent care services such as day care, preschool, summer camps and non-employer sponsored before or after school programs. It can also be used for elder daycare when an elderly or disabled parent is considered a dependent and the dependent care account holder is covering more than 50 percent of the elderly or disabled parent's maintenance costs. The annual contribution limit for a Dependent Care FSA is based on the account holder's tax filing status. Generally, joint filers have double the limit of single or separate filers. However, even if each spouse has access to a separate FSA through his or her employer, they are still subject to the mandated maximum limits.

2018 Dependent Care FSA Pretax Contribution Limits:
Account holder is single: $2,500
Account holder is married and filed a separate tax return: $2,500
Account holder is married and files a joint return or filed as single/head of household: $5,000

FSA Savings: Use it or lose it!

You need to carefully budget your FSA spending for 2018. Any leftover 2018 FSA contributions that are not used by March 15, 2019, will be forfeited to the Company.

How does the Health Savings Account (HSA) Work?

The medical plan is administered by United HealthCare www.myUHC.com
The Health Savings Account is administered by Optum Bank www.optumbank.com

The HSA PPO Medical Plan

The Health Savings Account PPO is considered a high-deductible health plan. The plan is administered much like the Value PPO option, although the HSA PPO has higher deductibles and out-of-pocket maximums. If you choose to participate, your payroll deductions/ premiums will be lower and the company will contribute to your Health Savings Account.

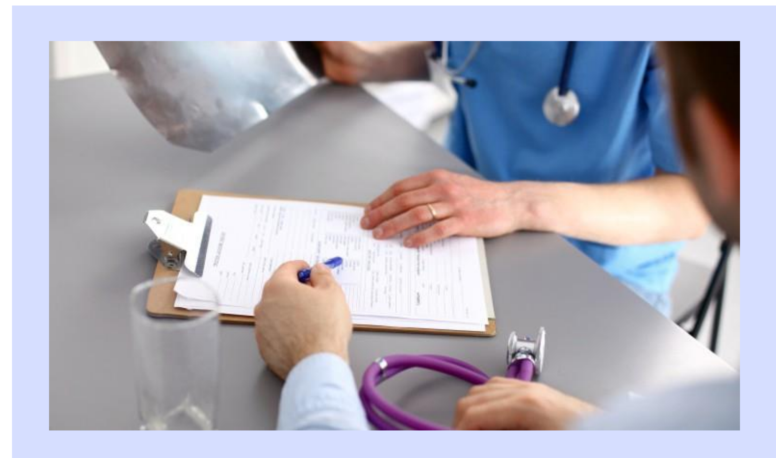
Your Health Savings Account

Think of your Health Savings Account like a "Healthcare 401(k)." If you don't use all of the money, the balance in your account rolls over from year to year. Since you own your account, you choose when to save and when to spend your funds to pay for your eligible health care expenses (medical, dental, vision, pharmacy). Similar to your 401(k) you can contribute to your Health Savings Account on a pre-tax basis up to the IRS limit.

The company will help increase your savings by making contributions to your account. For 2018 the company will deposit their entire contribution, once you are eligible, in to your account as soon as administratively possible.

Your interest earnings accumulate tax-deferred and withdrawals from your Health Savings Account for "qualified medical expenses" are free from Federal Income tax. The Health Savings Account is a great way to build up dollars to pay for your health care expenses today or in the future.

