Employee Benefits

Full and Part Time

Summary Plan Description

2018

ABX AIR

Summary Plan Description

for

Full-Time & Part-Time Employees

2018

Data contained herein is based on information available as of 1/1/2018. This booklet does not contain any information regarding laws passed or administration changes beyond the above stated date. Nothing contained in this booklet is intended to be a term or condition of the Company's employment of any individual. The company specifically reserves the right to eliminate, modify, and interpret any of these programs and guidelines at any time at its sole discretion.

TABLE OF CONTENTS

SCHEDULE OF MEDICAL BENEFITS 2018

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 . . .
Care 24 -NurseLine: 1-888-887-4114 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 copayment do not apply)	Not covered	100% (deductible and copayment do not apply)	Not covered	100% (deductible and coinsurance do not apply)	Not covered
Well Baby Care	100% up to 2nd birthday (deductible does not apply)	Not covered	100% up to 2nd birthday (deductible does not apply)	Not covered	Covered under Preventive Care	Not covered
Chiropractic	$45 copay Limit 12 visits per/cal year	60% of MNRP[1] Limit 6 visits per/cal year (deductible applies)	$45 copay Limit 12 visits per/cal year	50% of MNRP[1] Limit 6 visits per/cal year (deductible applies)	80% Limit 12 visits per/cal year (deductible applies)	60% of MNRP[1] Limit 6 visits per/cal year (deductible applies)
Physician Services Office Visits	$25 copay/ office visit $45 copay/ specialist visit (deductible does not apply)	60% of MNRP[1] (deductible applies)	$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	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% hospital visits and surgery (deductible applies)	60% of MNRP[1] (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 . . .
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 per year) Home Health Care[2] (up to 130 visitsper year) Hospice Care[2]	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 $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)	100% of MNRP[1]after $150 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 60% of MNRP[1]after $200 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	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) 80% 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)
Virtual Doctors (using United HealthCare programs)	100% (deductible does not apply)	n/a	100% (deductible does not apply)	n/a	100% *(deductible applies)*	n/a
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)	60% of MNRP[1] (deductible applies)	80% (deductible applies) (does not count)	50% of MNRP[1] (deductible applies)	80% (deductible applies) (does not count	60% of MNRP[1] (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 . . .
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)	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)	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) (deductibles apply)	Not covered
Mental Health and Substance Abuse[3]						
Inpatient Care[3] (maximums apply; see Mental Health and Substance Abuse section)	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)
Office Visits Outpatient Care[3] (maximums apply; see Mental Health and Substance Abuse section)	100%, after $25 copayment)	60% of MNRP[1] (deductible applies)	100%, after $25 copayment	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Session for Partial Hospitalization Intensive Outpatient Treatment [3]	100%, after $25 copayment	60% of MNRP[1] (deductible applies)	100%, after $25 copayment	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (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 . . .
Annual Deductible	$550/person; $1,100/family (applies except where specified)	$700/person; $1,400/family (applies except where specified)	$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 (applies except where specified)	$3,100 individual plan; $6,200 total for family plan (applies except where specified)
Out-Of-Pocket Maximum	$2,000/person; $4,000/family (except where specified)	$6,400/person; $12,800/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; $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.
NOTE: Copayments do not apply towards deductible

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

MEDICAL PLAN

The company medical plan is intended to help you meet the costs of medically necessary services and supplies required for the treatment of an illness or accidental injury. Coverage applies anywhere in the world. You and your eligible dependents must be covered under the Medical Plan at the time expenses are incurred for benefits to be payable. (Payment of medical benefits is subject to limitations, exclusions, and definitions; refer to these sections for more information.)

You have three options for medical coverage that are provided through United HealthCare (UHC) Insurance Company: the Enhanced PPO option (closed plan - eligibility subject to hire date), the Value PPO option, or the HSA PPO option. Refer to the appropriate section for more information on these medical coverage options.

For a list of UHC network providers, call UHC member services at 888-350-5607 or visit the UHC website at www.MYUHC.COM and select the "United Healthcare Choice Plus" product.

Eligibility and Effective Date

Employees

Eligible employees are regularly scheduled full-time (FT) or part-time (PT) employees. Eligible employees are regularly scheduled to work 15 or more hours per week.

- Eligible employees may also enroll their eligible dependents.

Employees who are members of a collective bargaining unit are eligible only if the collective bargaining agreement provides for participation in this Medical Plan.

You are not eligible to enroll if you are working in a capacity that (at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary) is considered contract labor or independent contracting.

New FT and PT employees become eligible for Medical Plan coverage on the day after completing 30 days of service.

- You will be covered by the Plan as soon as you become eligible.
- You are required to complete the Self Service Insurance Enrollment form online **within 30 days from date of hire.**
- In order to decline coverage you must complete the Self Service Insurance Enrollment form online **within 30 days from date of hire.**

If you fail to complete the Self Service Insurance Enrollment form online before your effective date of coverage, you will automatically default to DECLINE COVERAGE/ NO COVERAGE.)

Dependents

Your eligible dependents are covered under this Plan on the date your coverage is effective if you are eligible and enroll each dependent for coverage.

Your eligible dependents are:

- Your legal spouse: 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 are certifying that he /she does not have access to employer-sponsored medical coverage through their job. **Failure to disclose other coverage will subject you to possible disciplinary action.** Your children under age 26, (regardless of marital, residence, or job status) including your natural children, legally adopted children, children placed for adoption, stepchildren and any other children, provided you are their legal guardian or you claim the children as dependents for federal income tax purposes.
- Your unmarried child who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, provided such child was covered under this Plan at the time of disability and immediately prior to his or her 26th birthday.

If you do not enroll your dependents when they are first eligible, you must wait until the next open enrollment period in the fall for a January 1 effective date, except in the event of a Family/Work status change (see Family/Work Status Changes section).

If your spouse is also an employee of this company and is covered under the company medical plan:

- They must be on their own plan,
- Your dependent children may be enrolled under only one parent's coverage.

If one of your dependents is an employee and is eligible for medical care coverage

- He/ she may not be enrolled as both a covered dependent and an employee.
- He/ she may be enrolled as a dependent under only one parent's coverage

Dependent Verification

To enroll your dependents you must verify that they are eligible to participate in the Plans. To verify their eligibility you must provide the following documentation to the Human Resources department prior to enrollment. Dependents will lose eligibility if these documents are not submitted. The documents are:

- Marriage certificate for your spouse
- Birth certificates or adoption documentation for your children.

Social Security Numbers for Dependents-

The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires all health plans 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 your dependents tax 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 check social security numbers by going to Employee Self Service and clicking on **BENEFITS,** then **DEPENDENTS.** Click the box next to your dependent's name and click on **CHANGE (pencil icon)** to verify the social security number is entered in the Tax-ID field. .

Benefits Enrollment

Initial enrollment: Your initial enrollment election is a commitment for the remainder of the calendar year. As a new hire, you have until your effective date (30 days from your date of hire) to complete the Self Service Insurance Enrollment form online. If you are newly eligible for the Medical Plan due to a change in employment status, you will have 30 days from status change date to complete the Self Service Insurance Enrollment form. If a form is not completed within the specified time, you will automatically be enrolled in "Default/No Coverage."

Open Enrollment: You will be given the opportunity to review your participation in the companies benefit plans on an annual basis each fall for a January 1 effective date. This is called an "Open Enrollment" period. Your Open Enrollment election is a 12-month commitment beginning January 1. Other than open enrollment, you may change your annual election during the year *only* if you meet one of the family or work status changes described in the next section.

Default coverage: If you do not complete the Self Service Insurance Enrollment form within the specified time, you will automatically be enrolled in "Default Coverage." For your initial enrollment in the Plan, "default coverage" means **NO COVERAGE**.

Special Enrollments/Notice of Employee Rights

If you have declined coverage under the Medical Plan for yourself, your spouse and/or your dependents because of other health coverage, you may be eligible to change your election during the year and elect company coverage if: the other coverage was COBRA and it has now been exhausted; eligibility for the other coverage was lost or, if the other coverage was employer provided and the employer stopped contributing toward that coverage. To obtain coverage you complete the Self Service Enrollment and supplied any needed documentation within 30 days after your other coverage ends.

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 your dependents, provided you complete The Self Service electronic enrollment and supplied any needed documentation within 30 days of the event.

Family/Work Qualified Status Change

Your benefit election is in force for the full plan year (January 1 through December 31) following the enrollment period (unless your coverage terminates). **You are eligible to change your election during the year only if you have a qualifying change in your family or work status, complete Self Service enrollment and submit the required documentation to Human Resources within 30 days of the qualifying event.**

The change in your election will apply only to the affected individual(s) and must be consistent with the change in family or work status. Qualifying family and work status changes are:

- **Legal marital status change** due to marriage, death of a spouse, divorce, legal separation or annulment.
- **Number of dependents change** due to birth, adoption, placement for adoption or death of a dependent
- **Employment status changes** for you, your spouse or dependent due to ending or starting employment, a strike, lockout or commencement or return from an unpaid leave of absence (including an FMLA leave); or a change in employment status with the consequence that you,

your spouse or dependent becomes or ceases to be eligible for coverage (such as a switch between part-time and full-time status).

- **Residence or worksite change** (for you, your spouse or dependent) that could affect your benefits.
- **Dependent child's eligibility change** which causes a dependent to satisfy or cease to satisfy eligibility requirements due to age or a similar change.

You may add or stop coverage for yourself or a covered dependent, as applicable, if you experience any of the following qualifying events:

- **Coordination of coverage with another group plan.** If the plan of your spouse's or dependent's employer has a different coverage period than this Plan, or allows mid-year election changes for qualified status change events, you may be able to change your election under this Plan. Any change in your election will be prospective only and will correspond with your eligibility for and enrollment in your spouse's or dependent's coverage.

- **Medical coverage with another group plan ends.** If you declined coverage under this Plan for yourself, your spouse and/or your dependents because of other medical coverage, you may be eligible to change your election during the year and elect coverage if: 1) the other coverage was COBRA and it has now been exhausted; 2) eligibility for the other coverage was lost or, 3) if the other coverage was employer provided, the employer stopped contributing toward that coverage.

- **Medicare or Medicaid.** A coverage election may be changed for you, your spouse or a dependent that becomes entitled to or loses eligibility for coverage under Medicare or Medicaid. (*See the "Coordination of Benefits with Medicare" section for more information.)*

- **Judgment, decree or order.** You may change your election, if necessary, to comply with a court or administrative order which affects coverage for your child. You may also enroll your eligible child if so required due to a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order (QMCSO)) that requires medical coverage for your child. Coverage starts on the date specified in the QMCSO. If you are not already enrolled, you must enroll at the same time your child is enrolled. A new Self Service Insurance Enrollment form should be completed. (*See the "Qualified Medical Child Support Order" section for more information.)*

- **Cost of coverage under this Plan**. If the cost of your medical coverage increases or decreases during the plan year, you will be notified of the cost change and the amount of your contributions will be adjusted automatically for your share of the increase or decrease. If the cost of your medical coverage increases significantly, as determined by the Plan Administrator, but not less than a 10% increase, you may change your election to either increase your future contributions or elect another similar coverage. You may not revoke your election without electing another coverage.

- **Significant change in coverage under this Plan.** If your medical coverage is significantly curtailed, as determined by the Plan Administrator, or ceases altogether, you may revoke your election and, if you choose, elect another similar coverage for the balance of the plan year. If, during the plan year, a new medical coverage is offered, you may change your election to elect the new coverage; if your coverage is eliminated, you may change to another similar coverage.

- **Change in regularly scheduled hours that affect benefits eligibility.** If your employment status changes from a casual position with no medical benefit eligibility to a full-time or part-time position with medical benefit eligibility, you will be allowed to make a coverage election at that time. Your casual employment will count toward your 30-day eligibility waiting period.

Dates for Qualifying Status Changes			
QUALIFYING STATUS CHANGE	**To change coverage, complete the online Self Service Enrollment. Your enrollment must be completed by:**	**Proof Required**	**Benefits Start/Loss Date**
Marriage:	30 days from date of marriage.	A copy of the marriage certificate.	Covered from the date of marriage.
Divorce, legal separation or annulment	30 days from date of separation, divorce or annulment.	A copy of court papers showing the date the separation, divorce or annulment was final.	Covered dependents lose coverage the end of the month the event was final. COBRA information is sent to the cancelled dependents.
A newborn infant	30 days from date of birth	Birth Certificate	Covered from date of birth.
A newly adopted child	30 days from the date of your child's placement for adoption.	A copy of the final adoption papers showing the date adoption was finalized.	Covered from date the child is physically placed with you for adoption & you assume financial responsibility.
Court Order to enroll child(ren)	30 days from the date on the court order.	Copy of the court order.	Date specified on the court order.
Death of a covered employee.	30 days from the date of death.	Copy of death certificate	Dependent coverage ends at end of the month in which the person died.
Gain or loss of insurance for dependents.	30 days from the date of the event.	Notice from dependent's employer of date benefits gained or lost.	Date following the event.
Change in hours that affect your benefits eligibility.	30 days from the status change.	No proof required.	Covered the date your status changed (provided you have satisfied the waiting period.)

Cost

Currently, the company pays most of the cost of UHC-sponsored Medical Plan coverage for eligible active employees and their eligible dependents. See enrollment materials for cost information.

Within 30 days of your hire date, and again during each annual open enrollment period, Human Resources will give you information about your share of the premium for coverage for that Plan year. Your contributions will be deducted from your pay before your withholding taxes are calculated, thereby reducing your income taxes and FICA taxes. You will be given an opportunity to elect pretax coverage each year during the open enrollment period. **It is your responsibility to notify Human Resources/Benefits if your payroll deductions are not correct.**

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018.
Contact your State for more information on eligibility –

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website:
http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
</table>

IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, you can contact either:

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

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

Maximum Lifetime Benefits

The lifetime limit on the dollar value of benefits under Cafeteria Plan no longer applies.

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits a group health plan from requesting or requiring an individual or family member of an individual from undergoing a genetic test. It provides that such prohibition does not: (1) limit the authority of a health care professional to request an individual to undergo a genetic test; or (2) preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment. It requires the plan to request only the minimum amount of information necessary to accomplish the intended purpose. It also prohibits a group health plan from requesting, requiring, or purchasing genetic information: (1) for underwriting purposes; or (2) with respect to any individual prior to such individual's enrollment in connection with such enrollment (provided that incidentally obtained information is not a violation).

Enhanced PPO, Value PPO and Health Savings Account (HSA) PPO Plans

Through the Enhanced PPO Choice Plus, the Value PPO Choice Plus option or the HSA PPO Choice Plus, you have flexibility to see the providers who meet you or your family's health care needs. Some examples of providers are physicians, therapists, chiropractors, hospitals, rehabilitation facilities, skilled nursing facilities, and durable medical equipment providers. "PPO" refers to "preferred provider organization" — this is a national network of health care providers who have negotiated with United HealthCare (UHC) to participate in their Choice Plus network. Here is how it works.

These Plans have two levels of benefits: network and non-network. Each time you need care; you decide whether to see network or non-network providers. You receive higher benefits for Covered Health Services if you see network providers. (See the Schedule of Medical Benefits at the beginning of the medical plan section for benefit amounts). Network providers agree to accept contracted rates for their services, and they agree not to bill any excess charges to you or to the company. Network providers will also file claims for you.

See Exclusions section for services and supplies not covered under the medical plan. See Definitions sections for explanation of terms.

Network and Non-Network Providers

If network providers are used, these Plans pay a greater portion of Eligible Expenses. This is called the network benefit level. To receive network benefits:

- You choose a network provider. You are not required to get a referral from a primary care physician to see specialists.
    - For a list of UHC network providers, call UHC member services at 1-888-350-5607 or visit their website at www.MyUHC.com. Follow the instructions below to register:
        - Click on the "Register Now" button on the left hand side
        - On the registration website - you will need to put in:
        - Your name

- Date of birth
- Your UHC Member ID Number and Group Number. (Both of these numbers are on the front of your UHC ID card)
- Once logged on your will see the "Find a Doctor" link on the left hand side.

- You pay any required coinsurance, copayments and deductibles.
- The Plans pay benefits at the level shown on the Schedule of Medical Benefits (at the beginning of the medical plan section).
- The provider handles claim filing and paperwork.

If non-network providers are used, these Plans pay a lesser portion of Eligible Expenses. This is called the non-network benefit level. With non-network benefits:

- You may need to pay the bill in full and file a claim with UHC for reimbursement (some non-network providers will handle claim filing with UHC).
- The Plans pay benefits at the level listed on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).
- You are responsible for any charges that exceed the maximum non-network reimbursement (MNRP) amount (See Maximum Non-Network Reimbursement Program section).

You must satisfy certain copayments and/or deductibles before any payment is made for Eligible Expenses. Then the medical plan pays the percentage of Eligible Expenses shown in the Schedule of Medical Benefits (at the beginning of the Medical Plan section).

Copayments, Deductibles and Coinsurance

Before benefits are payable, you must satisfy certain deductibles, and pay a copayment, or coinsurance. The medical benefits subject to the copayment/coinsurance/deductibles are shown in the Schedule of Medical Benefits (at the beginning of the Medical Plan section).

Copayment is the amount of Eligible Expenses you must pay to a network provider at the time services are given. The Enhanced and Value PPO Plans pay a copayment for office visits**.** Office visit copayments apply to network physicians. It applies to all Covered Health Services given in connection with each office visit. The office visit copayment does not apply to the prenatal and postnatal office visits after the initial visit to the network obstetrician/gynecologist who is primarily responsible for maternity care.

Copayments do not count toward the deductible but are applied to the Out-of-Pocket Maximum.

Deductible is the amount of Eligible Expenses you must pay each year from your own pocket before the plan will pay for certain Covered Health Services. After the deductible has been met, benefits are payable at the percentage shown in the Schedule of Medical Benefits. The network family deductible is the maximum amount a family will have to pay in any calendar year no matter how large a family may be. Any Eligible Expenses used to satisfy the deductible will apply whether network or non-network services are used. Copayments, non-notification penalties, medical expenses that exceed MNRP charges, and amounts over the maximum benefit limitations do not count toward the deductible.

Coinsurance is your share of the costs of the covered services, calculated as a percentage of the allowed amount for the service/medication after the deductible has been met.

Out-of-Pocket Maximum

The Plan's out-of-pocket maximum protects you against extremely high medical costs. This feature limits the costs you pay for most Covered Health Services. Once the out-of-pocket maximum dollar amount shown in the Schedule of Medical Benefits is reached during a Calendar Year, then most benefits are payable at 100% for the rest of that year.

Non-notification penalties, medical expenses that exceed MNRP charges, amounts over the maximum benefit limitations do not apply toward the out-of-pocket maximums. These will still apply even after the out-of-pocket maximum has been reached.

Any expenses used to satisfy the out-of-pocket maximum will apply whether network or non-network services are used.

Maximum Non-Network Reimbursement Program

Benefit payments to *non-network* providers are subject to Maximum Non-Network Reimbursement Program (MNRP). These MNRP limits assure that maximum expenses allowed under the Plan represent the fees set by United Healthcare based on a percentage of the published rates allowed by Medicare for the same or similar service or available data resources of competitive fees in that geographic area.

If part of your claim is denied because it exceeds the Plan's MNRP charge limit, you can contact your health care provider and ask if there is a special reason for the higher charge. If there is no special reason for the higher price, ask the health care provider to reduce the charge to the MNRP amount allowed by the medical plan.

If your health care provider believes higher charges are justified because of special circumstances related to your treatment, you can resubmit your claim. The resubmitted claim must include additional information from your health care provider that supports the higher charge. United HealthCare will reconsider your claim based on the supplemental information.

After the claim is reconsidered and a final decision has been made, you are responsible for any remaining charges in excess of the plan's MNRP charge limits.

Note: Medical expenses that exceed MNRP charges, amounts over the maximum benefit limitations under the Plan and non-notification penalties will not be applied toward the deductible and will not count toward the out-of-pocket maximum.

Cost Saving Feature: Remember the amount you pay toward your care is discounted if you go to network providers ("providers" includes physicians and hospitals). Network providers agree to accept contracted rates for their services, and they agree not to bill any excess charges to you. (For a list of UHC network providers, call UHC member services at 1-888-350-5607 or visit their website at www.MyUHC.com, select " Find Physician, Laboratory or Facility", then select "Medical Directory", then "All United Healthcare Plans", then select "Choice Plus".)

Non-Notification Penalty

If you have failed to pre-notify United Healthcare (UHC) in a timely manner, you will incur a Non-Notification Penalty amount shown on the Schedule of Medical Benefits (at the beginning of the Medical

Plan section). (See Personal Health Support section for services that require you to notify UHC prior to receiving services.) This penalty does not apply toward your deductible or out-of-pocket maximum.

A separate non-notification penalty applies to certain Mental Health & Substance Abuse benefits if United Behavioral Health (UBH) is not notified prior to receiving services. See the Mental Health & Substance Abuse section.

Personal Health Support Program

In order to qualify for maximum benefits, Covered Health Services under these Medical Plans are subject to the Personal Health Support Program at United HealthCare (UHC). Personal Health Support determines whether the services or supplies are Covered Health Services. **No benefits are payable unless Personal Health Support determines the services and supplies are covered under the Plan**. A Non-Notification penalty may be applied before certain benefits are payable.