- If you elect this medical option, you must open a Health Savings Account with Optum Bank. If you are electing this benefit for the first time and have not opened an Optum Bank - Health Savings Account, go to www.optumbank.com and open your account prior to the end of your enrollment period.
- A Health Savings Account is a tax-advantaged account meaning that you reduce your taxable income by the amount you deposit into your account.
- You may contribute to your Health Savings Account up to the maximum IRS limit of $2,950 per year for employee only coverage and $5,900 per year for all other coverage tiers.
- The company will make a contribution to your Health Savings Account in the amount of $500 per year for employee only coverage or $1,000 per year for all other coverage tiers. The company will deposit its prorated contribution to your Health Savings Account as soon as administratively possible following your eligibility date. (You must have an opened Health Savings Account to receive the company contribution).
- You will receive a debit card to pay for eligible medical expenses that are subject to the deductible/coinsurance or not covered by medical insurance, such as orthodontia, hearing aids, Lasik surgery, etc. You can use your card to pay for health care expenses as you incur them or choose to save your funds for future health care expenses.
- Unlike the Flexible Spending Account (FSA), any leftover money at year-end remains in your account until you use it. The money also earns interest while it is in your account.
- Even if you leave the company the funds in your Health Savings Account (your contributions and the company's) are yours and go with you to use for eligible health care expenses.
- For a complete list of eligible expenses see IRS publication 502 at www.irs.gov.



Covering Your Family Members

Is my spouse eligible to enroll in medical benefits?

Spouse Enrollment 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 to receive medical coverage through their employer's health plan **ARE NOT ELIGIBLE** to enroll in the company medical plan. **By enrolling your spouse in the company medical plan you are certifying that he or she does not have access to employer-sponsored medical coverage through their job.** Enrolling your spouse in medical coverage when they have access to employer-sponsored medical coverage through their job is against company policy and subject to possible disciplinary action.

Required Documents for Spouse and Child Coverage

Dependent Verification: If you are adding a child, you must submit a copy of their birth certificate. If you are adding a spouse, you must submit a copy of your marriage certificate. Your dependents are not eligible for benefits until their dependent verification documentation has been submitted. You will be able to upload your documents at the end of your enrollment or you can fax/mail them to your HR department.

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 CMS to detect 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 are required to provide the company with your dependents' tax identification numbers (Social Security Number). The number will only be used to report to the CMS. If you do not provide your dependents' Social Security Numbers, you cannot cover your dependents under our Plan.

Check to be sure!

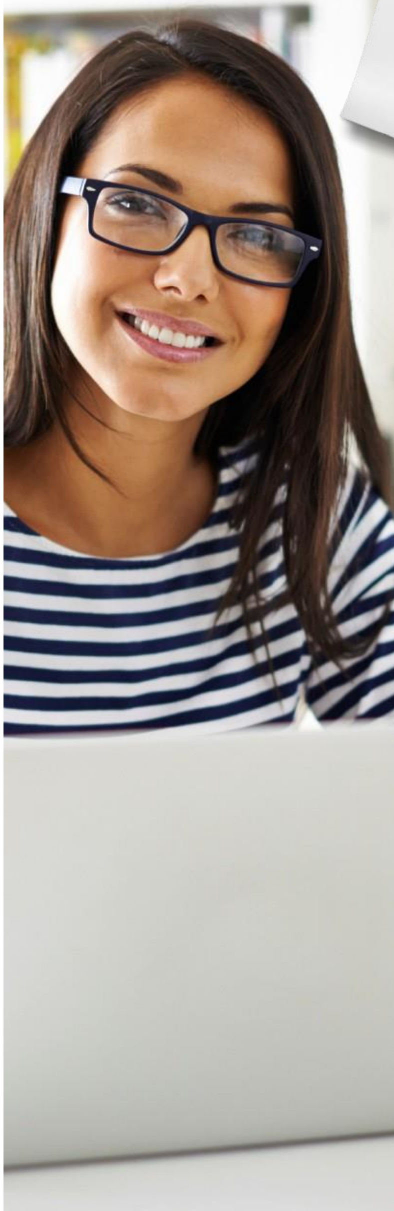
Does the company have your dependents' Social Security Numbers? Their medical coverage is dependent on it!

Log on to Self Service and click on "**BENEFITS**" then "**DEPENDENTS**." Click on your dependent's name. The Social Security Number should be in the "Tax ID" box. If it is not, enter the Social Security Number and click on the "Save" icon (looks like a computer disc).