The Personal Health Support program is designed to encourage an efficient system of care for you and your covered dependents by identifying and addressing possible unmet covered health care needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. The Personal Health Support activities are not a substitute for the medical judgment of your physician; the ultimate decision as to what medical care you and your dependents actually receive must be made by you and your physician.

Personal Health Support is triggered when UHC receives notification of an upcoming treatment or service. The notification process serves as a gateway to Personal Health Support activities and is an opportunity for the employee to let UHC know that he/she is planning to receive specific health care services. UHC Personal Health Support may be contacted by calling the telephone number listed on your ID card.

You can expect to receive telephone calls from UHC when certain treatments are involved. The ultimate decision on medical care must be made by the covered person and his/her physician. UHC Personal Health Support only determines if the listed service or supply is a Covered Health Service according to the Plan benefits and provisions.

The services requiring you or your physician to pre-notify UHC Personal Health Support include:

- Hospital inpatient admissions (if an Emergency admission to a provider occurs, UHC should be notified within two business days)
- Skilled Nursing Facility
- Home health care
- Hospice Care
- Maternity Services when hospital stay exceeds the 48/96 guidelines (see Pregnancy section)
- Transplants of organs and donor expenses (see Covered Health Services section)

Approval by Personal Health Support does not guarantee that benefits are payable under these Plans. Benefits are based on:

- The covered services and supplies actually performed or given.
- The covered person's eligibility under these Plans on the date the covered services and supplies are performed or given.
- Copayments, deductibles, coinsurance, maximum limits, exclusions and all other terms of these Plans.

How to notify Personal Health Support

Notify Personal Health Support by calling the toll-free number shown on your United HealthCare ID card at 1-888-350-5607.

When to notify Personal Health Support

For hospital inpatient confinement, Skilled Nursing Facility, Home Health Care, or Hospice Care, Organ/Tissue Transplants: at least 5 working days before the service start date or as soon as reasonably possible.

- Pregnancy is subject to the following notification time periods:
- Healthy Pregnancy Program — Personal Health Support should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in this prenatal program.
- Inpatient Confinement for Delivery of Child — Personal Health Support must be notified only if the inpatient care for the mother or child is expected to continue beyond: 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. For inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits, Personal Health Support must be notified before the end of these time periods.
- Non-Emergency Inpatient Confinement Without Delivery of Child — Confinement during pregnancy but before the admission for delivery, which is not Emergency Care, requires notification as a scheduled confinement. Personal Health Support must be notified prior to the scheduled admission.

- Emergency Care: When Emergency Care is required and results in a hospital confinement, the covered person (or that person's representative or physician) must call Personal Health Support within 48 hours of the date the confinement begins. If it is not reasonably possible to call Personal Health Support within 48 hours, Personal Health Support must be notified as soon as reasonably possible. When the Emergency Care has ended, however, Personal Health Support must be called before any additional services that require notification are received.

Benefits are Reduced if Personal Health Support is Not Notified

Benefits are reduced if you do not call United HealthCare Personal Health Support as required. This reduction is called a Non-Notification Penalty. A Non-Notification penalty applies to each confinement, surgical procedure, or treatment plan. The amount of the non-notification deductible is shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section). The amount of the non-notification penalty will never be more than the amount of the Eligible Expenses.

A Covered Person can appeal a decision by calling UHC Personal Health Support.

If you or your physician does not agree with Personal Health Support's decision, it can be appealed.

- The covered person or the physician can request Personal Health Support to reconsider the decision by writing (United HealthCare, ABX Air, Inc.-Medical Unit, P.O. Box 30555, Salt Lake City, UT 84130-0555) or telephoning 1-888-350-5607 within 60 days of the decision.

- If the covered person, the physician and Personal Health Support still cannot find an acceptable solution, this decision can be re-appealed. A different UHC physician will review the facts of the case — taking into account the covered person's and the attending physician's point of view — and make a final decision.

(Claim appeals are different and separate from medical necessity appeals. Refer to Claim Procedures.)

Virtual Visits

United Healthcare offers **Virtual Visits** allowing you to see and talk with a physician without an appointment via your mobile device or computer. This service is for common non-emergency acute conditions when your primary care physician or urgent care is inconvenient or unavailable. The virtual physician can write a prescription and electronically send it to your pharmacy. You can access Virtual Visits through the **Health4Me** app on your mobile device or **myuhc.com** on your computer. (See the Schedule of Medical Benefits at the beginning of the medical plan section for benefit amounts)

NurseLine

United's Care 24 NurseLine is a toll free, 24-hour, year-round source of immediate medical information and support to help you or your family make wiser treatment decisions. Registered nurses with emergency room or other triage experience give callers helpful information on just about any medical conditions. Commonly, nurses answer questions about:

- Minor injuries and illness
- Self-care and first aid
- Nutrition and wellness
- Prescription interactions and usage
- Local support groups and other agencies

Call the Care 24 NurseLine - 1-888-887-4114 .

Disease Management

Individuals with certain chronic conditions will be eligible to participate in United HealthCare's Disease Management Program. This program is designed to help people with chronic conditions improve their quality of life by providing high level support and information about their illness.

A specially trained registered nurse will be assigned to you and can help with questions about your disease and your treatment program. The nurse can also provide information about preventive care, other treatment options, and provide outreach to your doctors and specialists. The following conditions are currently supported:

- Asthma
- Diabetes
- Coronary Artery Disease
- Heart Failure

Additional conditions may be added in the future. Participation in the program is voluntary and provided at no cost to the participant.

Covered Health Services

- **IMPORTANT: YOU MUST PRE-NOTIFY UHC for certain HEALTH CARE FACILITY BENEFITS. Call UHC Personal Health Support at 1-888-350-5607.** Refer to Personal Health Support section for the services requiring you or your physician to pre-notify UHC Personal Health Support.
- Refer to the Mental Health and Substance Abuse section for covered services relating to mental health and substance abuse treatment. **Call United Behavioral Health (UBH) BEFORE receiving treatment 1-800-888-2998.**
- Refer to the Outpatient Prescription Drugs section for covered prescription drugs and medicines purchased from a network pharmacy.

Covered Health Services include the following listed health services, supplies and equipment required for the purpose of diagnosing or treating a sickness, injury, mental illness, substance abuse, or symptoms.

For benefit coverage amounts see the **Schedule of Medical Benefits** (at the beginning of the Medical Plan section). Logon to www.MyUHC.com to view your benefits and claims information or to locate network providers.

Ambulance Service

Ambulance ground transportation services are covered to the nearest hospital that has the necessary facilities when other forms of transportation would endanger a patient's life.

Bariatric Surgery

Surgical treatment of morbid obesity received on an inpatient basis. **You must notify UHC before obtaining services to avoid a non-notification penalty.** The Plans will cover eligible expenses incurred at the level shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).

Blood Transfusions

Inpatient or outpatient blood transfusion services, including the cost of blood and blood plasma if not replaced by a voluntary donor.

Dental

See Exclusions section.

Durable Medical Equipment

Durable medical equipment is a Covered Health Service if it meets all of the following and is ordered by a doctor:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

Durable Medical Equipment includes appliances which replace a lost body organ or part or help an impaired one to work including:

- Braces, crutches, casts, splints, initial artificial limbs or eyes, or other prosthetic appliances.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices

Emergency Air Transportation

Provided it is the only mode of transportation available to transport the patient to the closest facility capable of providing the immediate care medically necessary.

Emergency Room Care

If you experience an emergency, call 911 or get to an emergency room quickly. If you are admitted from the emergency room of a hospital, have the hospital notify UHC Personal Health Support within 48 hours by calling the member services number on your UHC identification card.

An emergency is the sudden onset of a medical condition a reasonable person would consider an emergency. Emergencies are signaled by acute symptoms that could reasonably be expected to result in:

- Serious jeopardy of the patient's health
- Serious impairment of bodily function
- Serious dysfunction of an organ or other body part
- Self-inflicted harm to the patient
- The patient harming others

Hospital charges for emergency room treatment of a life-threatening situation or other emergency listed above are covered at network rate with no deductible (for Enhanced and Value PPO only), regardless of whether you visit a network or non-network provider as shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section). Copays will apply to Enhanced and Value PPO Plans. Coinsurance will apply for all Plans.

If it's Not a True Emergency*: If* you go to the emergency room when your situation is not a true emergency, your care will be covered at a reduced benefit level as shown on the Schedule of Medical Benefits.

Home Health Care Benefits

Notify UHC before obtaining services to avoid a non-notification penalty. The Plans will cover eligible expenses incurred under a certified Home Health Care program at the level shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).

Notify UHC at the member services number on your UHC identification card. Your attending physician must certify to UHC Personal Health Support that proper treatment of the illness or injury would require hospitalization if services and supplies were not otherwise available under the Home Health Care program.

Any services and supplies furnished must be provided by an authorized Home Health Care Agency (see Definitions section) and must be medically necessary as determined by United HealthCare.

Eligible expenses covered as home health care benefits include:

- Charges for medical supplies, drugs, and medicines that require a prescription by a physician and are approved by the United States Food and Drug Administration for general use in treating the illness or injury for which they are prescribed.

- Up to 130 visits in any calendar year for:

    - Part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.);

- Physical therapy, occupational therapy, and speech therapy provided by the Home Health Care Agency;
- Laboratory services furnished by or on behalf of a hospital (covered under the Hospital Inpatient Benefits); and
- Part-time or intermittent home health aide services that consist primarily of caring for the patient.

A home health visit is a visit of up to 4 hours by a home health aide or a visit of any duration by any other member of a home health care team.

Medical expenses NOT covered as home health care benefits include:

- Services or supplies not included in the Home Health Care plan.
- Services of a person who ordinarily resides in your home or is a member of you or your spouse's family.
- Services or supplies not medically necessary in terms of generally accepted medical standards, as determined by United HealthCare.
- Services or supplies considered experimental in terms of generally accepted medical standards, as determined by United HealthCare.
- Services rendered in any period during which the patient is not under the continuing care of a physician.
- Custodial care and transportation services.
- Home Health Care expenses incurred for visits in excess of 130 visits in any calendar year.
- Benefits or services otherwise provided under the Plan.

Hospice Care Benefits

You or your physician must pre-notify United HealthCare (UHC) to avoid a non-notification penalty. Notify UHC at the member services number on your UHC identification card. These Plans will cover charges made by a Medicare-approved hospice for palliative care provided to a terminally ill patient with a life expectancy of six months or less. These Plans will cover eligible expenses at the level shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section). Covered hospice care includes nursing services, physician's services, drugs, medical appliances and supplies, physical and occupational therapy, medical social services, and respite care (described below) for the terminally ill patient and bereavement counseling services for covered family members. (Bereavement counseling must be given within 6 months after the patient's death and are limited to a total of 15 visits for each family.)

- If the patient's family is unable to attend to his/her needs for a brief interval, the Plan will pay for reasonable expenses incurred for respite care by a hospice-approved and United HealthCare-approved homemaker service. This reimbursement will cover one or more service intervals up to an aggregate maximum of seven days.

To be eligible for payment under these Plans, a patient's entry into a hospice program must be based on the recommendation of the attending physician and documentation to United HealthCare Personal Health Support of the presence of a condition that is unresponsive to currently available treatment. The physician must certify that the patient is terminally ill with six months or less to live.

To obtain more information about approved hospices, call the United HealthCare Personal Health Support toll-free number (1-888-350-5607) shown on your identification card.

Hospital Inpatient Benefits

Pre-admission notification is required by calling UHC at 1-888-350-5607. If you or your dependent are confined in a legally constituted hospital as an inpatient for the diagnosis or treatment of an injury or illness, these Plans will cover eligible expenses at the level shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section) for the following hospital services:

- Room and board up to the semiprivate room rate. If a private room is used, the maximum daily benefit will be limited to the hospital's most common daily semiprivate room rate.

- Other hospital services. Such services include: anesthesia, radiation therapy, x-ray, laboratory and pathological examinations, and all other hospital services charged by the hospital except services of physicians or special nurses and supplies not related to the medical care of the person confined.

- X-ray examinations, lab tests, and electrocardiograms provided in the outpatient department of a hospital.

- Intensive care. These Plans will cover charges for confinement in an intensive care, coronary care, or constant care unit in the hospital. Benefits are not provided for any other room reserved for you while you are in such a unit.

- Routine nursery care during the initial hospital confinement of a healthy newborn infant will be covered if the baby is the covered dependent of an enrolled employee.

Note: Hospital confinement means a hospital stay that continues for a period of at least 18 consecutive hours.

If you or your covered dependents, while covered for Hospital Inpatient Benefits, become hospital patients for a different and unrelated cause, you again become eligible for benefits.

Successive periods of hospital confinement due to the same or related illness or illnesses will be considered one confinement unless you have returned to active work or your dependent has not been hospital-confined for at least 90 days.

Benefits will not be payable for a period of confinement (or any part) that is not necessary in terms of generally accepted medical standards or a period of confinement (or any part) which is experimental in terms of generally accepted medical standards.

Pre-Admission Notification Required For Hospital Confinement

In order to qualify for maximum benefits, a request to pre-certify hospital admission must be made to Personal Health Support (see Personal Health Support Program section) and authorized before actual hospitalization occurs. Once the hospitalization has been pre-certified by United HealthCare, your benefits will be reimbursed at their designated level for the length of time it is medically necessary to remain in the hospital.

All non-emergency hospital admissions, excluding pregnancy, must be pre-authorized before you enter the hospital. (Your doctor or hospital must call for authorization if maternity stays exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section.)

- If the scheduled admission is in less than two weeks, your physician should telephone the information to Personal Health Support.

- If admission is necessary on an emergency basis, Personal Health Support must be notified within 48 hours of the date the confinement begins. For pre-admission certification purposes, emergency means life-threatening conditions and urgent conditions for which you are unexpectedly admitted to the hospital through the emergency room.

- Call Personal Health Support at the member services telephone number shown on your identification card 1-888-350-5607 for hospital certification.

Penalty For Non-Notification: If you have failed to pre-certify for hospital admission in a timely manner, you will incur a non-notification penalty amount shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).

Penalty For No Medical Necessity: Your benefits will be reduced by 100% (to $0) if the Personal Health Support review finds there is no medical necessity for the service. You or your physician may appeal this decision by calling the Personal Health Support member services telephone number shown on your identification card. (Claim appeals are different and separate from medical necessity appeals. Refer to Claim Procedures.)

Hospital Outpatient Benefits

These Plans will cover eligible expenses made by the Hospital at the level shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section) for the following outpatient care:

- Minor surgery
- Pre-surgical testing
- X-ray and radiation therapy and chemotherapy
- Use of outpatient facilities for emergency illnesses that occur suddenly and unexpectedly, which require immediate medical attention and where a life endangering condition exists. Examples include heart attacks, poisonings, and other conditions determined to be medical emergencies by United HealthCare.
- Freestanding emergency clinics and freestanding clinics qualified to provide outpatient X-ray and radiation therapy and chemotherapy will be covered the same as hospital outpatient facilities.

Hospital Outpatient Benefits do not include physician charges.

Infertility

These Plans pay for Eligible Expenses related to the treatment of infertility including: office visits, fertility tests, diagnostic x-ray and laboratory services, surgical procedures. The maximum benefit payable under the Medical Plan for treatment of infertility during an individual's lifetime is $10,000 for each covered person. Eligible prescription drugs are covered up to an additional $5,000 lifetime maximum. Amounts you pay over the maximum benefit limitations do not apply toward the out-of-pocket maximum.

- **Artificial Insemination.** Covered services and supplies are limited to artificial insemination up to four times each month for one six-month period in the covered person's lifetime.
- **Assisted Reproductive Technology.** Covered services and supplies for Assisted Reproductive Technology (ART) are limited to a covered person who has undergone extensive screening and has been selected for ART because United HealthCare has determined, in its discretion, that for that person:
    - ART is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.

- There is no less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the following assisted reproductive technology procedures: In vitro fertilization services, Gamete intrafallopian transfer, Zygote intrafallopian transfer, Microinjection techniques
- The covered person must have been unable to become pregnant through more conservative means for a minimum of 12 months, unless one partner has already been diagnosed as infertile.

The Plan does not cover: more than three attempts at ART; ART if infertility is the result of voluntary sterilization; ART services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant.

Mastectomy Related Services

If you elect breast reconstruction in connection with a mastectomy, the following coverage will be provided in a manner determined in consultation with you and your physician:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

The amount you must pay for such reconstruction is the same as for any other Covered Health Service. Limitations on benefits are the same as for any other Covered Health Service.

Physician Services

Covered Health Services provided by physicians include:

Medical Care and Treatment: Hospital, office visits, and emergency room services

Surgery: Services for inpatient or outpatient surgical procedures

Second Surgical Opinion: Expenses for a second surgical opinion

Reconstructive Surgery: Inpatient and outpatient reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following: birth defect, sickness, surgery to treat a sickness or accidental injury, and accidental injury.

- Reconstructive breast surgery following a necessary mastectomy related to breast cancer.
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury.
- Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Notify UHC Personal Health Support for benefits 5 business days before receiving services. By notifying Personal Health Support, UHC can verify that the service is a reconstructive procedure rather than a cosmetic one.

Assistant Surgeon Services: Eligible expenses for assistant surgeon services are limited to 20% of the amount of Eligible Expenses for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not covered.

Multiple Surgical Procedures: Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Eligible Expenses for multiple surgical procedures are limited as follows:

- Eligible Expenses for a secondary procedure are limited to 50% of the Eligible Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Eligible Expenses for any subsequent procedure are limited to 25% of the Eligible Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

Spinal manipulations (chiropractic): Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine. Covered services are limited to 12 visits per calendar year for in-network services.

Routine pediatrician visits: Covered during the initial hospital confinement of a healthy newborn infant provided the baby is the eligible dependent of an eligible employee and is enrolled for coverage within 30 days of birth. Circumcision of a newborn infant is covered provided the baby is the eligible dependent of an eligible employee and is enrolled for coverage within 30 days of birth.

Pregnancy

These Plans pay for medical expenses related to pregnancies of employees and their covered dependents in the same way as benefits are paid for sickness. Benefits are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery.
- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

The hospital or other provider is not required to get pre-authorization from United HealthCare for the time periods stated above. **However your doctor or hospital is required to call UHC for authorization for longer lengths of stay.**

These Plans may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

The office visit copayment does not apply to prenatal and postnatal physician visits (after the initial diagnosis) by the network obstetrician/gynecologist who is primarily responsible for the patient's maternity care.

Benefits are payable for pregnancy services provided by a licensed or certified Nurse-Midwife.

Note: Newborn children's medical expenses will be covered only if the children qualify as covered dependents of the employee under the eligibility rules of the Plan. To obtain health coverage for your newborn, you must enroll him/her within 30 days of birth (see Family/Work Status Changes section).

Healthy Pregnancy Program

These Plans offer a Health Pregnancy Program for pregnant employees and covered dependents. The Healthy Pregnancy program is a voluntary program for pregnant employees and dependents that strive to avert or delay premature delivery by combining patient education and Personal Health Support. Patients

are also automatically registered with the program anytime they are hospitalized for a complication during pregnancy.

To join the Healthy Pregnancy program call the UHC member services telephone number shown on your UHC identification card. A telephone questionnaire by the Personal Health Support nurse helps identify women who are at high risk for premature labor and delivery. A notification letter describing the program is sent to the patient's doctor. Of course, all decisions concerning treatment remain the responsibility of the patient and her doctor.

Preventive Care

The following preventive care benefits are payable at the level shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section) if services are obtained from a network provider: routine physical exam including diagnostic test and immunization, routine pap test, pelvic exam, mammogram, and well baby care. No benefits are payable to non-network providers.

Well Baby Care

Well baby care is periodic preventive health services for a covered child from birth up to two (2) years of age. The services must be given or supervised by a Physician and include the following: Medical history, periodic health evaluations, immunizations, and laboratory services in connection with periodic health evaluations. The services must be given at or about the following intervals: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years.

The services must be consistent with the Recommendations for Preventive Pediatric HealthCare as adopted by the American Academy of Pediatrics and the most current version of the Recommended Childhood Immunization Schedule/United States.

Rehabilitation Therapy - Inpatient

Pre-notification is required. Notify UHC Personal Health Support at the member services number on your ID card. Inpatient rehabilitation services of a hospital or rehabilitation facility is a covered service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Rehabilitation Therapy - Outpatient

Outpatient rehabilitation services must be performed by a licensed therapy provider, under the direction of a physician. The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person's condition. Outpatient rehabilitation services are covered at the level shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).

- **Physical therapy** services by a licensed physical therapist.
- **Occupational therapy** services by a certified occupational therapist.
- **Respiratory therapy** services by a certified inhalation therapist.
- **Speech therapy** services by a licensed speech therapist for services given to restore speech lost due to one of the following: congenital abnormality; surgery, radiation therapy or other treatment which affects the vocal chords; cerebral thrombosis (cerebral vascular accident); brain damage due to

accidental injury or organic brain lesion (aphasia) while covered under the plan; or accidental injury which happens while covered under the plan.

- **Speech therapy** for children under age 12. Services by a licensed speech therapist for a child under age 12 whose speech is impaired due to one of the following conditions: Infantile autism; developmental delay or cerebral palsy; hearing impairment; or major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

Skilled Nursing Facility

A skilled nursing facility is a specially qualified facility that has the staff and equipment to provide skilled nursing care or rehabilitation services and other health related services. **Pre-notification is required.** Notify UHC Personal Health Support at the member services number on your ID card. If you fail to pre-notify in a timely manner, you will incur a non-notification penalty amount shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section). These Plans will cover eligible expenses at the level shown on the Schedule of Medical Benefits.

- Eligible expenses made by a skilled nursing facility will be covered for room and board up to the semiprivate room rate and for other services and supplies.
- Coverage is provided for up to 120 days in the calendar year in a skilled nursing facility.
- The confinement must be certified as medically necessary by the attending physician as part of a formal hospital discharge plan or in lieu of hospitalization.

When you or a covered family member needs medical care you cannot receive at home, you may not need to be confined in a hospital. Your physician can authorize a stay in a skilled nursing facility as an alternative to hospital care for convalescing from an acute illness, treatment of a long-term illness where home care is not appropriate, or treatment of a terminal condition. Skilled services must be required on a daily basis.

To qualify for benefits under the Plan, the skilled nursing facility must be accredited by the Joint Commission on Accreditation of Hospitals or be approved by Medicare as a covered skilled nursing facility. Your physician must certify the stay with UHC Personal Health Support, demonstrating that treatment in a skilled nursing facility is an appropriate alternative to hospitalization.

Patients who require domiciliary or custodial type care such as help in dressing, feeding, bathing, or assistance with walking, etc. are not candidates for skilled nursing facility services. These are personal custodial type services not requiring the services of skilled professionals.

To obtain more information about skilled nursing facilities, call the member services toll-free number shown on your UHC identification card.

Sterilization Services

Vasectomy and tubal ligation (but not a reversal)

Transplant Services

Pre-notification with UHC is required. If your physician recommends an organ transplant, call United HealthCare Personal Health Support at least 5 days prior to treatment at the toll-free number shown on your identification card. The United HealthCare Nurse Specialist will assist you by confirming whether the proposed procedure and related donor expenses are covered under the Plan and will provide additional information to help you make sound decisions regarding your care.

Urgent Care Centers

These Plans cover health services at network urgent care centers. An urgent care center is a freestanding or hospital-based facility that provides health services to prevent serious deterioration of your health as a result of unforeseen sickness, injury or onset of symptoms. When your situation is not an emergency but you need care right away – such as a sprain, moderate wounds or uncontrolled fever – an urgent care center may be appropriate.

To locate an urgent care center near you, call UHC member services at 1-888-350-5607 or visit the website at www.myUHC.com . When your situation is not an emergency but you are not sure if urgent care is needed or not, you can call the NurseLine number on your UHC card 1-888-887-4114 to discuss the situation with a nurse.

Outpatient Prescription Drugs

These Plans cover outpatient prescription drugs and medicines purchased from a network pharmacy as shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section). Network pharmacies have an agreement with United HealthCare (UHC) to dispense prescription drugs to plan participants at cost-effective rates. Pharmacists participating in the network are located throughout the country, and the network is comprised mainly of chain-store pharmacies. Show the pharmacist your United HealthCare ID card so the pharmacist will know you are a member of the United HealthCare network.

To locate a participating pharmacy, call the pharmacy customer service number on your United HealthCare ID card 1-888-350-5607 or visit the website www.myUHC.com .

Covered Prescription Drugs

Benefits payable for outpatient prescription drugs include:

- Medically necessary drugs prescribed by your physician
- Birth control pills
- Insulin and diabetic supplies
- Self-administered injectables
- Prenatal vitamins prescribed during pregnancy
- Prescribed legend vitamins
- Infertility drugs (up to a $5,000 lifetime maximum per covered person)

Under this program, when using retail pharmacies, you may obtain the amount of drugs or medicines prescribed by your doctor, up to a maximum 31-day supply.

Using Network Pharmacies

When filling a prescription at a network pharmacy, present your United Health Care identification card to the pharmacist and then pay the copayment amount shown on the Schedule of Medical Benefits for each prescription or refill. If you use a non-network pharmacy, there is no coverage. For a complete list of participating pharmacies, contact the pharmacy customer service telephone number on your ID card or go to the website www.myuhc.com .

Show Your ID Card

When you fill a prescription at a network pharmacy be sure to show the pharmacist your United HealthCare identification card. This is important, because your pharmacist uses the card to verify your coverage and copayment amount. The card also enables the pharmacist to submit the remainder of the prescription cost to the Plan.

If you do not show your ID card and the network pharmacy cannot reach United HealthCare to confirm your coverage by this Plan, the pharmacist will ask you to pay the entire cost of the prescription, not just the copayment. You may then file a claim for reimbursement of the difference. Call the UHC number on the back of your ID card and ask for a Prescription Drug Reimbursement form.

Tier1/Tier2/Tier3 Drugs

Tier 1 is your lowest copayment option. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your doctor decide they are appropriate for your treatment.

Tier 2 is you middle copayment option. Consider Tier 2 medications if no Tier 1 medication is appropriate to treat your condition.

Tier 3 is your highest copayment option. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment. Compounded medications, those medications containing one or more ingredients that are prepared “on-site” by a pharmacist, are classified at the Tier 3 level, provided that all of the individual ingredients used in compounding are covered under the pharmacy benefit.

Network pharmacies will fill prescriptions with Tier 1 whenever possible.

Mail Order Prescription Drug Service

As part of your Prescription Drug program, you may order prescriptions through the HealthCare mail service. This option is useful if you use prescriptions on a regular basis for a chronic or long-term condition. Using the mail service is less expensive and more convenient then buying your medications at a retail pharmacy.

Through this service you can obtain a 90-day supply of your medication through the mail for about the cost of a 60-day supply. Your doctor must write the prescription to Optum RX for a full 90-day supply. The prescription can have up to 3 (three) refills, if appropriate.

To enroll in this service go to www.MYUHC.com and select “Pharmacies & Prescriptions” then “Go to OPTUMRX”, and select “Home Delivery” from the right navigation bar.

Prescription Drugs Not Covered

- Injectable drugs (This exclusion does not apply to insulin or self-administered injectables that can be injected subcutaneously.)
- Cosmetic drugs or drugs prescribed exclusively for cosmetic purposes
- Experimental drugs or medicines that have not been approved by the FDA
- Viagra and other prescription drugs for treatment of erectile dysfunction
- Nutritional supplements

- Over-the-counter drugs
- General and injectable vitamins (This exclusion does not apply to prenatal vitamins or prescribed legend vitamins.)
- Weight control drugs for treatment of obesity due to overeating (except appetite suppression drugs for morbid obesity indications only)
- Drugs that are not considered medically necessary, including any drug given in connection with a service or supply that is not medically necessary
- Immunization agents and biological serum
- Therapeutic devices or appliances, including colostomy supplies and support garments, contraceptive devices and supplies, hypodermic needles and syringes (This exclusion does not apply to diabetic supplies including insulin syringes with needles, blood testing strips - glucose, urine testing strips - glucose, ketone testing strips and tablets, lancets and lancet devices which are covered.)
- Replacement drugs resulting from a lost, stolen, broken or destroyed Prescription Order or Refill
- Progesterone suppositories
- Drugs dispensed in any amount, which exceed the supply limits
- Drugs given to a covered person while the person is a patient in a hospital, skilled nursing facility, nursing home, or similar institution that has its own drug dispensary (these drugs are covered as regular medical expenses)

Mental Health and Substance Abuse

These Plans pay benefits for mental health and substance abuse treatment as described in this section through United Behavioral Health (UBH). You have two ways of accessing care: network or non-network care.

To receive full benefits and avoid penalty, call United Behavioral Health BEFORE receiving treatment.

- Before receiving treatment call the UBH mental health/substance abuse number listed on your medical identification card: 1-800-888-2998.
- A counselor will listen to you, help clarify the problem and refer you to the network provider in your area best qualified to assess your situation and recommend a course of action.

Inpatient Care

- These Plans pay for medical expenses for inpatient mental health and substance abuse treatment. Plan benefits will depend on how you access your care:
- **Network:** If you see a network provider, the Plan pays the higher network benefit level as shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).
- **Non-Network:** If you see a non-network provider for care, the Plan pays the non-network benefit level as shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section). **NOTE:** Even if you see a non-network provider for inpatient care, you must notify United Behavioral Health prior to receiving treatment; **otherwise a penalty will apply.** Non-network care is subject to retrospective review.

Inpatient Care	Annual Maximum	Lifetime Maximum
• Mental Health	unlimited days for network or non-network care	none
• Substance abuse	unlimited days for network or non-network care	none

Note: The deductible for the Medical Plan listed on your Schedule of Medical Benefits does apply.

Outpatient Care

These Plans pay for medical expenses for outpatient treatment of mental health and substance abuse. The Plan benefits will depend on how you access your care:

- **Network:** If you see a network provider, the Plan pays the network benefit level as shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).
- **Non-Network:** If you see a non-network provider for care, the Plan pays the non-network benefit level as shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section). Non-network care is subject to retrospective review.

Outpatient Care	Annual Maximum	Lifetime Maximum
• Mental Health	unlimited days for network or non-network care	none
• Substance abuse	unlimited days for network or non-network care	none

Intermediate Care

These Plans pay for the following intermediate care:

- Day treatment or partial care, an intensive treatment that usually takes place 6-8 hours/day, at least 5 days a week.
- Structured outpatient care, which is a treatment program that occurs for 4-6 hours during the evening and 3-5 times a week, typically lasting 4-8 weeks.
- Residential care, a 24-hour treatment for individuals requiring intensive supervision but who do not require hospitalization
- Recovery home care, a living environment that is communal and sober where recovering individuals may live for some months during early recovery.

Plan benefits for intermediate care depend on how you access your care:

- If you call UBH before receiving treatment and are referred to a network provider, the Plan pays the network benefit level as shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).
- If you see a non-network provider, the Plan pays the non-network benefit level as shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section). Non-network care is subject to retrospective review.

Note: The deductible for the Medical Plan listed on your Schedule of Medical Benefits does apply.

Health Saving Account (HSA)

The HSA PPO medical option through United HealthCare qualifies as a high deductible plan and covers the same services and supplies that the Enhanced and Value PPO Option covers — with different payment provisions . Your deductible and out-of-pocket maximum is higher with this plan. Refer to the Schedule of Medical Benefits (located at the beginning of the Medical Plan section in this book) for payment levels under the HSA PPO option.

Participants enrolled in this medical plan are able to open a tax-advantaged Health Saving Account (HSA) with United HealthCare's partner bank OptumBank.

.

How the Health Savings Account Works

The Health Savings is a self-directed tax-advantage account that you can use to pay for medical expenses. You can fund this account up to pre-set government limits each year. Any unused amount remains in your account and carries over to the next year. If you leave employment your account goes with you.

Think of your HSA as a "health care 401(k)". You and the company contribute to this account. If you don't use all of the money you have deposited, the money in your account rolls over from year to year. If you leave the company your HSA account goes with you. Since you own your HSA, you choose when to spend your dollars on eligible health care expenses (medical, dental, prescription, and vision). Similar to a 401(k) you can contribute to your HSA on a pre-tax basis up to the IRS limits. The company will help increase your savings by making annual contributions to your account. Your interest earnings accumulate tax-deferred and withdrawals from your HSA for "qualified medical expenses" are free from Federal Income Tax. The HSA is a great way to build up dollars to pay for your health care expenses today or in the future.

The Company will contribute the following amounts to your account annually at the beginning of the year:

Single	$ 500
Family	$1,000

The company contribution will be prorated for employees hired after the first of the year.

You cannot receive the company contributions until you have opened your account. To open your Health Savings Account go to www.OptumBank.com and register.

NOTE: You must make a NEW election each year during the Open Enrollment period if you wish to continue to make contributions to your HSA. The employer contributions will continue automatically. You may make changes your contribution amount any time during the year.

Paying Qualified Expenses with your HSA

When you open your HSA you will receive a debit card. Medical expenses can be paid using the debit card at any credit card machine or providers office. Cash withdrawals can also be made at any ATM machine; however, use of an ATM machine will result in additional banking fees charged to your account. The cash withdrawals can be used to reimburse yourself for qualified expenses you have paid out of your pocket.

You are responsible for verifying that HSA funds are used for qualified medical expenses (IRS section 213(d)) and for keeping records to verify that contributions were used to pay for qualified expenses. Keep ALL receipts, including ATM receipts. The IRS may request receipts if you are ever audited.

You can check your account balance and other account information on-line at www.OptumBank.com.

Eligibility

To open an HSA, you must be:

- Covered by the high deductible HSA Medical Plan
- Not covered by any other medical plan that is not a high deductible plan (e.g. spouse's plan)
- Not entitled to benefits under Medicare
- Not claimed as a dependent on another person's tax return.

Termination of Coverage

Your Medical Plan coverage will terminate at the end of the calendar month in which:

- Your employment ends
- You are no longer an eligible employee,
- Or on the date the Plan is terminated.

You may qualify for an extension of coverage in certain circumstances described in the Special Extensions of Coverage section below.

Coverage for your enrolled dependents will terminate at the end of the calendar month in which:

- Your coverage terminates, or
- You are no longer eligible coverage, or
- Your dependent is no longer eligible, or
- On the date your spouse becomes eligible for medical coverage through her employer.

See the Special Extensions of Coverage section, the Continuation Coverage Privilege (COBRA) section and the Health Insurance Portability and Accountability Act-HIPAA section for related information in the event your or your dependents' coverage terminates.

Medical Plan benefits cannot be converted to individual coverage.

Special Extensions of Coverage

During Approved Disability Leave

If you have one or more years of service and are on an approved medical leave of absence for your illness or injury, your medical coverage for you and your dependents may be extended for up to a maximum of one year. You must continue to pay your share of the premium. Doctor certifications are required to extend benefits. If you are still disabled at the end of the one-year period, you may continue your health care coverage at your expense for the balance of the COBRA continuation coverage period.

If you have less than one year of service, your benefits will end on the last day of the month after you reach 30 days on leave (including Alternate Duty). You will be eligible for COBRA benefits and notice will be sent with a separate letter.

During Family Medical Leave

If you meet the requirements for Family Medical Leave, the company will maintain or reinstate any health care coverage, which you had under this Plan prior to the leave. You must continue to pay your share of the premium, if any. See the "Family Medical Leave" section for details.

During a Personal Leave of Absence

Your medical coverage remains in effect until the end of the month in which you last worked. You may enroll in the health care COBRA continuation coverage program at your expense.

During a Uniformed Services Leave (Military Leave of Absence)

If your uniformed services leave is less than 31 days, your medical coverage continues during the leave. You must continue to pay your share of the premium.

If your uniformed services leave is 31 days or more, your medical coverage remains in effect until the end of the month in which you last worked. You and your dependents may enroll in the health care COBRA continuation coverage program at your expense.

During Jury Duty (or Court Witness)

Your medical coverage continues when you are required to serve as a juror or as a court witness. You must continue to pay your share of the premium.

Leave for trials that are expected to be of lengthy duration (over 30 days) must be requested for approval through Human Resources.

After Your Death

If you die, medical coverage for your dependents remains in effect until the end of the month in which your death occurs. Your dependents may enroll in the health care COBRA continuation coverage program at their expense, provided they were enrolled in health care coverage before your death.

During Hospital Confinement

If you or one of your dependents are confined as an inpatient in a hospital (or Other Covered Health Care Facility) when medical coverage terminates, benefits will continue for Eligible Expenses incurred by the patient while continuously confined to the hospital (or Other Covered Health Care Facility) for 90 days from the date medical coverage terminated, or until the patient is discharged from the hospital (or Other Covered Health Care Facility), if earlier.

Reinstatement of Coverage

If your medical coverage terminates because you cease to meet the definition of an eligible employee, medical coverage for you and your eligible dependents may be reinstated immediately (without waiting 30 days) if you return to active work in an eligible class within 12 months from the date your eligibility ceased.

If loss of eligibility and reinstatement of coverage occur within the same calendar year, the calendar year deductible and copayment requirements and the annual benefit maximum provisions will be applied only once for that year.

Third Party Liability

If you or a dependent incur expenses because of the negligence of another person or organization and the Medical Plan reimburses you for those expenses (or pays benefits), United HealthCare has the right to pursue reimbursement for those benefits from the third party (subrogation) where permitted by law. In addition, United HealthCare has the right to:

- Require you to do whatever is reasonably necessary to secure the Plan's right to reimbursement for medical payments from a third party.
- Receive reimbursement from you for Plan benefits provided or paid to you if you received payment for the same benefits from another source.
- Credit against future Plan benefits an amount equal to Plan benefits provided or paid to you if you received payment for the same benefits from another source.

Recovery of Overpayments

United HealthCare has the right to:

- Receive reimbursement for benefits paid in excess of amounts required under the Plan or for benefits paid for services you are not legally required to pay or do not pay.
- Require you to do whatever is reasonably necessary to recover payment when the refund is due from another person or organization.
- Recover from you the amount paid for claims of ineligible dependents.
- Credit against future plan benefits an amount equal to the refund due.

Coordination of Benefits (COB)

If you or your dependents have other medical coverage in addition to being covered under this Plan, the benefits under this Plan will be coordinated with the benefits of other plan(s).

Specifically, in a calendar year, this Plan will pay its regular benefits but not more than the amount which, *when added to the benefits payable by the other plan or plans*, will equal 100% of allowable expenses.

Allowable expenses means any necessary, MNRP expense incurred during a calendar year while eligible for benefits under this Medical Plan, part or all of which would be covered under any of the other plans.

Other plans include any plan providing benefits or services for medical treatment when benefits or services are provided by group insurance or any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or by individual health insurance policies or contracts, medical expense provisions of automobile Personal Injury Protection (PIP) policies, automobile no-fault insurance benefits, or homeowners insurance policies.

Coordination of benefits typically occurs if you and your dependents are covered by more than one group insurance plan. One plan will be considered the "primary" plan, and the other will be the "secondary" plan.

To obtain proper payment of your medical bills, send your claim to the primary plan first, then send the secondary plan a copy of your bills along with a copy of the primary plan's "explanation of benefits paid" statement.

To determine which plan is primary and which plan is secondary, follow the rules listed below:

1. Order of payments for an employee
   - Primary plan is the Company Plan
   - Secondary plan is the plan sponsored by the spouse's employer
2. Order of payments for the children of an employee
   - Primary plan is the plan of the parent whose birthday occurs earlier in the year
   - Secondary plan is the plan of the parent whose birthday occurs later in the year
3. Order of payments for children of divorced parents
   - Primary plan is determined by court decree; otherwise,
   - Primary plan is the plan of the natural or adoptive parent with custody
   - Secondary plan is the plan of the step-parent with custody
   - Tertiary (third) plan is the plan of the natural or adoptive parent without custody
4. Order of payments for persons covered by a plan for active employees (and their dependents) and by a plan for retirees, laid-off employees or COBRA coverage continuants (and their dependents)
   - Primary plan is the plan for active employees (and their dependents)
   - Secondary plan is the plan for retirees, laid-off employees or COBRA coverage continuants (and their dependents)
5. Order of payments if not covered above
   - Primary plan is the plan which has covered the individual the longest
   - Secondary plan is the plan which has covered the individual for less time
6. Order of payments if the other group plan or individual policy does not contain a coordination of benefits provision
   - Primary plan is the plan that does not contain a coordination of benefits provision
   - Secondary plan is the Company Plan

United HealthCare has the right to release and obtain any information it considers necessary to administer this provision and to recover overpayments.

Coordination of Benefits with Medicare

If you are an active employee:

The company medical plan is normally the "primary" plan for employees who continue to work past age 65. Medicare normally provides "secondary" coverage. Medicare will cover Medicare-eligible expenses to the extent they are not paid by this Plan. The company plan will also normally pay benefits before Medicare for your covered spouse who is age 65 or older. You have the option of waiving coverage under this Plan and enrolling in Medicare. Medicare will be the only coverage for you. If you have questions about this election, please contact Human Resources.

If you are undergoing treatment for end-stage renal disease (ESRD):

For active employees, employees on approved disability leave, and their dependents, the Company Plan is the primary coverage for the first 30 months following entitlement to Medicare due to ESRD, and Medicare is the secondary coverage. If the employee or dependent still has ESRD after this 30-month period, Medicare then becomes the primary coverage, and the Company Plan becomes the secondary coverage.

Claim Procedures

If you selected the Enhanced PPO, Value PPO, or HSA Plan options and see a network provider, your provider will bill the Plan directly. If you use a network pharmacy, the pharmacy will bill the Plan directly.

If you are in the Enhanced PPO or Value PPO you may be responsible for copayments to a network provider at the time of service.

If you see a non-network provider you may need to file a claim form with United HealthCare (UHC).