STEP 3

Enroll for Your 2018 Benefits!

Your Health
Your Money
Your Choice



You have 30 days from your day of employment to make your benefit elections. No changes can be made to your benefits after the 30 days unless you have a qualified status change.

How to Enroll

Go online to EMPLOYEE SELF SERVICE and follow steps A B C

A BEFORE ENROLLING, CHECK YOUR DEPENDENTS OR ADD NEW ELIGIBLE DEPENDENTS

- ☐ Log on to Self Service, click on the **BENEFITS** tab then **DEPENDENTS**.
- ☐ **To add a new dependent**: click on the "ADD" button in the upper left corner (icon that looks like a piece of paper with a + in the middle) and complete the form, including the Social Security/Tax ID Number. When finished click on the "Submit" button in the upper left corner (icon that looks like a computer disc).
  - ☐ **Dependent verification**: If you are adding a child you must submit a copy of their birth certificate. If you are adding a spouse you must submit a copy of your marriage certificate. Your dependents are not eligible for benefits until their dependent verification documentation has been submitted. You will be able to upload your documents at the end of your enrollment, or you can fax/mail them to your HR department. Dependent verification documentation must be submitted by the end of your enrollment period.
- ☐ **To edit dependent information:** click on your dependent's name and make any necessary changes. When finished click on the "Submit" button in the upper left corner (icon that looks like a computer disc).

Note: All dependents must have their social security number (Tax ID #) listed on the Dependent page

Note: Spouses are not eligible to enroll in the company medical plan if they are eligible to receive health insurance through their employer. Enrolling your spouse in medical coverage when they have access to employer-sponsored medical coverage through their job is against company policy and subject to possible disciplinary action.

STEP 3 Enroll for Your 2018 Benefits! - continued

Your Health
Your Money
Your Choice

B TO ENROLL IN YOUR 2018 BENEFITS: CLICK ON THE "BENEFITS" TAB, THEN "New Hire/ Benefit Changes"

- ☐ **To enroll in benefits:** check the box next to each benefit you want to enroll in. When finished click on the "Continue" button in the upper left corner (gray arrow pointing to the right).

  Note: For all medical plans the base prices will be shown; the wellness discount is not shown.

- ☐ **To enroll dependents:** check the box next to their name(s). When finished, click on the "Continue" button in the upper left corner (gray arrow pointing to the right).

  Note: If your dependents are not showing, go back and complete step A and add your dependent(s).

- ☐ **To elect FSA or HSA contribution amounts**: (only if you enrolled in an FSA or HSA), in the first box enter the *annual* amount you want to contribute OR in the second box enter the *bi-weekly* amount you want to contribute. DO NOT do both. When finished click on the "Continue" button in the upper left corner (gray arrow pointing to the right).

C CONFIRM AND SUBMIT YOUR ENROLLMENTS

- ☐ **Review your elections**: by scrolling down.
- ☐ **Make any needed changes:** click the "Cancel" button in the upper left corner (gray arrow pointing to the left) to return to the enrollment screen.
- ☐ **Upload your dependents' verification documents, if needed**: scroll to the bottom of the page and find the word "Attachments." Click on the "Choose File" button to upload your documents. Dependent verification documentation must be submitted by the end of your enrollment period.
- ☐ **Submit your elections:** when your elections are correct print a copy for your files, then click on the "Submit" button in the upper left corner (icon that looks like a house). **IMPORTANT:** Do not click on "Save as Draft," as this will NOT submit your election.
- ☐ **Enrollment is done!** Once you submit your elections the file is forwarded to the Benefits Administrator for approval or rejection.
- ☐ **Check if your enrollment has been approved**: click on "IN BOX" then "My Messages."

IMPORTANT LEGAL NOTICES

The following notices are mandated by federal law.

SBC
In compliance with health care reform, the company provides an SBC for each medical plan for which you are eligible to help you compare your coverage options. SBCs are available on the Benefits Website.