Time Limit for Filing Claims

All claims must be submitted for payment **within 12 months** of the date expenses are incurred. Claims not submitted within this time limit will not be paid. If a non-network provider submits a claim on your behalf, you are still responsible for ensuring the timeliness of the submission.

How to File a Claim Form for Non-Network Benefits

Only claims for expenses incurred on or after the effective date of your coverage will be processed. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements and bills are submitted with the claim form to the United HealthCare Claim Office.

1. To receive prompt payment for your claims, follow the procedures listed below as closely as possible.

    - Complete the United HealthCare (UHC) claims form.

    - For doctor's services, attach your doctor's itemized bill or have your doctor complete his or her required portion of the claim form.

    - For hospital services, attach the itemized hospital bill that lists all services and supplies received.

    - For prescription drugs not filled at a participating pharmacy use a OptumRX claim form and be sure to attach itemized bills showing the name of the individual for whom the drugs were prescribed, the prescription number, the diagnosis, the cost, and the name of the doctor prescribing the drug.

    - Dental expenses incurred as a result of an accident should be submitted with complete accident details to the Medical Plan for payment.

    Note: The "Other Coverage Information" section must be completed on each claim form. Also, if the expense is related to an accident, the "Accident Information" section must be completed on each related claim.

2. Your claim and all bills connected with it should be submitted to United HealthCare promptly following the date expenses are incurred. You must submit original bills. United HealthCare will not accept photocopies, except for secondary coordination of benefit claims.

3. Payments can be handled in two ways:

    - You may assign payment of benefits by signing the authorization on the claim. If you do assign your benefits, the payment will be sent directly to the provider of service; or

    - You may pay the bill directly, in which case the benefit checks will be made payable to you.

All benefit checks other than those assigned will be mailed by the claims office to you.

4. You should forward the completed claim form together with itemized bills to the following address:

United HealthCare
Medical Unit
P.O. Box 30555
Salt Lake City, UT 84130-0555

Claim Inquiries: 1-888-350-5607
The group number is **703940**

Mental Health and Substance Abuse Claims

If you receive network mental health or substance abuse benefits authorized by United Behavioral Health (UBH), there is no need to file a claim form. When services are received from non-network providers, you must submit a claim form to UBH to receive benefits.

Request claim forms directly from UBH by calling the mental health/substance abuse number on your identification card: 1-800-888-2998.

Claim Procedures for Alternate Recipients under Qualified Medical Child Support Orders (QMCSO)

The Claim Procedures must be followed for claims of alternate recipients under qualified medical child support orders. The Plan pays the provider if the claim is assigned. See the "Qualified Medical Child Support Order" section for more information.

Routine Questions

If there is any question about a claim payment, an explanation may be requested directly from United HealthCare by calling 1-888-350-5607 (the group number is **703940**). You may also logon to www.MyUHC.com to view your claims information.

Claim Determination

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from United HealthCare (UHC) within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UHC will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, UHC will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from United HealthCare (UHC) within 15 days of the claim.

If you filed a pre-service claim improperly, UHC will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UHC will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45- day timeframe, UHC will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45 days period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

You will receive notice of the benefit determination in writing or electronically within 72-hours after United HealthCare (UHC) receives all necessary information, taking into account the seriousness of your condition.

- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

- If you filed an urgent claim improperly, UHC will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, UHC will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will be notified of a determination no later than 48 hours after:

- UHC's receipt of the requested information; or

- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for the extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Claim Appeals

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact United HealthCare (UHC) in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to UHC within 180 days after your receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field that was not involved in the prior determination. UHC may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeal Determinations

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by UHC of the decision within 15 days from receipt of a request for appeal of a denied claim. A second level appeal will be conducted and you will be notified by UHC of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims, the first level appeal will be conducted and you will be notified by UHC of the decision within 30 days from receipt of a request for appeal of a denied claim. A second level appeal will be conducted and you will be notified by UHC of the decision within 30 days from receipt of a request for review of the first level appeal decision.

- For urgent claims procedures, see "Urgent Claim Appeals That Require Immediate Action" below.

- For appeals of concurrent care claims, the appeal will be conducted under timeframes and procedures that are appropriate to the type of claim that was denied. Refer to either pre-service, post-service or urgent claims appeals.

If you are not satisfied with the first level appeal decision of UHC, you have the right to request a second level appeal from UHC as the Plan Administrator. Your second level appeal request must be submitted to UHC within 60 days from receipt of first level appeal decision.

For pre-service and post-service claim appeals, the company has delegated to UHC the exclusive right to interpret and administer the provision of the Plan. UHC's decisions are conclusive and binding. Please note that UHC's decision is based only on whether or not benefits are available under the Plan for the treatment or procedure. The determination as to whether the health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call UHC as soon as possible. UHC will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, the company has delegated to UHC the exclusive right to interpret and administer the provisions of the Plan. UHC's decisions are conclusive and binding.

Definitions

Alcoholism Treatment Facility: An institution approved by United HealthCare providing treatment for chronic alcoholism and operating under the direction and control of the Department of Health (or the equivalent department) of the state where services are provided.

Calendar Year: A period of one year beginning with January 1st.

Coinsurance: The portion of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.

Copayment: The set amount you must pay to a network provider at the time services are given. Copayments do not count toward any deductible but are applied to the Out-of-Pocket Maximum. The HSA PPO medical Plan does not have copayments for medical services.

Cosmetic Procedures: procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Covered Family Members or Covered Person: The Employee and the Employee's wife or husband and/or Dependent children who are covered under this Plan.

Covered Health Services: Covered Health Services are those health services, supplies or equipment provided for the purpose of diagnosing or treating a sickness, injury, mental illness, substance abuse, or symptoms. Covered Health Services will be provided:

- When the Plan is in effect;

- Prior to the date that any of the individual termination conditions set forth in this Summary Plan Description; and

- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

A Covered Health Service must meet each of the following criteria:

- It is supported by national medical standards of practice.

- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

- It is the most cost-effective method and yields a similar outcome to other available alternatives.

- It is a health service or supply that is described in this section, and which is not excluded under General Exclusions.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well conducted randomized trials or cohort studies, as described.

Custodial Care: Personal care services that do not require the skills of qualified technical or professional personnel. Such services can be performed safely and effectively by the average non-medical person without the direct supervision of skilled personnel, and therefore are not considered skilled services and are not covered expenses under the Medical Plan.

Deductible: The amount of Eligible Expenses you must pay each year from your own pocket before the Plan will pay its portion of the Covered Health Service.

Eligible Expense(s): The amount that will be paid for Covered Health Services incurred while the Plan is in effect. The Eligible Expenses must be incurred for the care of an accidental injury or Sickness. An Eligible Expense is incurred on the date that the Covered Health Service is performed or given. Each Covered Person must satisfy certain copayments, deductibles and/or penalties before any payment is made for certain Covered Health Services. Then the Plan pays the percentage of Eligible Expenses shown on the Schedule of Medical Benefits (at the beginning of the Medical Plan section).

Experimental or Investigational Services: Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

If you are not a participant in a qualifying Clinical Trial and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Freestanding Emergency Clinic: An approved freestanding emergency clinic is one that offers the same service as a hospital emergency room.

Generic Drug: A chemically equivalent copy designed from a brand-name drug whose patent has expired. A generic is typically less expensive and sold under a common or "generic" name for that drug (e.g., the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). (Also called generic equivalent)

Home Health Care Agency: A hospital or other organization which is licensed or certified under a public health law or a similar law to provide home health care services or is recognized as a home health care agency by Medicare.

Hospice: A Medicare-approved hospice.

Hospital: An institution operated for the care and treatment of sicknesses and injuries on an inpatient basis and having facilities for diagnosis, 24-hour nursing service, and, except in the case of a hospital primarily concerned with the treatment of chronic diseases, major surgery. The term "hospital" shall not include an establishment that is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, or a hotel.

Hospital confinement: A hospital stay that continues for a period of at least 18 consecutive hours.

Illness: State of being sick.

Injury: Trauma or damage to some part of the body.

Maximum Non-Network Reimbursement Program Charge: The MNRP charge (as determined by the plan) is the lowest of:

- The usual charge by the physician or other provider of the services or supplies for the same or similar services or supplies; or
- The usual charge of most other physicians or other providers of similar training or experience in the same or a similar geographic area for the same or similar services or supplies; or
- The actual charge for the services or supplies.

Medically Necessary: Those health care services and supplies that are determined by United HealthCare to be medically appropriate and meet all the following conditions:

- Necessary to meet the basic health needs of the covered person.
- Rendered in the most cost efficient manner and type of setting appropriate for the delivery of the health service or supply.

- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by United HealthCare.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the covered person or of his or her physician.
- Demonstrated through prevailing peer-reviewed medical literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or
    - Safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For purposes of this definition, the term "life threatening" is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.

The fact that a physician has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a particular injury, sickness or pregnancy does not mean that it is a "medically necessary" service or supply as defined above. The definition of "medically necessary" or "medical necessity" used herein relates only to coverage, and differs from the way in which a physician engaged in the practice of medicine may define these terms.

Medicare: The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Nurse: A registered nurse (R.N.), including a licensed or certified nurse-midwife.

> **Note:** Expenses for professional nursing services of a Christian Science nurse shall be included on the same basis and subject to the same terms and limitations, as expenses for other nursing services provided such nurse is listed in the Christian Science Journal current at the time such services are provided as:
>
> - Having completed nurses training at a Christian Science Benevolent Association Sanitarium
> - Being a graduate of another nurses training course
> - Having had three consecutive years of Christian Science nursing, including two years of training

Other Covered Health Care Facility: As used in the "Special Extensions of Coverage - During Hospital Confinement" section means:

- A Skilled Nursing Facility
- A Hospice

Outpatient Rehabilitation Facility: A facility which is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured or sick persons and which is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility or fully meets the tests established by UHC for a Comprehensive Outpatient Rehabilitation Facility.

Physician: A physician or surgeon operating within the scope of his or her license as:

- Medical Doctor (M.D.)
- Osteopath (D.O.)
- Podiatrist (D.P.M.)
- Doctor of Dentistry (D.D.S., D.M.D.)
- Chiropractor (D.C.)

- Licensed Clinical Psychologist (Ph.D.)

  Note: Expenses for actual visits for healing purposes made by a Christian Science practitioner who is listed as such in the Christian Science Journal current at the time of such visits shall be considered for benefits subject to the same terms and limitations as if such expenses were charged by a Physician.

Preferred Provider Organization (PPO): A program in which contracts are established with providers of medical care for discounted rates. Providers under such contracts are referred to as preferred providers. While benefits are usually available from non-participating providers, the Plan pays more for services received from preferred providers.

Preferred Provider: Physicians, hospitals, and other health care professionals who contract to provide health services to persons covered by a particular health plan. See also preferred provider organization.

Private-Duty Nursing: Skilled services, which include skilled nursing, skilled teaching and skilled rehabilitation services, are those services which meet all of the following criteria:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- Are ordered by a physician;
- Meet medical necessity criteria for treatment of the illness, injury or pregnancy;
- Approved by Personal Health Support.

Sickness (illness): A medical disease, disorder, or condition.

Skilled Nursing Facility: If the facility is approved by Medicare as a Skilled Nursing Facility, then it is covered by this Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing room and board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Sickness.
- It maintains a daily medical record of each patient who is under the care of a licensed Physician.
- It is authorized to administer medication to patients on the order of a licensed Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A Skilled Nursing Facility, which is part of a Hospital, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:
If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center: A free-standing or hospital-based facility that provides health services which are required in order to prevent serious deterioration of a covered person's health and which are required as a result of unforeseen sickness, injury or onset of symptoms. Examples include health services to treat a sprain, moderate wounds, or uncontrolled fever.

Virtual Visits : United Healthcare offers **Virtual Visits** allowing you to see and talk with a physician without an appointment via your mobile device or computer. This service is for common non-emergency acute conditions when your primary care physician or urgent care is inconvenient or unavailable. The virtual physician can write a prescription and electronically send it to your pharmacy. You can access Virtual Visits through the **Health4Me** app on your mobile device or **myuhc.com** on your computer. (See the Schedule of Medical Benefits at the beginning of the medical plan section for benefit amounts)

EMPLOYEE ASSISTANCE PROGRAM

For those times that you may experience personal difficulties or concerns, the company provides an Employee Assistance Program (EAP). This is a confidential program designed to provide and/or refer you for care or related services.

The company has contracted with United Behavioral Health (UBH), an independent corporation that provides professional counseling and referral services. Employees and family members can contact UBH by telephone 24 hours a day, seven days a week using the toll-free number 1-800-888-2998.

A confidential appointment will be scheduled within seven business days (or sooner, in a crisis situation). An experienced UBH counselor will help assess your situation and suggest possible solutions and available resources. Often that is all the help you need. If additional help is recommended, you or your eligible dependent will be referred to an appropriate outside agency or service.

Call the EAP toll-free number 1-800-888-2998 and give them the group number **703940**. The EAP may help with a variety of situations:

- Work and family responsibilities
- Single parenting, parent-child conflict
- Depression
- Marriage problems
- Aging parents, elder care
- Alcohol and drug abuse
- Compulsive gambling
- Physical abuse
- Stress
- Eating disorders

How the EAP Works

The Employee Assistance Program (EAP) is a confidential assessment and referral program sponsored by the company to help employees and their families solve personal problems that may affect their health, family life or job performance. Just as corporations seek assistance through consultants, you can seek expert help through the EAP.

The EAP offers specialized personal counseling, which can provide the relief and the assistance you may sometimes need. Counseling is a natural extension of self-help. It is a tool you can use to take or regain control of what happens in your life.

Cost

The EAP is a benefit provided by the company for its employees. There is no charge to the employee or family member for the initial telephone call or subsequent counseling sessions (up to three). There is no limit to the number of problems you have. You will receive three free sessions per problem.

If additional help is suggested, treatment may be reimbursed through your company medical benefit program, subject to any applicable limits or deductible.

Eligibility and Effective Date

You are automatically enrolled for EAP benefits when you enroll for the company medical plan coverage.

Confidentiality

By law, absolute privacy is guaranteed to anyone who seeks counseling. No one will know about the matter you have asked about, unless you choose to tell them.

Remember that the EAP is administered by an independent organization. UBH will not disclose names or any other personal information to the company.

SCHEDULE OF DENTAL BENEFITS

Plan Feature	Enhanced Dental Option	Basic Dental Option
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 cleaning) • 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 and 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.**

Call MetLife Dental at 1-800-942-0854, the group number is **302073**, for:

- questions on plan coverage
- network dentists
- claims questions

DENTAL PLAN

The dental plan is designed to help you pay for certain services and supplies that are necessary for the diagnosis and treatment (both preventive and therapeutic) of the gums, teeth, and other tissues of the mouth. Dental benefits are paid by MetLife,1-800-942-0854, www.metlife.com/dental , the group number is **302073**.

There are two types of dental coverage: the Enhanced Dental Option and the Basic Dental Option.

You and your eligible dependents must be covered under the dental plan at the time expenses are incurred for benefits to be payable. A charge will be considered incurred on the date the procedure or service is rendered or the supply is furnished.

If your coverage terminates while you are undergoing a course of treatment involving bridges, dentures, crowns or root canal therapy, benefits for these services may be extended for up to 2 (two) months in certain circumstances. (See "Extended Benefits" in Special Extensions of Coverage Section)

Dental benefits cover only those dental expenses that are considered reasonable and customary for the service provided in the geographic area where the expense is incurred. (See Reasonable and Customary Charge section.)

Eligibility and Effective Date

Employees

Eligible employees are regularly scheduled full-time (FT) or part-time (PT) employees. Eligible employees are regularly scheduled to work 15 or more hours per week.

Employees who are members of a collective bargaining unit are eligible only if the collective bargaining agreement provides for participation in this Dental Plan.

You may choose dental coverage for yourself and your dependents, even if you decline medical coverage. You must choose dental and vision together. If you elect dental and vision, there is a bi-weekly cost to you.

You are not eligible to enroll if you are working in a capacity that (at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary) is considered contract labor or independent contracting.

New employees become eligible for Plan coverage on the day after completing 30 days of service. You will be covered by the Plan as soon as you become eligible and complete the Self Service Insurance Enrollment online **within 30 days from date of hire**.

If you fail to complete the Self Service Insurance Enrollment online before your effective date of coverage, you will automatically default to DECLINE/ No Coverage.

Dependents

Your eligible dependents are covered under this Plan on the date your coverage is effective if you are eligible and enroll each dependent for coverage.

Your eligible dependents are:

- Your legal spouse
- Your children under age 26, (regardless of marital, residence, or job status) including your natural children, legally adopted children, children placed for adoption, stepchildren and any other children, provided you are their legal guardian or you claim the children as dependents for federal income tax purposes.
- Your unmarried child who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, provided such child was covered under this Plan at the time of disability and immediately prior to his or her 26th birthday.

If you do not enroll your dependents when they are first eligible, you must wait until the next open enrollment period in the fall for a January 1 effective date, except in the event of Family/Work status changes (see Family/Work Qualified Status Changes section).

If your spouse is an employee and is covered under this Plan, your dependent may be enrolled under only one parent's coverage.

If one of your dependents is an employee and is eligible for coverage under the company plan, he or she may not be enrolled as both a covered dependent and an employee.

Enrollment

Initial enrollment: Your initial enrollment election is a commitment for the remainder of the calendar year. As a new hire, you will have 30 days from hire date to complete the electronic Group Insurance Enrollment form. If you are newly eligible for the Plan due to a change in employment status, you will have 30 days from status change date to complete your enrollment in Self Service. If elections are not made within the specified time, you will **NOT HAVE COVERAGE**.

Open Enrollment: You will be given the opportunity to review your participation in the benefit plans on an annual basis each fall for a January 1 effective date. This is called an "Open Enrollment" period. Your Open Enrollment election is a 12-month commitment beginning January 1. Other than open enrollment, you may change your annual election during the year only if you have a qualified event described below. ..

Default coverage: If you do not enroll within the specified time, you will automatically be defaulted in to Decline/No coverage

Special Enrollments/Notice of Employee Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you submit an enrollment form within 30 days after your other coverage ends. 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, provided you complete an electronic enrollment form within 30 days.

If you declined coverage under the Dental Plan for yourself, your spouse and/or your dependents because of other coverage, you may be eligible to change your election during the year and elect coverage if: the other coverage was COBRA and it has now been exhausted; eligibility for the other coverage was lost or, if the other coverage was employer provided, the employer stopped contributing toward that coverage.

Family/Work Qualified Status Change

Your benefit election is in force for the full plan year (January 1 through December 31) following the enrollment period (unless your coverage terminates).

You are eligible to change your election during the year only if you have a qualifying change in your family or work status and complete a Self Service Insurance Enrollment form online within 30 days of the qualifying event.

The change in your election will apply only to the affected individual(s) and must be consistent with the change in family or work status. Generally, to be consistent, you must have gained or lost benefit eligibility in this Plan or another employer's plan due to the event, and your election change must be on account of and correspond to the gain or loss. Qualifying family and work status changes are:

- Legal marital status change due to marriage, death of a spouse, divorce, legal separation or annulment
- Number of dependents change due to birth, adoption, placement for adoption or death of a dependent
- Employment status changes for you, your spouse or dependent due to ending or starting employment, a strike, lockout or commencement or return from an unpaid leave of absence (including an FMLA leave); or a change in employment status with the consequence that you, your spouse or dependent becomes or ceases to be eligible for coverage (such as a switch between casual and full-time status)
- Residence or worksite change (for you, your spouse or dependent) that could affect your benefits
- Dependent child's eligibility change which causes a dependent to satisfy or cease to satisfy eligibility requirements due to age or a similar change

You may add or stop coverage for yourself or a covered dependent, as applicable, if you experience any of the following qualifying events:

- **Coordination of coverage with another group plan:** If the plan of your spouse's or dependent's employer has a different coverage period than this Plan, or allows mid-year election changes for qualified status change events, you may be able to change your election under this Plan. Any change in your election will be prospective only and will correspond with your eligibility for and enrollment in your spouse or dependent's coverage.
- **Dental coverage with another group plan ends:** If you declined coverage under this Plan for yourself, your spouse and/or your dependents because of other coverage, you may be eligible to change your election during the year and elect coverage if: 1) the other coverage was COBRA and it has now been exhausted; 2) eligibility for the other coverage was lost or, 3) if the other coverage was employer provided, the employer stopped contributing toward that coverage.
- **Medicare or Medicaid:** A coverage election may be changed for you, your spouse or a dependent who becomes entitled to or loses eligibility for coverage under Medicare or Medicaid. (See the "Coordination of Benefits with Medicare" section for more information.)
- **Judgment, decree or order:** You may change your election, if necessary, to comply with a court or administrative order which affects coverage for your child. You may also enroll your eligible child if so required due to a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order

(QMCSO)) that requires medical coverage for your child. Coverage starts on the date specified in the QMCSO. If you are not already enrolled, you must enroll at the same time your child is enrolled. A new electronic Group Insurance Enrollment form should be completed. (See the "Qualified Medical Child Support Order" section for more information.)

- **Cost of coverage under this Plan:** If the cost of your coverage increases or decreases during the plan year, you will be notified of the cost change and the amount of your contributions will be adjusted automatically for your share of the increase or decrease. If the cost of your coverage increases significantly, as determined by the Plan Administrator, but not less than a 10% increase, you may change your election to either increase your future contributions or elect another similar coverage. You may not revoke your election without electing another coverage.

- **Significant change in coverage under this Plan:** If your coverage is significantly curtailed, as determined by the Plan Administrator, or ceases altogether, you may revoke your election and, if you choose, elect another similar coverage for the balance of the plan year. If, during the plan year, a new coverage is offered, you may change your election to elect the new coverage; if your coverage is eliminated, you may change to another similar coverage.

- **Change in regularly scheduled hours that affects benefits eligibility:** If your employment status changes from a casual position with no benefit eligibility to a full-time or part-time position with benefit eligibility, you will be allowed to make a coverage election at that time. Your casual employment will count toward your 30-day eligibility waiting period.

Dates for Qualifying Status Changes			
QUALIFYING STATUS CHANGE	**To change coverage, complete the Self Service Enrollment form online. The form must be completed by:**	**Proof Required**	**Benefits Start/Loss Date**
Marriage:	30 days from date of marriage.	A copy of the marriage certificate.	Covered from the first day of marriage.
Divorce, legal separation or annulment	30 days from date of separation, divorce or annulment.	A copy of court papers showing the date the separation, divorce or annulment was final.	Covered dependents lose coverage the end of the month the event was final. COBRA information is sent to canceled dependents.
A newborn infant	30 days from date of birth	Birth Certificate	Covered from date of birth.
A newly adopted child	30 days from the date of your child's placement for adoption.	A copy of the final adoption papers showing the date adoption was finalized.	Covered from date the child is physically placed with you for adoption & you assume financial responsibility.
Court Order to enroll child(ren)	30 days from the date on the court order.	Copy of the court order.	Date specified on the court order.
Death of a covered employee.	30 days from the date of death.	Copy of death certificate	Dependent coverage ends at end of the month in which the person died.

Gain or loss of insurance for dependents.	30 days from the date of the event.	Notice from dependent's employer of date benefits gained or lost.	Date following the event.
Change in hours that affect your benefits eligibility.	30 days from the status change.	No proof required.	Covered the date your status changed (provided you have satisfied the wait period.)

Cost

The company pays a portion of the cost of Dental Plan coverage for eligible active employees and their eligible dependents. See enrollment materials for cost information.

Within 30 days of your hire date, and again during each annual open enrollment period, Human Resources will give you information about your share of the premium for coverage for that Plan year. **It is your responsibility to notify Human Resources/Benefits if your payroll deductions are not correct.**

Your contributions will be deducted from your pay before your withholding taxes are calculated, thereby reducing your income taxes and FICA taxes. You will be given an opportunity to elect pretax coverage each year during the open enrollment period.

Enhanced Dental Option

You may see any dentist of your choice. However, the plan offers an option when choosing a dentist.

If you choose a dentist contracted to participate in the MetLife network, your dental care cost is discounted. Participating dentists have agreed to accept discounted fees, which mean you will not have to pay above reasonable and customary charges. The choice to use a network dentist is entirely up to you.

If you are interested in a list of participating network dentists, call MetLife at 1-800-942-0854 or logon to www.metlife.com/dental .

Annual Deductible

The annual deductible is the cost of covered dental expenses that you must incur before benefits are payable. The deductible amount is the first $25 of covered expenses per individual per calendar year. Refer to the Schedule of Dental Benefits at the beginning of this Plan for expenses that are subject to an annual deductible provision.

Lifetime Deductible

A lifetime deductible does not apply.

Payment Levels

The plan pays 100% of reasonable and customary Covered Expenses for Preventive and Diagnostic Treatment.

After you have satisfied the annual deductible, the plan pays 80% of reasonable and customary basic restorative (routine treatment) expenses, and 50% of reasonable and customary major restorative (Prosthodontics) expenses.

The Plan pays 50% of reasonable and customary Orthodontia expenses up to $1,000 lifetime maximum (deductible does not apply to Orthodontia).

Refer to the Schedule of Benefits at the beginning of this Plan.

Payment of Dental benefits is subject to the limitations, exclusions, and definitions contained in this book.

Covered Dental Services and Supplies

Preventive and Diagnostic Treatment

Covered at 100% of the reasonable and customary charge. Deductible does not apply.

- Oral examinations, teeth cleaning, and bitewing x-rays
- Periodontal cleaning
- Topical application of fluoride solutions
- Space maintainers
- Full mouth series of x-rays
- Tests and lab examination, including bacteriologic cultures, pulp vitality tests and diagnostic casts
- Application of dental sealants to unrestored, non-decayed permanent molars once every 36 months, for children under age 14

Basic Restorative Services – Routine Treatment

Covered at 80% of the reasonable and customary charge. Deductible applies.

- Extraction and alveolectomy at the time of tooth extraction
- Dental surgery
- Amalgam, silicate, acrylic and composite fillings
- Necessary treatment for relief of dental pain
- General anesthesia and diagnostic x-ray and lab procedures required in relation to dental surgery
- Consultations required by the attending dentist
- Repair, or recementing of crowns, inlays, fixed or removable dentures, or relining or rebasing of dentures
- Endodontics (root canal therapy)
- Periodontal treatment (diseases of the gums)
- Drugs and medicines requiring a dentist's prescription

Major Restorative Services – Prosthodontics

Covered at 50% of the reasonable and customary charge. Deductible applies.

You should obtain a pre-treatment estimate from MetLife prior to beginning major restorative services with your dentist. Refer to "Request a Pre-Treatment Estimate" section for details.

- Crowns, inlays, and onlays - A crown used as an abutment to a partial denture is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required
- Partial or complete dentures or fixed bridgework when necessary to replace one or more natural teeth lost after the effective date of coverage for an individual
- Replacement of existing prosthodontic appliances, provided that:

- The existing denture or bridgework is at least five years old and cannot be made serviceable; or
- The existing denture or bridgework was temporarily installed after the effective date of coverage for the individual and is replaced by a permanent appliance within twelve months; or
- The replacement denture or bridgework is made necessary as the result of an initial placement of an opposing denture while covered.

- Dental implants consisting of alloplastic material placed into or onto a jawbone to support a crown

Orthodontia

Covered at 50% of the reasonable and customary charge (Deductible does not apply). The Enhanced Dental Option covers Orthodontic care for adults and children and coverage for appliances or treatment for Bruxism (grinding of the teeth). There is a combined $1,000 lifetime maximum for Orthodontia and Bruxism.

Basic Dental Option

Annual Deductible

An annual deductible does not apply.

Lifetime Deductible

All covered Dental Expenses are subject to a lifetime deductible provision. The deductible is the first $50 of covered expenses incurred while the individual is covered. The deductible is required only once during the lifetime of the individual. Refer to the Schedule of Benefits at the beginning of this Plan.

Payment Levels

After you have satisfied the deductible, the Dental Plan pays 80% of reasonable and customary charges for Preventive, Diagnostic and Basic Restorative (Routine Treatment) and 50% of reasonable and customary charges for Major Restorative (Prosthodontics). Orthodontia is not covered.

Refer to the Schedule of Benefits at the beginning of this Plan.

Payment of Dental benefits is subject to the limitations, exclusions, and definitions contained in this booklet.

Covered Dental Services and Supplies

Please see the Enhanced Dental section for covered services and supplies. Basic Dental covers the same types of services and supplies as Enhanced dental, except for Orthodontia and treatment of Bruxism. However, the payment levels and deductible provisions are different.

Request a Pre-Treatment Estimate

A pre-treatment estimate is a calculation of dental benefits that takes place before services are rendered by your dentist. You should obtain a pretreatment estimate prior to beginning any plan of treatment that is expected to cost more than $300.

To receive a pretreatment estimate, ask your dentist to send MetLife a claim form that outlines the plan of

treatment. Once the treatment plan has been reviewed by MetLife, you and your dentist will receive a detailed estimate of expected benefits.

This estimate will help you to make an informed decision. It will detail the Plan's share of the cost for the proposed treatment and your share of the expected cost.

It is important to note that a pre-treatment estimate is only for determining benefit coverage and is not a guarantee of benefits. Actual benefits are determined when an actual claim for services is received and processed. The decision to receive any dental services is solely between you and your dentist.

Reasonable and Customary Charge

No more than the reasonable and customary charge for dental services or supplies will be covered by this Plan. The reasonable and customary charge (as determined by the plan) is the lowest of:

- The usual charge by the dentist or other provider of the services or supplies for the same or similar services or supplies; or
- The usual charge of most other dentists or other providers of similar training or experience in the same or a similar geographic area for the same or similar services or supplies; or
- The actual charge for the services or supplies.

Maximum Benefits

The maximum amount the Plan will pay for all covered expenses (Preventive, Diagnostic, Routine and Prosthodontic treatment expenses combined) in any one calendar year for any one person is shown on the Schedule of Dental Benefits at the beginning of this Plan.

Exclusions

Covered dental expenses do not include, and no payment will be made for, the following:

- Charges associated with the initial installation of dentures or bridgework, replacing a tooth or a group of teeth, which were lost prior to the effective date of coverage, unless the device includes a replacement of at least one tooth lost while covered.
- Any service rendered before coverage became effective.
- Treatment other than by a licensed dentist or licensed physician; however, the scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision of and billed by the dentist.
- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
- Replacement of a lost, missing, or stolen prosthetic device.
- Replacement or repair of an orthodontic appliance (except as specified for the Enhanced Dental Option).
- Any services that are covered by any workers' compensation law or employer's liability law, or services an employer is required by law to furnish in whole or in part.
- Services or supplies for which no charge is made that the covered person is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.

- Services or supplies that are not necessary or are considered experimental in terms of generally accepted dental standards.
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- Any duplicate prosthetic device or any other duplicate appliance.
- Oral hygiene and dietary instruction.
- A plaque control program (a series of instruction on the care of the teeth).
- Myofunctional therapy or correction of harmful habits (except as specified under the Enhanced Dental Option for treatment of Bruxism).
- Appliances, restorations and procedures to alter vertical dimension (except as specified for the Enhanced Dental Option).
- Orthodontic treatment or correction of malocclusion (except as specified for the Enhanced Dental Option).
- Expenses for services other than those specifically indicated as covered.
- Services to the extent that such services are otherwise provided under this Plan or any other plan sponsored by the company.

Terminations of Coverage

Your Dental Plan coverage will terminate at the end of the calendar month in which:

- Your employment ends,
- You are no longer an eligible employee,
- Or on the date the Plan is terminated.

You may qualify for an extension of coverage in certain circumstances described in the Special Extensions of Coverage section below.

Coverage for your enrolled dependents will terminate at the end of the calendar month in which

- Your coverage terminates, or
- You are no longer eligible for dependent coverage, or
- Your dependent is no longer eligible;

See the “Continuation Coverage Privilege (COBRA)” section and the “Health Insurance Portability and Accountability Act - HIPAA” section for related information in the event your or your dependents’ coverage terminates.

Dental benefits cannot be converted to individual coverage.

Special Extensions of Coverage

During Approved Disability Leave

If you are on an approved medical leave of absence for your illness or injury, your coverage for you and your dependents may be extended for up to a maximum of one year. You must continue to pay your share of the premium, if any. Doctor certifications are required to extend benefits.

If you are still disabled at the end of the one-year period, you may continue your health care coverage at your expense for the balance of the COBRA continuation coverage period.

During Family Medical Leave

If you meet the requirements for Family Medical Leave, the company will maintain or reinstate any health care coverage which you had under this Plan prior to the leave. You must continue to pay your share of the premium, if any. See the "Family Medical Leave" section for details.

During a Personal Leave of Absence

Your coverage remains in effect until the end of the month in which you last worked. You may enroll in the health care COBRA continuation coverage program at your expense.

During a Uniformed Services Leave (Military Leave of Absence)

- If your uniformed services leave is less than 31 days, your coverage continues during the leave, provided you continue to be enrolled in the Dental Plan. You must continue to pay your share of the premium.
- If your uniformed services leave is 31 days or more, your coverage remains in effect until the end of the month in which you last worked. You and your dependents may enroll in the health care COBRA continuation coverage program at your expense.

During Jury Duty (or Court Witness)

Your coverage continues when you are required to serve as a juror or as a court witness. You must continue to pay your share of the premium, if any.

Leave for trials that are expected to be of lengthy duration (over 30 days) must be requested for approval through Human Resources.

After Your Death

If you die, coverage for your dependents remains in effect until the end of the month in which your death occurs. Your dependents may enroll in the health care COBRA continuation coverage program at their expense, provided they were enrolled in health care coverage before your death.

Extended Benefits

Under limited circumstances, if a course of treatment had started before your dental coverage terminated, your dental benefits will be extended up to 2 (two) months for:

- Dental prosthesis (bridges or dentures) where the impression was taken and the prosthesis was ordered while the patient was covered under the plan.
- A crown, if the dentist prepared the tooth for the crown while the patient was covered under the plan.
- Root canal therapy, if the dentist opened the tooth while the patient was covered under the plan.

Reinstatement of Coverage

If your dental coverage terminates because you cease to meet the definition of an eligible employee, coverage for you and your eligible dependents may be reinstated immediately (without waiting 30 days) if you return to active work in an eligible class within 12 months from the date your eligibility ceased.

If loss of eligibility and reinstatement of coverage occur within the same calendar year, the annual benefit maximum provisions will be applied only once for that year.

Third Party Liability

Third party liability refers to the situation where a covered individual is injured by another party who is legally responsible for paying the resulting dental bills.

If you are injured by a third party, Plan benefit payments for your dental care expenses related to the injury will be pended until the MetLife Claim Office receives your signed Third Party Agreement form.

If you receive payment from a third party, you must return to the Plan any duplicate payments you receive.

Coordination of Benefits (COB)

If you or your dependents have other coverage in addition to being covered under this Plan, the benefits under this Plan will be coordinated with the benefits of other plan(s).

Specifically, in a calendar year, this Plan will pay its regular benefits but not more than the amount which, when added to the benefits payable by the other plan or plans, will equal 100% of allowable expenses.

Allowable expenses means any necessary, reasonable and customary expense incurred during a calendar year while eligible for benefits under this Dental Plan, part or all of which would be covered under any of the other plans.

Other plans include any plan providing benefits or services for dental treatment when benefits or services are provided by group insurance or any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or by individual health insurance policies or contracts, dental expense provisions of automobile Personal Injury Protection (PIP) policies, automobile no-fault insurance benefits, or homeowners insurance policies.

Coordination of benefits typically occurs if you and your dependents are covered by more than one group insurance plan. One plan will be considered the “primary” plan, and the other will be the “secondary” plan.

To obtain proper payment of your dental bills, send your claim to the primary plan first, then send the secondary plan a copy of your bills along with a copy of the primary plan’s “explanation of benefits paid” statement.

To determine which plan is primary and which plan is secondary, follow the rules listed below:

1. Order of payments for an employee
    - Primary plan is the Company Plan
    - Secondary plan is the plan sponsored by the spouse’s employer

2. Order of payments for the spouse of an employee
    - Primary plan is the plan sponsored by the spouse’s employer

- Secondary plan is the Company Plan

3. Order of payments for the children of an employee
   - Primary plan is the plan of the parent whose birthday occurs earlier in the year
   - Secondary plan is the plan of the parent whose birthday occurs later in the year

4. Order of payments for children of divorced parents
   - Primary plan is determined by court decree; otherwise,
   - Primary plan is the plan of the natural or adoptive parent with custody
   - Secondary plan is the plan of the step-parent with custody
   - Tertiary (third) plan is the plan of the natural or adoptive parent without custody

5. Order of payments for persons covered by a plan for active employees (and their dependents) and by a plan for retirees, laid-off employees or COBRA coverage continuants (and their dependents)
   - Primary plan is the plan for active employees (and their dependents)
   - Secondary plan is the plan for retirees, laid-off employees or COBRA coverage continuants (and their dependents)

6. Order of payments if not covered above
   - Primary plan is the plan which has covered the individual the longest
   - Secondary plan is the plan which has covered the individual for less time

7. Order of payments if the other group plan or individual policy does not contain a coordination of benefits provision
   - Primary plan is the plan that does not contain a coordination of benefits provision
   - Secondary plan is the Company Plan

MetLife has the right to release and obtain any information it considers necessary to administer this provision and to recover overpayments.

Claim Procedures

Time Limit for Filing Claims

All claims must be submitted within 12 months of the date expenses are incurred. Claims not submitted within this time limit will not be paid.

How to File a Claim for Benefits

Only claims for expenses incurred on or after the effective date of your coverage will be processed. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required dental statements and bills are submitted with the claim form to the MetLife Claims Office.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

To receive prompt payment for your claims, follow the procedures listed below as closely as possible.

1. Complete the MetLife claims form, download claim form from benefits website.

- For dentist's services, attach your dentist's itemized bill or have your dentist complete his or her required portion of the claim form.
- For dental prescription drugs, be sure to attach itemized bills showing the name of the individual for whom the drugs were prescribed, the prescription number, the diagnosis, the cost, and the name of the dentist prescribing the drug.
- Dental expenses incurred as a result of an accident should be submitted with complete accident details to the Medical Plan for payment.

Note: The "Other Coverage Information" section must be completed on each claim form. Also, if the expense is related to an accident, the "Accident Information" section must be completed on each related claim.

2. Your claim and all bills connected with it should be submitted to MetLife promptly following the date expenses are incurred. You must submit original bills. MetLife will not accept photocopies, except for secondary coordination of benefit claims.

3. Payments can be handled in two ways:
   - You may assign payment of benefits by signing the authorization on the claim form. If you do assign your benefits, the payment will be sent directly to the provider of service; or
   - You may pay the bill directly, in which case the benefit checks will be made payable to you.

4. Forward the completed claim form together with itemized bills to the following address:

   MetLife Dental Claims
   P.O. Box 981282
   El Paso, TX 79998-1282

   Claim inquiries: 800-942-0854
   The Dental group number is **302073**.

All benefit checks other than those assigned will be mailed by the claims office to you. If any benefits have been denied, you will receive an "explanation of benefits" statement.

Claim Procedures for Alternate Recipients under Qualified Medical Child Support Orders (QMCSO)

The Claim Procedures must be followed for claims of alternate recipients under qualified medical child support orders. The plan pays the provider if the claim is assigned. See the "Qualified Medical Child Support Order" section for more information.

Routine Questions

If there is any question about a claim payment, an explanation may be requested directly from MetLife by calling 1-800-942-0854.

The Dental group number is **302073**.

Claim Appeals

In the event a claim is denied in whole or in part, MetLife will notify you in writing within 30 days after your claim was filed (45 days under special circumstances). If an extension beyond 30 days is necessary to

make a decision on your claim, you will receive a notice indicating the reason for the delay and the date you may expect a final decision.

MetLife's notice of claim denial will include:

- The specific reason(s) for denial with reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why the material or information is necessary; and
- The steps to be taken if you wish to have the decision reviewed.

How to Appeal a Claim Decision

If MetLife denies your claim, you may make two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of the patient
- The Plan #: **302073**
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination
- As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim

Appeal Process

After MetLife receives your written request appealing the initial determination or the determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination.

The person who reviews your appeal will not be the same person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

Appeal Determinations

MetLife will notify you in writing of its final decision within 30 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you

prior to the expiration of the initial 30-day period, state the reason(s) why such an extension is needed, and state when MetLife will make its determination.

VISION PLAN

The Vision Plan is designed to help pay for certain routine vision care expenses incurred by both you and your covered dependents. There are no deductibles or precertification requirements. Vision claims are paid by EyeMed Vision Care.

You may see any licensed vision care provider of your choice. However, the plan offers an option when choosing a vision care provider.

If you choose a vision care provider contracted to participate in the EyeMed Vision Care network, your vision care cost is discounted. EyeMed Vision Care network providers have agreed to accept discounted fees, which mean your Vision Plan benefit can go farther. The choice to use a network provider is entirely up to you.

For a list of provider locations nearest you call EyeMed Vision Care at 1-866-723-0513. The group number **9681974** or log on to www.eyemedvisioncare.com and choose the "Access Network" option.

To receive network benefits:

- Make an appointment with a network provider.
- Present your EyeMed Vision Care card to the network provider. The provider will verify your Vision Plan eligibility with EyeMed Vision Care.
- At your appointment, you will receive discounts towards the cost of your routine vision exam and/or eyewear.
- The network provider will handle claim filing for Vision Plan benefits.
- You will be responsible for paying the network provider for any amount exceeding Vision Plan benefits. *See Vision Exam and Eyewear.*

To receive non-network benefits:

- You make an appointment with a non-network provider of your choice.
- You pay the bill in full and file a claim form with EyeMed Vision for reimbursement. An EyeMed claim form is located on the Benefits website.
- The Plan pays up to the maximum benefit amounts available for routine vision exams and eyewear. See Vision Exam and Eyewear.
- You are responsible for any charges that exceed the Vision Plan benefit amounts.

Eligibility and Effective Date

Employees

Eligible employees are full-time and part-time employees regularly scheduled to work 15 or more hours per week. Full-time and part-time employees may also enroll their eligible dependents. Employees who are members of a collective bargaining unit are eligible only if the collective bargaining agreement provides for participation in this Plan.