Women's Health and Cancer Rights Act of 1998
The "Women's Health and Cancer Rights Act of 1998" was signed into law on October 21, 1998. The Act requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy must provide coverage for:

All stages of reconstruction of the breast on which the mastectomy has been performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
and Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles and coinsurance provisions applicable to other such medical and surgical benefits provided under the Medical Expense Plan. Please refer to your Summary Plan Description (SPD) available on the Benefits Website for deductibles and coinsurance information applicable to the option in which you choose to enroll.

HIPAA Privacy Practices
The company Medical Plans comply with the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which provides safeguards on your protected health information maintained by the company Medical Plans. The Plans maintain a Notice of Privacy Practices that provides information to individuals whose protected health information ("PHI") will be used or maintained by the plans.

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.

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 a company Medical Plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards you or your dependent's other coverage). However, you must request enrollment within 30 days after you or your dependent's 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.

Rights under the Newborns' and Mothers' Health Protection Act of 1996
The "Newborns' and Mothers' Health Protection Act of 1996" was signed into law on September 26, 1996. The Act affects the amount of time the mother and newborn child are covered for a hospital stay following childbirth. In general, group health plans and health insurance issuers that are subject to the Act may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Care beyond this point must be precertified but group health plans subject to the Act may not require that a provider obtain authorization from the plan, or an insurance issuer if applicable, for prescribing a length of stay in excess of 48 hours (or 96 hours). Mother or newborn child may leave earlier if the attending physician, in consultation with the mother, decides to discharge the patients earlier. Under the Act, the time limits affecting the stay begin at the time of delivery, if the delivery occurs in a hospital. If the delivery occurs outside the hospital, the stay begins when the mother or newborn is admitted in connection with the childbirth. This coverage may be subject to annual deductibles and coinsurance provisions applicable to other such hospital benefits provided under the company Medical Plan. Please refer to the Summary Plan Description for deductibles and coinsurance information applicable to the options in which you choose to enroll.

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 August 10, 2017. Contact your State for more information on eligibility.

ALABAMA - Medicaid	ALASKA - Medicaid	ARKANSAS - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Program Website: http://myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/pages/medicaid/default.aspx	Website: http://myarhipp.com Phone: 1-855-692-7447
COLORADO - Health First Colorado (Medicaid) and Child Health Plan Plus (CHP+)	**FLORIDA - Medicaid**	**GEORGIA - Medicaid**
Health First Website: https://healthfirstcolorado.com Health First Phone: 1-800-221-3943/state relay 711 CHIP+ Web: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHIP+ Phone: 1-800-359-1991/state relay 711	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 1-404-656-4507
INDIANA - Medicaid	**IOWA - Medicaid**	**KANSAS - Medicaid**
Indiana Health Plan for low-income adults age 19-64: Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid: Website: http://www.in.gov/medicaid/ Phone: 1-800-403-0864	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://www.kdheks.gov/hcf/Medicaid/ Phone: 1-785-296-3512

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

KENTUCKY - Medicaid	LOUISIANA - Medicaid	MAINE - Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-695-2447	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS - Medicaid and CHIP	**MINNESOTA - Medicaid**	**MISSOURI - Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
MONTANA - Medicaid	**NEBRASKA - Medicaid**	**NEVADA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/hipp Phone: 1-800-694-3084	Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: https://dwss.nv.gov/ Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid	**NEW JERSEY - Medicaid and CHIP**	**NEW YORK - Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1-603-271-5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	**NORTH DAKOTA - Medicaid**	**OKLAHOMA - Medicaid**
Website: https://dma.ncdhhs.gov/ Phone: 1-919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