You may choose vision coverage for yourself and your dependents, even if you decline medical coverage. You must choose dental and vision together. If you elect dental and vision, there is a bi-weekly cost to you.

You are not eligible to enroll if you are working in a capacity that (at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary) is considered contract labor or independent contracting.

New employees become eligible for Plan coverage on the day after completing 30 days of service.

You will be covered by the Plan as soon as you become eligible and complete the online Self Service Insurance Enrollment **within 30 days from date of hire**.

If you fail to complete an enrollment in Self Service before your effective date of coverage, you will automatically be covered by the default/No coverage option.

Dependents

Your eligible dependents are covered under this Plan on the date your coverage is effective if you are eligible and enroll each dependent for coverage.

Your eligible dependents are:

- Your legal spouse
- Your children under age 26, (regardless of marital, residence, or job status) including your natural children, legally adopted children, children placed for adoption, stepchildren and any other children, provided you are their legal guardian or you claim the children as dependents for federal income tax purposes.
- Your unmarried child who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, provided such child was covered under this Plan at the time of disability and immediately prior to his or her 26th birthday.

If you do not enroll your dependents when they are first eligible, you must wait until the next open enrollment period in the fall for a January 1 effective date, except in the event of Family/Work qualified status changes (see Qualified Status Changes section).

If your spouse is an employee and is covered under this Plan, your dependent may be enrolled under only one parent's coverage.

If one of your dependents is an employee and is eligible for coverage under the plan, he or she may not be enrolled as both a covered dependent and an employee.

Enrollment

Initial enrollment: Your initial enrollment election is a commitment for the remainder of the calendar year. As a new hire, you will have 60 days from hire date to complete the electronic Group Insurance Enrollment form. If you are newly eligible for the Plan due to a change in employment status, you will have 30 days from status change date to complete your enrollment in Self Service. If elections are not made within the specified time, you will **NOT HAVE COVERAGE**.

Open Enrollment: You will be given the opportunity to review your participation in the benefit plans on an annual basis each fall for a January 1 effective date. This is called an "Open Enrollment" period. Your

Open Enrollment election is a 12-month commitment beginning January 1. Other than open enrollment, you may change your annual election during the year only if you have a qualified event.

Default coverage: If you do not enroll within the specified time, you will automatically be defaulted in to Decline/No coverage

Vision Care Services

Eye Exam, with dilation if necessary:
- In-Network: $0 copay
- Out of Network: Up to $50

Packages – Frames, Lens and Lens Options Package:
- In-Network: $0 copay, $100 allowance; 20% off balance
- Out of Network: Up to $100

Contact Lenses:
- Conventional -
  - In-Network: $0 copay, $100 allowance; 15% off balance
  - Out of Network: Up to $100
- Disposable -
  - In-Network: $0 copay, $100 allowance; 100% off balance
  - Out of Network: Up to $100
- Medically Necessary -
  - In-Network: $0 copay
  - Out of Network: Up to $500

Special Enrollments/Notice of Employee Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you submit an enrollment form within 30 days after your other coverage ends. 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, provided you complete an electronic enrollment form within 30 days.

If you declined coverage under the Plan for yourself, your spouse and/or your dependents because of other health coverage, you may be eligible to change your election during the year and elect coverage if: the other coverage was COBRA and it has now been exhausted; eligibility for the other coverage was lost or, if the other coverage was employer provided, the employer stopped contributing toward that coverage.

Family/Work Qualified Status Changes

Your benefit election is in force for the full plan year (January 1 through December 31) following the enrollment period (unless your coverage terminates).

You are eligible to change your election during the year only if you have a qualifying change in your family or work status. It is your responsibility to make the status changes on the Self Service benefits enrollment site and provide the needed documentation to Human Resources within 30 days of the qualifying event.

The change in your election will apply only to the affected individual(s) and must be consistent with the change in family or work status. Generally, to be consistent, you must have gained or lost benefit eligibility in this Plan or another employer's plan due to the event, and your election change must be on account of and correspond to the gain or loss. Qualifying family and work status changes are:

- Legal marital status change due to marriage, death of a spouse, divorce, legal separation or annulment.

- Number of dependents change due to birth, adoption, placement for adoption or death of a dependent.

- Employment status changes for you, your spouse or dependent due to ending or starting employment, a strike, lockout or commencement or return from an unpaid leave of absence (including an FMLA leave); or a change in employment status with the consequence that you, your spouse or dependent becomes or ceases to be eligible for coverage (such as a switch between part-time and full-time status).

- Residence or worksite change (for you, your spouse or dependent) that could affect your benefits.

- Dependent child's eligibility change which causes a dependent to satisfy or cease to satisfy eligibility requirements due to age or a similar change.

You may add or stop coverage for yourself or a covered dependent, as applicable, if you experience any of the following qualifying events:

- **Coordination of coverage with another group plan:** If the plan of your spouse's or dependent's employer has a different coverage period than this Plan, or allows mid-year election changes for qualified status change events, you may be able to change your election under this Plan. Any change in your election will be prospective only and will correspond with your eligibility for and enrollment in your spouse's or dependent's coverage.

- **Vision coverage with another group plan ends:** If you declined coverage under this Plan for yourself, your spouse and/or your dependents because of other coverage, you may be eligible to change your election during the year and elect coverage if: 1) the other coverage was COBRA and it has now been exhausted; 2) eligibility for the other coverage was lost or, 3) if the other coverage was employer provided, the employer stopped contributing toward that coverage.

- **Medicare or Medicaid:** A coverage election may be changed for you, your spouse or a dependent that becomes entitled to or loses eligibility for coverage under Medicare or Medicaid. (See the "Coordination of Benefits with Medicare" section for more information.)

- **Judgment, decree or order:** You may change your election, if necessary, to comply with a court or administrative order which affects coverage for your child. You may also enroll your eligible child if so required due to a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order (QMCSO)) that requires medical coverage for your child. Coverage starts on the date specified in the QMCSO. If you are not already enrolled, you must enroll at the same time your child is enrolled. A new electronic Group Insurance Enrollment form should be completed. (See the "Qualified Medical Child Support Order" section for more information.)

- **Cost of coverage under this Plan:** If the cost of your coverage increases or decreases during the plan year, you will be notified of the cost change and the amount of your contributions will be adjusted automatically for your share of the increase or decrease. If the cost of your coverage increases significantly, as determined by the Plan Administrator, but not less than a 10%

increase, you may change your election to either increase your future contributions or elect another similar coverage. You may not revoke your election without electing another coverage.

- **Significant change in coverage under this Plan:** If your coverage is significantly curtailed, as determined by the Plan Administrator, or ceases altogether, you may revoke your election and, if you choose, elect another similar coverage for the balance of the plan year. If, during the plan year, a new coverage is offered, you may change your election to elect the new coverage; if your coverage is eliminated, you may change to another similar coverage.

- **Change in regularly scheduled hours that affects benefits eligibility:** If your employment status changes from a casual position with no benefit eligibility to a full-time or part-time position with benefit eligibility, you will be allowed to make a coverage election at that time. Your casual employment will count toward your 60-day eligibility waiting period.

Dates for Qualifying Status Changes			
QUALIFYING STATUS CHANGE	**To change coverage, complete the Self Service Enrollment form online. The form must be completed by:**	**Proof Required**	**Benefits Start/Loss Date**
Marriage:	30 days from date of marriage.	A copy of the marriage certificate.	Covered from the day of marriage.
Divorce, legal separation or annulment	30 days from date of separation, divorce or annulment.	A copy of court papers showing the date the separation, divorce or annulment was final.	Covered dependents lose coverage the end of the month the event was final. COBRA information is sent to canceled dependents.
A newborn infant	30 days from date of birth	Birth Certificate	Covered from date of birth.
A newly adopted child	30 days from the date of your child's placement for adoption.	A copy of the final adoption papers showing the date adoption was finalized.	Covered from date the child is physically placed with you for adoption & you assume financial responsibility.
Court Order to enroll child(ren)	30 days from the date on the court order.	Copy of the court order.	Date specified on the court order.
Death of a covered employee.	30 days from the date of death.	Copy of death certificate	Dependent coverage ends at end of the month in which the person died.
Gain or loss of insurance for dependents.	30 days from the date of the event.	Notice from dependent's employer of date benefits gained or lost.	Date following the event.
Change in hours that affect your benefits eligibility.	30 days from the status change.	No proof required.	Covered the date your status changed (provided you have satisfied the 60-day wait period.)

Cost

The company shares in the cost of the combined Dental and Vision Plan coverage for eligible active employees and their eligible dependents. See enrollment materials for cost information.

Within 30 days of your hire date, and again during each annual open enrollment period, Human Resources will give you information about your share of the premium for coverage for that Plan year**. It is your responsibility to notify Human Resources/Benefits if your payroll deductions are not correct.**

Your contributions will be deducted from your pay before your withholding taxes are calculated, thereby reducing your income taxes and FICA taxes. You will be given an opportunity to elect pretax coverage each year during the open enrollment period.

Vision Coverage

You and your dependents must be covered under the Vision Plan at the time covered Vision Exam or Eyewear expenses are incurred for benefits to be payable. A charge will be considered incurred on the date the procedure or service is rendered or the supply is furnished.

If you and/or your dependent's coverage should terminate, no Eyewear benefits will be provided unless lenses, contact lenses, or frames were ordered prior to the date coverage terminates and are delivered within 60 days after the date coverage terminates.

Payment of Vision benefits is subject to the limitations, exclusions, and definitions contained in this book.

Vision Exam

Vision benefits cover most of the cost of a routine vision examination. You and each covered dependent will be eligible for reimbursement for one vision examination from any licensed optometrist or ophthalmologist once each calendar year up to a **maximum of $50**.

Eyewear

The Plan provides for reimbursement for one eyewear purchase (frames, prescription lenses, and contacts) once each calendar year up to a **maximum of $100**.

There are no restrictions on size, tints, coatings, no-line bifocals, or frames. A change in prescription is not required for reimbursement. You may purchase your eyewear from any licensed optometrist, ophthalmologist, or optician.

Note: Benefits are provided only for one claim for each covered person (the first claim received) each year. As a result, you should wait until a covered person's eyewear expenses are $100 (or if less than $100, you are sure no further eyewear expenses will be incurred by that person for the rest of the year) before you file a claim. For example, if your dependent wears disposable contacts, keep receipts for refills until expenses for the contacts are $100 or more; then file the claim, and you will be reimbursed the full benefit.

Exclusions

Covered vision care expenses do not include, and no payment will be made for, the following:

1. Expenses for services or supplies received by a covered person before the Vision Plan benefits start for that person.
2. Services or supplies that are not prescribed as necessary by an ophthalmologist or an optometrist, or are considered experimental in terms of generally accepted vision care standards.
3. Services or supplies that are covered by any workers' compensation law or employer's liability law, or services an employer is required by law to furnish in whole or in part.
4. Services or supplies in connection with medical or surgical treatment of the eye.
5. Drugs or medications other than those required for the vision examination.
6. Special or unusual services and procedures such as orthoptics, vision training, and subnormal vision aids.

7. Replacement of lost, stolen or broken lenses or frames, unless at the time of such replacement the covered person is eligible for reimbursement for one eyewear purchase (for that calendar year).
8. Services or supplies to the extent that benefits are otherwise provided under this Plan or under any other plan sponsored by the company.
9. Services or supplies for which no charge is made that the covered person is legally obligated to pay or for which no charge would be made in the absence of the vision care coverage.
10. Lenses that do not require a prescription; frames for non-prescription lenses.
11. Frame-wear insurance.

Termination of Coverage

Your Vision Plan coverage will terminate at the end of the calendar month in which

- Your employment ends, and you are no longer an eligible employee,
- Or on the date the Plan is terminated.
  You may qualify for an extension of coverage in certain circumstances described in the Special Extensions of Coverage section below.

Coverage for your enrolled dependents will terminate at the end of the calendar month in which

- Your coverage terminates, or
- You are no longer eligible for dependent coverage, or
- Your dependent is no longer eligible;

See the "Continuation Coverage Privilege (COBRA)" section and the "Health Insurance Portability and Accountability Act HIPAA" section for related information in the event your or your dependents' coverage terminates.

Vision Plan benefits cannot be converted to individual coverage.

Special Extensions of Coverage

During Approved Disability Leave

If you are on an approved medical leave of absence for your illness or injury, your coverage for you and your dependents may be extended for up to a maximum of one year. You must continue to pay your share of the premium, if any. Doctor certifications are required to extend benefits. If you are still disabled at the end of the one-year period, you may continue your health care coverage at your expense for the balance of the COBRA continuation coverage period.

During Family Medical Leave

If you meet the requirements for Family Medical Leave, the company will maintain or reinstate any health care coverage which you had under this Plan prior to the leave. You must continue to pay your share of the premium, if any. See the "Family Medical Leave" section for details.

During a Personal Leave of Absence

Your coverage remains in effect until the end of the month in which you last worked. You may enroll in the health care COBRA continuation coverage program at your expense.

During a Uniformed Services Leave (Military Leave of Absence)

If your uniformed services leave is less than 31 days, your coverage continues during the leave, provided you continue to be enrolled in the Vision Plan. You must continue to pay your share of the premium.

If your uniformed services leave is 31 days or more, your coverage remains in effect until the end of the month in which you last worked. You and your dependents may enroll in the health care COBRA continuation coverage program at your expense.

During Jury Duty (or Court Witness)

Your coverage continues when you are required to serve as a juror or as a court witness. You must continue to pay your share of the premium, if any.

Leave for trials that are expected to be of lengthy duration (over 30 days) must be requested for approval through Human Resources.

After Your Death

If you die, coverage for your dependents remains in effect until the end of the month in which your death occurs. Your dependents may enroll in the health care COBRA continuation coverage program at their expense, provided they were enrolled in health care coverage before your death.

Reinstatement of Coverage

If your vision coverage terminates because you cease to meet the definition of an eligible employee, vision coverage for you and your eligible dependents will be reinstated immediately (without waiting 30 days) if you return to active work in an eligible class within 12 months from the date your eligibility ceased.

Third Party Liability

Third party liability refers to the situation where a covered individual is injured by another party who is legally responsible for paying the resulting vision bills.

If you are injured by a third party, Plan benefit payments for your vision care expenses related to the injury will be pended until the EyeMed Vision Care Claim Office receives your signed Third Party Agreement form. If you receive payment from a third party, you must return to the Plan any duplicate payments you receive.

Coordination of Benefits (COB)

If you or your dependents have other vision coverage in addition to being covered under this Plan, the benefits under this Plan will be coordinated with the benefits of other plan(s).

Specifically, in a calendar year, this Plan will pay its regular benefits but not more than the amount which, when added to the benefits payable by the other plan or plans, will equal 100% of allowable expenses.

Allowable expenses means any necessary, usual and customary expense incurred during a calendar year while eligible for benefits under this Vision Plan, part or all of which would be covered under any of the other plans.

Other plans include any plan providing benefits or services for vision or medical treatment when benefits or services are provided by group insurance or any arrangement of coverage for individuals in a group,

whether on an insured or uninsured basis, or by individual health insurance policies or contracts, medical expense provisions of automobile Personal Injury Protection (PIP) policies, automobile no-fault insurance benefits, or homeowners insurance policies.

Coordination of benefits typically occurs if you and your dependents are covered by more than one group insurance plan. One plan will be considered the "primary" plan, and the other will be the "secondary" plan. To obtain proper payment of your vision bills, send your claim to the primary plan first, then send the secondary plan a copy of your bills and a copy of the primary plan's explanation of benefits paid.

To determine which plan is primary and which plan is secondary, follow the rules listed below:

1. Order of payments for an employee
   - Primary Plan is the Company Plan
   - Secondary plan is the plan sponsored by the spouse's employer

2. Order of payments for the spouse of an employee
   - Primary plan is the plan sponsored by the spouse's employer
   - Secondary plan is the Company Plan

3. Order of payments for the children of an employee
   - Primary plan is the plan of the parent whose birthday occurs earlier in the year
   - Secondary plan is the plan of the parent whose birthday occurs later in the year

4. Order of payments for children of divorced parents
   - Primary plan is determined by court decree; otherwise,
   - Primary plan is the plan of the natural or adoptive parent with custody
   - Secondary plan is the plan of the step-parent with custody
   - Tertiary (third) plan is the plan of the natural or adoptive parent without custody

5. Order of payments for persons covered by a plan for active employees (and their dependents) and by a plan for retirees, laid-off employees or COBRA coverage continuants (and their dependents)
   - Primary plan is the plan for active employees (and their dependents)
   - Secondary plan is the plan for retirees, laid-off employees or COBRA coverage continuants (and their dependents)

6. Order of payments if not covered above
   - Primary plan is the plan which has covered the individual the longest
   - Secondary plan is the plan which has covered the individual for less time

7. Order of payments if the other group plan or individual policy does not contain a coordination of benefits provision
   - Primary plan is the plan that does not contain a coordination of benefits provision
   - Secondary plan is the Company Plan

EyeMed Vision Care has the right to release and obtain any information it considers necessary to administer this provision and to recover overpayments.

Claim Procedures

Time Limit for Filing Claims

All claims must be submitted within 12 months of the date expenses are incurred. Claims not submitted within this time limit will not be paid.

How to File a Claim for Benefits

Only claims for expenses incurred on or after your effective date of coverage will be processed.

- You will be reimbursed for only one claim for each covered person (the first claim received) each calendar year.
- As a result, you should wait until a covered person's eyewear expenses are $100 (or, if less than $100, you are sure no further eyewear expenses will be incurred by that person for the rest of the year before you file a claim).

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required vision care statements and bills are submitted with the claim form to the EyeMed Vision Care Claims Office.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

If you go to a participating EyeMed Provider location, you will not need to file a claim form. The below instructions apply only to non-network claims.

To receive prompt payment for your claims, follow the procedures listed below as closely as possible.

1. Complete the EyeMed claim form located on the Benefit website.

   Complete your portion of the claim form and ask your vision care provider to complete the rest or attach an itemized bill.

   Note that you must complete the "Other Coverage Information" section of the claim form.

2. Your claim and all bills connected with it should be submitted to EyeMed Vision Care promptly after the date vision care expenses are incurred. You must submit original bills. EyeMed Vision Care will not accept photocopies, except for secondary coordination of benefit claims.

3. You or your vision care provider may mail the form to the EyeMed Vision Care claim office address on the form:

   EyeMed Vision Care
   Attention: OON Claims
   PO Box 8504
   Mason, OH 45040-7111

   Claim inquiries: 1-866-723-0513, group #9681974.

4. Payment of the claim.

   EyeMed Vision Care will normally send the benefit check to you. You are responsible for paying the vision care provider.

Please note that the vision care provider may legitimately require you to pay the bill or a portion of it *before* you receive payment from EyeMed Vision Care.

Claim Procedures for Alternate Recipients under Qualified Medical Child Support Orders (QMCSO)

The Claim Procedures must be followed for claims of alternate recipients under qualified medical child support orders. The Plan pays the provider if the claim is assigned. See the "Qualified Medical Child Support Order" section for more information.

Routine Questions

If there is any question about a claim payment, an explanation may be requested directly from the EyeMed Vision Care Claims Office by calling 1-866-723-0513. The group number is 9681974.

Claim Appeals

In the event a claim is denied in whole or in part, EyeMed Vision Care will notify you in writing within 30 days after your claim was filed (45 days under special circumstances). If an extension beyond 30 days is necessary to make a decision on your claim, you will receive a notice from EyeMed Vision Care indicating the reason for the delay and the date you may expect a final decision.

The notice of claim denial will include:

- The specific reason(s) for denial with reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why the material or information is necessary; and
- The steps to be taken if you wish to have the decision reviewed.

How to Appeal a Claim Decision

If EyeMed denies your claim, you (or your authorized representative) may request a review of your claim and you may request free of charge copies of documents relevant to the claim. Your appeal should be sent to the attention of "Quality Assurance Department" at 4000 Luxottica Place, Mason, Ohio within 180 days after you receive notice of the denial of the claim. When requesting a review, at a minimum include the following information:

- Name of the patient and claim number from the EyeMed denial information
- The Plan #: # 9681974.
- The reason you believe the claim was improperly denied
- Submit any data, questions, or comments you deem appropriate.

All the information will be reevaluated by a qualified individual who was not involved in the decision being appealed. You will be informed of the decision in writing within 30 days after receipt of your written request for claims review. If special circumstances require an extension of time to review your claim, you will receive written notification of the final decision as soon as possible but not later than 60 days after your request for review. If such an extension is required, you will receive notice prior to the expiration of the initial 30-day period indicating the reason for the delay and the date you may expect a final decision.

Upon your written request, EyeMed Vision Care will provide you free of charge with copies of documents, records and other information relevant to your claim.

Definitions

Contact lenses mean lenses which do not fit into a frame but are fitted directly into the covered person's eye.

Covered vision care expenses means the charges for services and supplies within the maximum limits that are provided by an ophthalmologist, an optometrist, or an optician. The services must be necessary in terms of generally accepted vision care standards.

Frame or frames means an eyeglass frame into which two lenses are fitted.

Lenses means ophthalmic corrective lenses, either glass or plastic, ground or molded, as prescribed by an ophthalmologist or an optometrist, to be fitted into a frame.

Ophthalmologist means a doctor of medicine or osteopathy, who within the scope of his or her license performs a vision exam and prescribes lenses or contact lenses to improve visual acuity.

Optician means a person who is legally qualified and licensed:

- To supply lenses or contact lenses which are prescribed by an ophthalmologist or an optometrist to improve visual acuity;
- To grind or mold the lenses or contact lenses or have them ground or molded according to a prescription;
- To fit lenses into a frame;
- To adjust the frame to fit the face; and
- To fit contact lenses to the eye.

Optometrist means any person who is legally qualified and licensed to practice optometry.

Optometry means the measurement of vision and the prescription of lenses to improve visual acuity.

Vision exam means an exam performed by an ophthalmologist or an optometrist to evaluate the health and visual status of the eyes. A vision exam includes, but is not limited to:

- A case history;
- An external exam of the eye;
- A determination of refractive status;
- Binocular measure;
- An exam of the interior of the eye;
- Prescribing lenses or contact lenses;
- Checking the lenses or contact lenses when the prescription is filled

LIFE INSURANCE PLAN

Eligibility and Effective Date

For Employees Only

Eligible employees are **full-time employees** who are regularly scheduled to work 32 hours per week.

Employees who are members of a collective bargaining unit are only eligible if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary, is considered as contract labor or independent contracting.

New employees become eligible to join the Life Insurance Plan on the day after completing 60 days of service.

You will be covered by the Plan as soon as you become eligible. You need to complete the **Beneficiary** Form and return it to the Benefits Department.

If you not are actively at work on the date your coverage would normally start, it will not become effective until you return to work.

If you terminated and have been rehired within 12 months, your benefits will begin immediately provided you worked for the company at least 60 days when previously employed. (See Reinstatement of Coverage section.) If you had not worked 60 days before you terminated, you will not be eligible for benefits until the 61st day after you are rehired.

Cost

The company pays the full premium cost of this Life Insurance for you.

Under current federal income tax law, the premium the company pays for the first $50,000 of your coverage under the Life Insurance Plan is tax-free to you. The cost of your coverage over $50,000 is taxable.

The company computes the taxable value of the premium paid for your coverage in excess of $50,000 (your “imputed income”) based on the uniform group term life insurance premium rates specified for tax purposes in the Internal Revenue Code. The amount of your imputed income is included on your annual W-2 form. You are responsible for reporting this income on your tax return.

Plan Benefit

In the event of your death from any cause whatsoever, your beneficiary will be paid your Life Insurance benefit. Your Life Insurance benefit is equal to 1½ times your base annual salary, up to a maximum coverage amount of $350,000. If the coverage amount is not an even multiple of $1,000, it will be adjusted to the next higher multiple of $1,000.

Adjustments in your Life Insurance amount due to a salary change will automatically occur on the date of the salary change provided you are actively at work on that date. Otherwise, the adjustment will occur on the date you return to active work.

Your Life Insurance coverage will be reduced to 1 times your base annual salary when you reach age 65 (up to a maximum of $234,000) and to 75% of your base annual salary when you reach age 70 (up to $175,000). If the coverage amount is not an even multiple of $500, it will be adjusted to the next higher multiple of $500.

Your Beneficiary

Your beneficiary is the person or persons you name to receive your Life Insurance benefit in the event of your death. Complete the Beneficiary Form and return it to the Benefits Department to assure that Life Insurance benefits are paid in accordance with your wishes.

You may change your beneficiary designation at any time. If you do not name a beneficiary, or if your named beneficiary does not survive you, your Life Insurance benefit will be paid to the person or persons in the following order of priority:

- Your spouse;
- Your child(ren) equally;
- Your parent(s) equally;
- Your brother(s) and sister(s) equally;
- Your estate.

Accelerated Benefit Option

You may elect to receive up to 50% of your Life Insurance benefit while living if you meet each of the following requirements.

- You must be terminally ill with a life expectancy of 12 months or less.
- Covered under the plan for an amount of life insurance of at least $10,000
- You must be under 65 years of age.
- You must provide certification of your terminal illness. The certification must be made by a physician legally licensed to practice medicine and must be accepted by the insurance company before Accelerated Benefits are payable. The insurance company may require an independent medical examination at their expense.

Accelerated Benefits are based on the amount of your Life Insurance on the date the insurance company accepts certification of your terminal illness. After the insurance company accepts your certification, your Accelerated Benefit will be payable to you in one lump sum. You may request a minimum Accelerated Benefit amount of $3,000, and a maximum of $500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of Your Amount of Life Insurance. This option may be exercised only once.

Points to Note About the Accelerated Benefit Option

Accelerated Benefits can be used to pay for special nursing requirements or hospice arrangements, to purchase needed medical equipment or custodial care, or for other expenses.

Accelerated Benefits are payable only once during your lifetime.

Your Accelerated Benefit payment reduces the amount of your Life Insurance benefit that may be converted to an individual life insurance policy.

You are responsible for any tax effects of electing an Accelerated Benefit. In addition, payment of an Accelerated Benefit may adversely affect your eligibility for government benefits or entitlements. You are encouraged to consult legal or tax counsel before requesting an Accelerated Benefit.

Accelerated Benefits are not available if:

- All or part of your Life Insurance benefit is to be paid to your former spouse as part of a divorce settlement; or
- You have assigned your Life Insurance; or
- Your Life Insurance benefit is less than $10,000; or
- You are required by a government agency to request payment of Accelerated Benefits in order to apply for, obtain, or keep a government benefit or entitlement.

Termination of Insurance

Your Life Insurance coverage will terminate at the end of the calendar month in which:

- Your employment ends, or
- You are no longer an eligible employee, or
- You exceed one year on medical leave of absence, or
- The insurance policy is terminated, if earlier.

You may qualify for an extension of coverage in certain circumstances described in the Special Extensions of Coverage section below.

If your coverage ends, you may be eligible to convert all or part of your Life Insurance coverage to an individual life insurance policy. See Conversion Policy section for details.

Special Extensions of Coverage

Continuation of Coverage during Disability

The company will continue Life Insurance coverage for you while you are receiving Long Term Disability benefits if you complete the Waiver of Premium form and qualify for continued coverage. You are required to cooperate with the insurance company in completing this form in order to have continued Life Insurance coverage.

If you are not eligible for Long Term Disability Benefits, but are on an approved medical leave of absence for your illness or injury, your Life Insurance coverage will be continued until the end of your Family Medical Leave if you complete the Waiver of Premium form and qualify for continued coverage. You are required to cooperate with the insurance company in completing this form in order to have continued Life Insurance coverage. (See “During Family Medical Leave” below.)

When your group coverage ends, you may convert to an individual policy (see Conversion Policy section).

During Family Medical Leave

If you meet the requirements for Family Medical Leave, the company will maintain or reinstate any coverage you had under this Plan prior to the leave. See the Family Medical Leave section for details.

During a Personal Leave of Absence

Your Life Insurance coverage remains in effect until the end of the month in which you last worked.

During a Uniformed Services Leave of Absence

Your Life Insurance coverage remains in effect until the end of the month in which you last worked.

During Jury Duty

Your life insurance coverage continues when you are required to serve as a juror or as a court witness.

Leave for employees selected for special trials of lengthy duration (over 30 days) must be requested from Human Resources.

Reinstatement of Coverage

If your Life Insurance coverage terminates because you cease to meet the definition of an eligible employee, Life Insurance coverage for you will be reinstated immediately (without waiting 60 days) if you return to active work in an eligible class within 12 months from the date your eligibility ceased.

Conversion Policy

If your coverage terminates while this group policy is in force, you can convert all or part of your Life Insurance coverage to an individual life insurance policy by applying to The Hartford within 31 days after your group Life Insurance coverage terminates. The individual life insurance policy will take effect when the 31-day conversion period ends. Contact your Benefits Department for the necessary life insurance conversion form.

If you die during the 31-day conversion period, your beneficiary will be paid the life insurance amount you had the right to convert. This payment will be made whether or not you applied for an individual life insurance policy.

Claim Procedures

How to File a Claim for Benefits

All claim forms can be obtained from Human Resources.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements are submitted with the claim form.

The completed claim form should be returned to Human Resources.

When the claim has been processed, you (or your beneficiary) will be notified. Accelerated Life Insurance benefits will be paid to you. Death benefits will be paid to your Life Insurance beneficiary. If any benefits have been denied, you (or you beneficiary) will receive a written explanation.

Claims Are Paid By:

The Hartford
Group Benefits Division
P.O. Box 2999Hartford, CT 06104

Routine Questions

If there is any question about a claim payment, an explanation may be requested directly from

The Hartford – 1-800-523-1124

Requesting a Review of Claims Denied in Whole or in Part

In the event a claim is denied in whole or in part, The Hartford will notify you (or your beneficiary) in writing within 90 days after the claim was filed (180 days under special circumstances). If an extension beyond 90 days is necessary to make a decision on the claim, you (or your beneficiary) will receive a notice from The Hartford indicating the reason for the delay and the date you may expect a final decision.

The Hartford's notice of claim denial will include:

- The specific reason(s) for denial with reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why the material or information is necessary; and
- The steps to be taken if you (or your beneficiary) wish to have the decision reviewed.

You (or your beneficiary) or your authorized representative may request a review of the claim and may review pertinent documents. The request for review should be sent to Group Insurance Claims Review at the address of The Hartford office that processed the claim within 60 days after you (or your beneficiary) receive notice of the denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions, or comments you (or your beneficiary) deem appropriate.

All the information will be reevaluated, and you (or your beneficiary) will be informed of the decision in writing within 60 days after receipt of the written request for claims review. If special circumstances require an extension of time to review your claim, you (or your beneficiary) will receive written notification of the final decision as soon as possible but not later than 120 days after the request for review.

ELIGIBILITY – REVIEW AND APPEAL

If you (or your beneficiary or your legal representative) believes that you have been improperly denied eligibility in this plan or improperly denied the opportunity to make an election change due to a qualified change in status, follow the appeal procedures and timelines described above. However, instead of contacting The Hartford in writing, contact the Plan Administrator by writing to your Company Benefits Department as follows:

ABX Air, Inc.
Human Resources, 2061-H
145 Hunter Drive
Wilmington, OH 45177

The Plan Administrator has the sole discretionary authority to determine eligibility for benefits and to construe the terms of eligibility for the disability, life and accident plans.

If your initial request for eligibility or an opportunity to make a family status change is denied, and your written appeal is denied, you may pursue legal remedies under section 502(a) of ERISA. Before you may pursue these legal remedies however, you must first exhaust this review and appeals process. If you do take legal action, you must file suit within two years after the date of the event upon which the claims is based.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN

This coverage provides you with additional protection in case of accidental death or dismemberment occurring on or off the job. If you suffer a covered loss as a direct result of accidental bodily injury, Accidental Death and Dismemberment (AD&D) benefits are payable as specified in the Plan Benefit section below. If you die as a result of a covered accident, the AD&D benefit will be paid in addition to your Life Insurance Benefit.

Eligibility and Effective Date

For Employees Only

Eligible employees are **full-time employees** who are regularly scheduled to work 32 hours per week.

Employees who are members of a collective bargaining unit are only eligible if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary, is considered as contract labor or independent contracting.

New employees become eligible to join the AD&D Plan on the day after completing 60 days of service.

- You will be covered by the AD&D Plan as soon as you become eligible. You need to complete the Beneficiary Form and return it to the Benefits Department.
- If you are not are actively at work on the date your coverage would normally start, it will not become effective until you return to work.

If you terminated and have been rehired within 12 months, your benefits will begin immediately provided you worked for the company at least 60 days when previously employed. (See Reinstatement of Coverage section.) If you had not worked 60 days before you terminated, you will not be eligible for benefits until the 61st day after you are rehired.

Cost

The company pays the full premium cost of this AD&D Insurance for you.

Plan Benefit

Your Accidental Death and Dismemberment Insurance benefit (Principal Sum) is equal to 1½ times your base annual salary, up to a maximum coverage amount of $350,000. If the coverage amount is not an even multiple of $1,000, it will be adjusted to the next higher multiple of $1,000.

Adjustments in your Accidental Death and Dismemberment Insurance amount due to a salary change will automatically occur on the date of the salary change provided you are actively at work on that date. Otherwise, the adjustment will occur on the date you return to active work.

Your AD&D coverage will be reduced to 1 times your base annual salary when you reach age 65 (up to a maximum of $234,000) and to 75% of your base annual salary when you reach age 70 (up to a maximum

of $175,000). If the benefit amount is not an even multiple of $500, it will be adjusted to the next higher multiple of $500.

100% of the Principal Sum will be paid for:

- Loss of life
- Loss of both hands or both feet
- Loss of sight of both eyes
- Loss of one hand and one foot
- Loss of one hand or one foot and sight of one eye
- Quadriplegia (total paralysis of both upper and both lower limbs)
- Speech and hearing in both ears

50% of the Principal Sum will be paid for:

- Loss of one hand or one foot
- Loss of sight of one eye
- Paraplegia (total paralysis of both lower limbs)
- Hemiplegia (total paralysis of upper and lower limbs on one side of the body)
- Speech
- Hearing in both ears

25% of the Principal Sum will be paid for:

- Loss of thumb and index finger of the same hand

If you suffer more than one of the losses listed above as a result of any one covered accident, benefits will be paid only for the greatest loss.

Points to Note about AD&D Insurance

- The Principal Sum is the maximum amount that would be paid for all covered injuries to any one person resulting from any one accident.

- AD&D Insurance will not be paid for loss caused or contributed to, directly or indirectly, by:

    - Physical or mental illness or treatment for the illness; or
    - Any infection, except infection caused by an external visible wound accidentally sustained; or
    - Insurrection, war, or any act of war, except while traveling on company business; or
    - Suicide, attempted suicide, or intentionally self-inflicted injury; or
    - Committing or trying to commit a felony or other serious crime or an assault; or
    - Travel or flight in an aircraft, including boarding or alighting therefrom, while operating, learning to operate, or serving as a crew member, except on a company aircraft on Company business.

- AD&D Insurance will not be paid if loss of life, limb, or sight occurs more than 365 days after the accident.

- For the purpose of this AD&D Insurance, loss means with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to eyes, entire and irrecoverable loss of sight; with regard to paralysis (quadriplegia, paraplegia and hemiplegia) the complete and irreversible paralysis of such limbs; with regard to thumb and index finger; actual severance through or above the metacarpophalangeal joints; with regard to speech, entire and irrecoverable loss of speech; with regard to hearing, entire and irrecoverable loss of hearing in both ears.
- AD&D Insurance will not be paid for types of losses not specifically listed under “Plan Benefit.”

Termination of Insurance

Your AD&D Insurance coverage will terminate at the end of the calendar month in which:

- Your employment ends, or
- You are no longer an eligible employee, or
- The insurance policy is terminated, if earlier.

You may qualify for an extension of coverage in certain circumstances described in the Special Extensions of Coverage section below.

AD&D Insurance cannot be converted to an individual insurance policy.

Special Extensions of Coverage

During Approved Disability Leave

If you are on an approved medical leave of absence for illness or injury, your AD&D Insurance coverage continues until the end of your Family Medical Leave. (See "During Family Medical Leave below").

During Family Medical Leave

If you meet the requirements for Family Medical Leave, the company will maintain or reinstate any coverage you had under this Plan prior to the leave. See the Family Medical Leave section for details.

During a Personal Leave of Absence

Your AD&D Insurance coverage remains in effect until the end of the month in which you last worked.

During a Uniformed Services Leave of Absence

Your AD&D Insurance coverage remains in effect until the end of the month in which you last worked.

During Jury Duty

Your AD&D coverage continues when you are required to serve as a juror or as a court witness.

Leave for employees selected for special trials of lengthy duration (over 30 days) must be individually requested through your Benefits Department.

REINSTATEMENT OF COVERAGE

If your AD&D Insurance coverage terminates because you cease to meet the definition of an eligible employee, it will be reinstated immediately (without waiting 60 days) if you return to active work in an eligible class within 12 months from the date your eligibility ceased.

Claim Procedures

How to File a Claim for Benefits

All claim forms can be obtained from your Benefits Department.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements are submitted with the claim form.

The completed claim form should be returned to your Benefits Department.

When the claim has been processed, you (or your beneficiary) will be notified. Dismemberment and loss of sight benefits will be paid to you. Death benefits will be paid to your Life Insurance beneficiary unless you have designated a different beneficiary for your AD&D Insurance. If any benefits have been denied, you (or your beneficiary) will receive a written explanation.

Claims Are Paid By:

The Hartford
Group Benefits Division
P.O. Box 2999
Hartford, CT 06104

Routine Questions
If there is any question about a claim payment, an explanation may be requested directly from

The Hartford – 1-800-523-2233

CLAIM APPEALS

Initial Determination
In the event a claim is denied in whole or in part, The Hartford will notify you (or your beneficiary or your authorized representative) in writing within 90 days after receipt (180 days in special circumstances). If an extension beyond 90 days is necessary to make a decision on the claim, you (or your beneficiary or your authorized representative) will be notified in writing by The Hartford indicating the reason for the delay and the timeframe for final decision.

If the claim is denied, The Hartford's notice of claim denial will include:

- The specific reason(s) for denial with reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why the material or information is necessary; and
- The steps to be taken if you (or your beneficiary) wish to have the decision appealed.

You (or your beneficiary or your authorized representative) may request, free of charge, a copy of pertinent documents related to the claim that were reviewed by the service representative in making its determination.

Appeal of the Initial Determination

If The Hartford denies your claim, you, your beneficiary, or your authorized representative may file an appeal in writing. Upon request, The Hartford will provide you free of charge with copies of documents and information relevant to your claims.

You have 60 days after receiving notification of the claim denial to file a written appeal. You must submit your appeal to The Hartford at the address indicated on the claim form. The appeal must be in writing and include at least the following information:

- Name of Employee
- Reference to the initial decision
- An explanation of why you are appealing the initial determination
- As part of your appeal you may submit any written comments, documents, records, or other information relating to your claim.

After The Hartford receives your written request appealing the initial determination or the determination on the first appeal, The Hartford will conduct a full and fair review of your claim. Deference will not be given to initial denials, and The Hartford review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination.

The person who reviews your appeal will not be the same person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, The Hartford will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

The Hartford will notify you, your beneficiary, or your authorized representative of the decision in writing within 60 days after receipt of your written appeal. If special circumstances require an extension of time to review your claim, you, your beneficiary, or your authorized representative will receive written notification of the final decision as soon as possible but not later than 120 days after your request for review.

ELIGIBILITY – REVIEW AND APPEAL

If you (or your beneficiary or your legal representative) believes that you have been improperly denied eligibility in this plan or improperly denied the opportunity to make an election change due to a qualified change in status, follow the appeal procedures and timelines described above. However, instead of contacting The Hartford in writing, contact the Plan Administrator by writing:

ABX Air, Inc.
Human Resources, 2061-H
145 Hunter Drive
Wilmington, OH 45177

The Plan Administrator has the sole discretionary authority to determine eligibility for benefits and to construe the terms of eligibility for the disability, life and accident plans.

If your initial request for eligibility or an opportunity to make a family status change is denied and your written appeal is denied, you may pursue legal remedies under section 502(a) of ERISA. Before you may pursue these legal remedies however, you must first exhaust this review and appeals process. If you do take legal action, you must file suit within two years after the date of the event upon which the claims is based.

SHORT TERM DISABILITY PLAN

Should you become disabled because of a non-occupational accident or illness, including pregnancy disability, your Short Term Disability (STD) benefit may provide you with a weekly income through the 180th day of your disability.

Eligibility and Effective Date

For Employees Only

Eligible employees are full-time employees who are regularly scheduled to work 32 hours per week.

Employees who are members of a collective bargaining unit are only eligible if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary, is considered as contract labor or independent contracting.

New employees become eligible to join the Short Term Disability Plan on the day after completing 60 days of service. To be covered by the Short Term Disability (STD) Plan you must elect the coverage on Self Service within 60 days of your hire date.

If you are away from work on the date when your coverage would normally start, it will not become effective until you return to work.

If you terminate employment and are rehired within 12 months, your benefits will begin immediately provided you worked for the company at least 60 days when previously employed. (See “Reinstatement of Coverage”.) If you had not worked 60 days before you terminated, you will not be eligible for benefits until the 61st day after you are rehired.

If you decline coverage when first eligible and later wish to elect coverage due to Open Enrollment or another qualifying event, you must provide Evidence of Insurability (“EoI”) and be approved by The Hartford Insurance Company. You may request the “EoI” form from Human Resources.

Enrollment

Initial enrollment. Your initial enrollment election is a commitment for the remainder of the calendar year. As a new hire, you will have 60 days from hire date to complete the Self Service Insurance Enrollment form online. If you are newly eligible for Short Term Disability due to a change in employment status, you will have 30 days from status change date to complete the electronic Group Insurance Enrollment form.