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

OREGON - Medicaid	PENNSYLVANIA - Medicaid	RHODE ISLAND - Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347
SOUTH CAROLINA - Medicaid	**SOUTH DAKOTA - Medicaid**	**TEXAS - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com Phone: 1-800-440-0493
UTAH - Medicaid and CHIP	**VERMONT - Medicaid**	**VIRGINIA - Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Medicaid and CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid	**WEST VIRGINIA - Medicaid**	**WISCONSIN - Medicaid**
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 Ext. 15473	Website: http://mywvhipp.com Phone: 1-855-MyWVHIPP (1-859-699-8447)	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING - Medicaid		
Website: https://wyequalitycare.acs-inc.com Phone: 1-307-777-7531		

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Required Legal Notices

Date: 10/13/2017
Name of Entity/Sender: ABX Air, Inc.
Contact/Office: Benefits Department, 145 Hunter Dr., Wilmington, OH 45177

Important Notice About Your Prescription Drug Coverage and Medicare Notice of Creditable Coverage

If this Creditable Coverage notice has been delivered to you by electronic means, you have the right to receive a written notice and may request a copy of this notice at no charge by contacting your Human Resources Department. Also, if you are the employee participant under the companies group health plan, you are responsible for providing a copy of this notice to each of your Medicare Part D eligible dependents covered under this plan.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the companies of ATSG, (covered by the ABX Air Cafeteria Plan) 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 your current 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. ABX Air Inc., the Plan Sponsor, has determined that the prescription drug coverage offered by the company Medical Plans for employees 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?
Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 31st. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment Period (SEP) to sign up for a Medicare prescription 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 coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back only during Open Enrollment or with a qualified event. Contact your Human Resources Department for more information.

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 coverage with the company and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.
If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following November to enroll.

For More Information About This Notice or Your Current Prescription Drug Coverage
For more information contact your Human Resources Department. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the company changes.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Required Legal Notices

Women's Preventive Care Services

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.

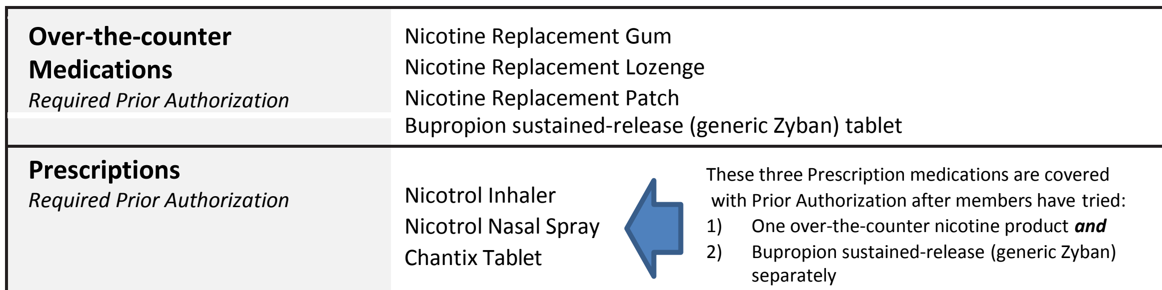
This communication is not intended, nor should it be construed, as legal or tax advice. Please contact a competent legal or tax professional for legal advice, tax treatment and restrictions. Federal and state laws and regulations are subject to change.

Required Legal Notices

Tobacco cessation drugs covered at no cost to members

Good news for those looking to kick the habit. 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 *Required Prior Authorization*	Nicotine Replacement Gum Nicotine Replacement Lozenge Nicotine Replacement Patch Bupropion sustained-release (generic Zyban) tablet	
Prescriptions *Required Prior Authorization*	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

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

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.

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.

Healthy Directions Wellness Program

2018 EMPLOYEE
HEALTH & WELLNESS PROGRAM
Let's get Healthy with *Healthy Directions!*

2018 EMPLOYEE HEALTH & WELLNESS PROGRAM

Let's get Healthy with *Healthy Directions!*

OVERVIEW

The Healthy Directions Wellness Programs are voluntary programs offering you incentives to improve your overall health and earn savings on your health insurance premiums per pay. Check out our multiple opportunities to participate and receive a Wellness Discount quarterly.

WHY SHOULD I JOIN?

Besides the out-of-pocket savings on your premiums (per pay), there are additional benefits to being part of a wellness program. It is important for your own well-being and achieving a healthy lifestyle for you as well as your family. Join the employee health and wellness program today, and *"Point Yourself Toward a Better Lifestyle!"*

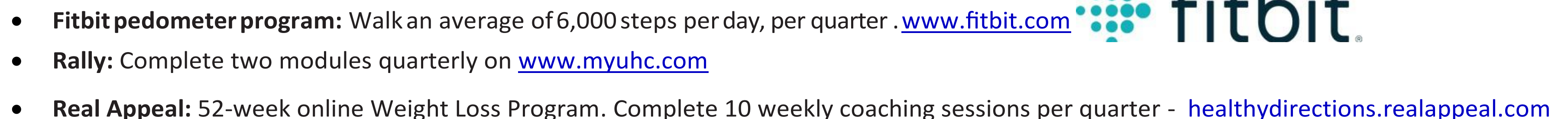
WHAT PLANS ARE AVAILABLE?

Each quarter you have the opportunity to participate in a wellness program and receive "Wellness" reductions in your base price of premiums. If an employee fails to achieve any of the requirements in any quarter, the following quarter's premiums will be deducted at the "base rate."

WHAT ARE THE QUARTERLY REQUIREMENTS?

**see full information at http://myabx.com/wellness/index.html*

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



- **Fitbit pedometer program:** Walk an average of 6,000 steps per day, per quarter . www.fitbit.com
- **Rally:** Complete two modules quarterly on www.myuhc.com
- **Real Appeal:** 52-week online Weight Loss Program. Complete 10 weekly coaching sessions per quarter - healthydirections.realappeal.com

After completion of an above program, data is reported to HR and your wellness discount will be applied to those who successfully complete the quarterly requirements. Individuals with pedometers other than a Fitbit product can participate in the Company Wellness Program.For more details contact Tracey Dykes, ABX Air Human Resources at 937.366.2134 (#62134) tracey.dykes@abxair.com .

Healthy Directions Wellness Program

2018 EMPLOYEE
HEALTH & WELLNESS PROGRAM
Let's get Healthier in 2018 with Healthy Directions!

real appeal®

Lasting weight loss

without turning your life upside down

ALL THIS! At no cost to you!

Real Moves

Real Success Guide

Real Foods

We give you all the tools you need to succeed.

Plus, your very own transformation coach

Enroll using a smartphone, tablet or personal computer at
healthydirections.realappeal.com

Available at <u>no cost</u> to eligible employees, spouses and dependents 18 and older on our UnitedHealthcare plan with a body mass index (BMI) of 23 or higher.

GREAT HEALTH RECOMMENDATIONS, JUST FOR YOU.

Rally can help you get healthier, one small step at a time.

Rally shows you how to make simple changes to your daily routine, set smart goals and stay on target. You'll get personalized recommendations on how to move more, eat better and feel happier—and have fun doing it.

Get Your Rally Age

Start with the quick Health Survey and get your Rally Age to help you assess your overall health. Rally will then recommend missions for you: simple activities designed to help immediately improve your diet, fitness and mood. Start easy, and level up when you're ready.

Build Better Habits

Plus, on Rally there are lots of ways to earn Rally coins, which you can use for chances to win great rewards. Rack up coins for joining missions, pushing yourself in a challenge and even just for logging in every day.

Rally is available at no additional cost to you, as part of your health plan benefits.

Win Cool Stuff

FIND YOUR MISSION TODAY.

Register today at myuhc.com®.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities. Your Health Age is based on self-disclosed information, including any applicable biometric screening data.

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SUMMARY OF MATERIAL MODIFICATIONS

Value PPO Plan
Health Savings Account PPO Plan

Please review the 2018 Summary of Benefits for full details. **Effective: January 1, 2018**

The information contained in this New Hire Guide is considered your
Notice of Summary of Material Modifications

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.

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