Open Enrollment. You will be given the opportunity to review your participation in the company benefit plans on an annual basis each fall for a January 1 effective date. This is called an “Open Enrollment” period. Your Open Enrollment election is a 12-month commitment beginning January 1. Other than open enrollment, you may change your annual election during the year only if you meet one of the family or work status changes described below.

Default coverage. If you do not complete the electronic enrollment form within the specified time, you will automatically be defaulted in to “Decline/No coverage.

Family/Work Status Changes

Your benefit election is in force for the full plan year (January 1 through December 31) following the enrollment period (unless your coverage terminates).

You are eligible to change your election during the year only if you have a qualifying change in your family or work status and complete an electronic enrollment form within 30 days of the qualifying event.

Qualifying family and work status changes are:

- **Legal marital status change** due to marriage, death of a spouse, divorce, legal separation or annulment.

- **Number of dependents change** due to birth, adoption, placement for adoption or death of a dependent.

- **Employment status changes** for you, your spouse or dependent due to ending or starting employment, a strike, lockout or return from an unpaid leave of absence (including an FMLA leave); or a change in employment status with the consequence that you, your spouse or dependent becomes or ceases to be eligible for coverage (such as a switch between part-time and full-time status).

- **Residence or worksite change** (for you, your spouse or dependent) that could affect your benefits.

- **Dependent child's eligibility change** which causes a dependent to satisfy or cease to satisfy eligibility requirements due to age or a similar change.

You may add or stop coverage for yourself, as applicable, if you experience any of the following qualifying events:

- **Significant change in coverage under this Plan.** If your disability coverage is significantly curtailed, as determined by the Plan Administrator, or ceases altogether, you may revoke your election for the balance of the plan year.

- **Change in regularly scheduled hours that affect benefits eligibility.** If your employment status changes from a casual or part-time position with no disability benefit eligibility to a full-time position with disability benefit eligibility, you will be allowed to make a coverage election at that time. Your casual or part-time employment will count toward your 60-day eligibility waiting period.

Dates for Qualifying Status Changes			
QUALIFYING STATUS CHANGE	**To change coverage, complete the Self Service Enrollment form online. The form must be completed by:**	**Proof Required**	**Disability Start/Loss Date**
Marriage:	30 days from date of marriage	A copy of the marriage certificate	Covered from the first day of marriage
Divorce, legal separation or annulment	30 days from date of separation, divorce or annulment	A copy of court papers showing the date the separation, divorce or annulment was final	First of the month following the event
A newborn infant	30 days from date of birth	Birth Certificate	Covered from date of birth. If you are out on leave, coverage begins the day your return from leave.
A newly adopted child	30 days of your child's placement for adoption	A copy of the final adoption papers showing the date adoption was finalized	Covered from date the child is physically placed with you for adoption & you assume financial responsibility. If you are out on leave, coverage begins the day you return from leave.
Change in hours that affect your benefits eligibility.	30 days from the status change	No proof required	Covered the date your status changed (provided you have satisfied the 60-day wait period.)

Cost

The company presently pays most of the cost of Short Term Disability coverage. Via payroll deduction, you pay the balance of the premium, 0.1% (.001) of the first $2,000 of weekly base salary.

Within 60 days of your hire date, and again during each annual open enrollment period, Human Resources will give you information about your share of the premium for Short Term Disability coverage for that Plan year. **It is your responsibility to notify the Benefits Department if your payroll deductions are not correct.**

Your contributions will be deducted before your withholding taxes are calculated (on a pre-tax basis), thereby reducing your income taxes and FICA taxes. You will be given an opportunity to elect coverage pretax each fall during the open enrollment period for a January 1 effective date. At the annual open enrollment, you will have a designated date to return your election form.

Plan Benefit

Your Short Term Disability benefit amount is the lesser of 50% of your base weekly earnings up to a maximum benefit of $1,000 per week, reduced by Other Income Benefits. If the benefit is not an even multiple of $1.00, it will be adjusted to the next higher multiple of $1.00. The maximum of payable benefits is 24 weeks for both injury or sickness.

Adjustments in your Short Term Disability benefit amount due to a salary change will occur on the date of the salary change, provided you are actively at work on that date. Otherwise, the adjustment will occur on the date you return to active work. Retroactive pay increases do not retroactively increase the amount of your monthly benefit.

Any plan design changes will only apply to disabilities that begin after the effective date of the change.

Points to Note about Short Term Disability Coverage

- To receive Short Term Disability benefits your disability must be severe enough to prevent you from performing the material and substantial duties of your own occupation and you must be under the continuous care of a qualified physician.

- Payments begin on the 15th calendar day of your disability and will stop on the earliest of

    - the date you are determined to be no longer disabled;
    - the end of the Plan's maximum benefits period of 180 days;
    - the date of your death; or
    - the date you fail to show requested written proof of disability.

- The Plan will not pay for disability due to illness or injury sustained by:

    - war or act of war
    - the commission of ,or attempt to commit a felony
    - an intentionally self-inflicted injury
    - any case where you are engaged in an illegal occupation
    - while working for pay or profit for another employer,
    - injury or illness for which you are covered under Workers' Compensation or a similar program.

- In the event that your coverage terminates while you are disabled, you will still continue to receive your Short Term Disability benefit during that period of disability, up to the maximums noted above.

- Successive absences from work are considered to be in the same period of disability unless separated by (1) two weeks of active, full time work, or (2) one full day of work and disability is due to a wholly different cause.

- Disability checks are issued weekly to your home address. After year-end, The Hartford sends you a W-2 statement for your income tax reporting.

Short Term Alternative Duty Program

The company has an alternative duty program for employees who are temporarily unable to perform the essential duties of their regular jobs because of illness, injury or pregnancy:

- If you are restricted from certain parts of your job (such as lifting) and the company can arrange to modify your duties or provide alternative duties, you will be offered modified or alternate duties within your capabilities.

- If you are able to work limited hours and have no other restrictions, and the company can arrange a limited hours schedule for you, you will be offered a limited schedule suitable to your condition; however, you would not receive Short Term Disability benefits.

- If the company offers you a temporary alternative duty assignment, you must accept it to remain eligible for Short Term Disability benefits.

- If you participate in the alternative duty program, you may receive Short Term Disability benefits if your weekly alternative duty pay is less than 80% of your regular base pay.

- Your Short Term Disability benefit will be adjusted as necessary so that your combined Short Term Disability benefit and alternative duty pay will not exceed 100% of your regular base pay.

- Your adjusted Short Term Disability benefits will continue while you participate in the alternative duty program as long as the claims administrator determines that you are disabled from your regular job, up to a maximum of 180 days.

- If you have two jobs with the Company, you must work alternate duty in both jobs to receive supplemental benefits.

- Supplemental payments begin on the 15th calendar day of your disability including your alternate duty assignment.

- If your alternate duty pay is the same as your regular pay, you will receive no supplemental STD benefit. However, the time worked in alternate duty will be applied towards the maximum of 180 days benefits allowed under this program as long as you are disabled from your regular work and are under the continuous care of a physician.

Third Party Liability

Third party liability refers to the situation where a covered employee is injured by another party who is legally responsible for compensating the employee for income lost as a result of the injury.

You are required to cooperate in providing all necessary and requested information and submitting bills related to your disability to any applicable party. If you do not pursue recovery of money from a liable third party, the Plan has the right to pursue any claim that you may have. If you receive payment for lost income from a third party, you must reimburse the Plan for benefit payments it has made to the extent of payment received from the third party. The Plan may recover such payment by reducing any future disability benefits payable to you.

State-Mandated Plans

In California, Hawaii, New Jersey, New York, Puerto Rico and Rhode Island, state law requires that non-occupational disability income insurance be provided through state funds or insurance programs.

Benefits paid to the employees who work in those states will conform to the law. You will receive supplemental benefits from this Plan only if the company benefits are greater than the state benefits.

If you work in one of the above listed states (except New York), contact the state disability department for benefit information. However, contact the Human Resources Department in regards to New York State disability.

Termination of Coverage

Your Short Term Disability coverage will terminate on the day on which:

- Your employment ends, or
- You are no longer an eligible employee, or
- You begin a personal Leave of Absence, or
- The Plan is terminated, if earlier.

You may qualify for an extension of coverage in certain circumstances described in the Special Extensions of Coverage section below.

Short Term Disability benefits cannot be converted to individual coverage.

Special Extension of Coverage

During Family Medical Leave
If you meet the requirements for Family Medical Leave, the company will maintain any coverage you had under this Plan prior to the leave. See the "Family Medical Leave" section for details. You must continue to pay your share of the premium, if any.

During Jury Duty
Your Short Term Disability coverage continues when you are required to serve as a juror or as a court witness. You must continue to pay your share of the premium, if any.
Leave for employees selected for special trials of lengthy duration (over 30 days) must be individually requested through Human Resources.

During a Uniformed Services Leave (Military Leave of Absence)If your uniformed services leave is less than 31 days, your disability coverage continues during the leave. You must continue to pay your share of the premium. If your uniformed services leave is 31 days or more, your disability coverage remains in effect until the end of the month in which you last worked.

Reinstatement of Coverage
If your Short Term Disability coverage terminates because you cease to meet the definition of an eligible employee, it may be reinstated immediately (without waiting 60 days) if you return to active work in an eligible class within 12 months from the date your eligibility ceased.

Claim Procedures

Time Limit for Filing Claims

All claims must be submitted within twelve months of the date of disability.

How to File a Claim

In the event a claim should occur for which benefits may be payable under this policy, please provide the disabled employee with a claim brochure "How to Report a Disability Claim" as soon as it is determined that the disability could extend beyond the elimination period.

The Employee should be instructed to call The Hartford to report a Claim:
Telephone: 1-800-549-6514 (8 am – 8 pm ET, M-F)

When you call, The Hartford will ask you to provide:

- Name, address, phone number, and other key identification information.
- Name of your department and last day of active full-time work.
- Your manager's name and phone number.
- The nature of your claim.
- Your treating physician's name, address, and phone and fax numbers.

What Happens Next?

Even after your claim has been filed, we may be in touch to check your progress, answer questions or obtain additional information from you. Our goal is to offer a smooth and hassle free experience–from your first benefits payment to your first day back at work. Feel free to also call us with anything that's on your mind. We're here to help.

Claims Are Paid By:

The Hartford
Benefit Management Services, Maitland Claim Office
P.O. Box 946790
Maitland, FL 32794-6790

Routine Questions

If there is any question about a claim payment, an explanation may be requested directly from The Hartford at: 1-800-549-6514. This number is operational between 8:00 am and 8:00pm Eastern Time, Monday through Friday. If you call outside this time frame, please leave a voicemail message and a representative will respond the next business day.

What If My Claim Is Denied?

If your claim is denied, you will receive information providing specific reasons for the denial and an explanation of how to appeal the denial. Upon receipt of the letter, you should contact your manager to schedule your return to work.

The Hartford will notify the company that your claim has been denied. Therefore, even if you plan to appeal the decision, you should contact your employer.

ELIGIBILITY – REVIEW AND APPEAL

If you, your beneficiary, or your legal representative believes that you have been improperly denied eligibility in this plan or improperly denied the opportunity to make an election change due to a qualified change in status, contact the Plan Administrator by writing to:

ABX Air, Inc.
Human Resources, 2061-H
145 Hunter Drive
Wilmington, OH 45177

The Plan Administrator has the sole discretionary authority to determine eligibility for benefits and to construe the terms of eligibility for the disability, life and accident plans.

If your initial request for eligibility or an opportunity to make a family status change is denied, and your written appeal is denied, you may pursue legal remedies under section 502(a) of ERISA. Before you may pursue these legal remedies however, you must first exhaust this review and appeals process. If you do take legal action, you must file suit within two years after the date of the event upon which the claims is based.

LONG TERM DISABILITY INSURANCE PLAN

For most of us, our jobs provide a major source of income, making our earning power a valuable asset. A serious injury or illness could prevent you from working for as long as you would like or force you to restrict your current job responsibility. To help protect you from these financial risks, the company provides a Long Term Disability Insurance Plan at no cost to you, to make sure you have a continued income if you become disabled.

Eligibility and Effective Date

For Employees Only

You are eligible for this Long Term Disability Insurance Plan if you have worked 12 months of continuous active employment for the company as a full-time employee, regularly scheduled to work 32 hours or more a week.

Employees who are members of a collective bargaining unit are only eligible if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary, is considered as contract labor or independent contracting.

Coverage begins the day after you complete 12 months of continuous active employment as a full-time employee. You continue to be eligible as long as you meet the requirements of a full-time employee.

If you are not actively at work the day you become eligible for this coverage, it will start the day you return to active full-time work.

If you terminate employment and are rehired within 12 months, your benefits will begin immediately provided you worked for the company full time for at least 12 months of continuous active employment when previously employed. (See “Reinstatement of Coverage”.) If you had not worked full time for 12 months of continuous active employment before you terminated, you will not be eligible for benefits until the day after you complete 12 months of continuous full-time service.

Cost

The company pays the full cost of Long Term Disability Insurance for you.

How the Plan Works

Definition of Disabled

You are disabled when The Hartford determines that:

1. You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
2. You have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of payments, you are disabled when The Hartford determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

The Hartford may require you to be examined by a doctor, other medical practitioner and/or vocational expert of our choice. The Hartford will pay for this examination. The Hartford can require an examination as often as it is reasonable to do so. They may also require you to be interviewed by an authorized representative of The Hartford.

Note that you may be considered disabled and receive benefits even if you are still working.

Your Long Term Disability Benefit

This Plan is designed to work with your other deductible sources of income (listed below) to make sure you receive at least 60% of your pre-disability monthly earnings after the 180th day of disability.

The maximum Long Term Disability benefit you can receive is $10,000 per month.

Adjustments in your monthly Long Term Disability benefit due to a salary change will automatically occur on the date of the earnings change, provided you are actively at work. Otherwise, the adjustment will occur on the date you return to active work. The new monthly benefit amount applies only to disabilities that begin after your salary changes. Retroactive pay increases do not retroactively increase the amount of your monthly benefit.

Disability checks are issued monthly to your home address. After year-end, The Hartford sends you a W-2 statement for your income tax reporting.

Any plan design changes will only apply to disabilities that begin after the effective date of the change.

Deductible Sources of Income

Long Term Disability benefit payments may be reduced by other deductible sources of income that you receive or are eligible to receive due to your disability or retirement. However, your monthly benefit under this Plan will always be at least $50 or 10% of your maximum monthly benefit, whichever is greater. Deductible sources of income may come from the following:

Payments from Workers' Compensation or similar programs that you are eligible to receive.

- Social Security disability benefits that you and your dependents receive or are entitled to receive.
- Social Security retirement benefits that you and your dependents receive.
- Disability benefits that you are eligible to receive from any other group insurance plan.
- Disability income payments required by state law that you are eligible to receive.
- Retirement benefits that you receive from the Company Retirement Income Plan (including the Profit Sharing Plan). Note: You may avoid this offset by deferring your Retirement Income Plan benefit until age 65.
- Amounts that you receive or are entitled to receive under any automobile liability insurance policy or the mandatory portion of any "no-fault" motor vehicle plan.
- Amounts that you receive from a third party (after subtracting attorney's fees) by judgment, settlement, or otherwise.

(For a complete list of deductible sources of income contact your Human Resources department to review the Hartford Policy document.)

If you receive other deductible sources of income, the insurance company has the right to reduce your benefit payments and to recover any Long Term Disability overpayments. During the first 24 months of disability payment, if your monthly disability earnings exceed 80% of your indexed monthly earnings, The Plan will stop sending your payments and your claim will end.

Employment While Disabled

Your Long Term Disability benefit, when added to any compensation you may earn while disabled ("disability earnings"), cannot exceed your indexed monthly earnings. If this happens, your monthly benefit amount will be reduced by the amount in excess of your indexed monthly earnings.

After 24 months of Long Term Disability payments, your monthly benefit amount will be reduced by 50% of any disability earnings.

Third Party Liability

Third party liability refers to the situation where a covered employee is injured by another party who is legally responsible for compensating the employee for income lost as a result of the injury. You are required to cooperate in providing all necessary and requested information and submitting bills related to your disability to any applicable party. If you do not pursue recovery of money from a liable third party, the Plan has the right to pursue any claim that you may have. If you receive payment for lost income from a third party, you must reimburse the Plan for benefit payments it has made to the extent of payment received from the third party. The Plan may recover such payment by reducing any future disability benefits payable to you.

Benefit Period

Benefit payments begin after you have been disabled for 180 consecutive days and are under a physician's regular care. During this 180-day elimination period, you may return to your regular full-time work for up to 30 calendar days. The days you are not disabled will be added to the 180-day elimination period.

Long Term Disability benefits will continue while you are disabled up to the maximum benefit period shown below, or to your Social Security normal retirement age if later.

Age When Disability Starts	Maximum Benefit Period
Under Age 60	To Age 65
60 but less than 61	60 months
61 but less than 62	48 months
62 but less than 63	42 months
63 but less than 64	36 months
64 but less than 65	30 months
65 but less than 66	24 months
66 but less than 67	21 months
67 but less than 68	18 months
68 but less than 69	15 months
69 and over	12 months

You must be seen regularly by a physician throughout your period of disability. In addition, the insurance company may require you to be examined by a physician of its choice as often as is reasonably necessary to verify your disability.

It is the company's goal that all employees return to work following a disability. Employees are expected to cooperate with the recommended treatment plan, participate in recommended rehabilitation programs, and try suggested work modifications or adaptations.

Misrepresentation of your condition in order to receive benefits is contrary to the aim of the program and hurts all employees. It is a crime if you knowingly and with intent to injure, defraud or deceive The Hartford or provide any information, including a claim that contains any false, incomplete or misleading information. Submission of materially false information will result in denial of your claim and you may be subject to prosecution and punishment to the full extent under state and/or federal law. The Hartford will pursue all appropriate legal remedies in the event of insurance fraud.

Termination of Payment

Benefit payments will stop on the earliest of:

1) the date you are no longer Disabled;
2) the date you fail to furnish Proof of Loss;
3) the date you are no longer under the Regular Care of a Physician;
4) the date you refuse a request that you submit to an examination by a Physician or other qualified medical professional;
5) the date of your death;
6) the date you refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable;
8) the date your Current Monthly Earnings:
    a) are equal to or greater than 80% of Your Indexed Pre-disability Earnings if you are receiving benefits for being Disabled from Your Occupation; or
    b) are greater than the lesser of the product of your Indexed Pre-disability Earnings and the Benefit Percentage or the Maximum Monthly Benefit if you are receiving benefits for being Disabled from any Occupation;
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration; or
10) the date you refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
    a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable you to perform the Essential Duties of your Occupation;
    b) adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the Essential Duties of Your Occupation;
    c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable you to perform the Essential Duties of Any Occupation, if you were receiving benefits for being disabled from any Occupation; or
    d) adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the Essential Duties of your Occupation, if you were receiving benefits for being disabled from your Occupation; provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate your medical limitation

Recurrent Disability

If you return to work (or begin performing all the duties of your regular job) after a period of receiving monthly Long Term Disability benefits, then become disabled again due to the same cause or a related cause, continued payments depend on how long you worked between your periods of disability.

- If you return to work and perform all duties of your regular job on a full-time basis for less than six consecutive months and the same medical condition disables you again, this recurrent disability will be considered part of the original disability period. In other words, the Plan considers this a single disability claim, and you may start receiving benefits right away -- instead of waiting 180 days. The

entire period is subject to the maximum benefit period and other terms of the Plan that applied when you first became disabled.

- If you return to work and perform all duties of your regular job on a full-time basis for six consecutive months or more and the same or a related medical condition disables you again, this recurrent disability will be treated as a new disability claim. You must complete a new 180-day waiting period before monthly benefits are payable. A new waiting period applies if a different medical condition causes your disability.

Mental Illness Benefit

The Plan pays Long Term Disability benefits up to 24 months for disability due to mental illness. After 24 months of benefit payments, these benefits continue only if you are in a hospital or similar institution for the condition causing the disability. In no event will benefits continue beyond the maximum benefit period.

Survivor Benefit

If you die while receiving Long Term disability benefits, the Plan will pay your spouse a lump sum equal to three times your last monthly benefit, with no reductions for other deductible sources of income or compensation earned while you were disabled. If you are not married at your death, payment will be divided equally among your children under age 25, with payments directly to the children, or to a person the insurance company agrees may receive the payment on their behalf. If you have no eligible survivors (spouse or children) no benefit will be paid

Limitations and Exclusions

Preexisting Condition Limitations

This Plan does not provide benefits for any disability related to a preexisting condition, unless: you have not received Medical Care for the condition for 90 consecutive days while insured and you have been continuously insured under the Policy for 365 consecutive days.

“Preexisting Condition” means a sickness or injury for which you received medical advice or treatment during the 90-day period immediately prior to the date your coverage begins.

Exclusions

This Plan does not cover any disability, which results from or is caused or contributed to by:

- War, insurrection, or rebellion
- Active participation in a riot
- Loss of a professional license, occupational license or certification
- Intentionally self-inflicted injuries or attempted suicide
- Commission of a crime for which you have been convicted under state or federal law.

Termination of Coverage

Your Long Term Disability coverage ends on the earliest of:

- The date the group Long Term Disability insurance master policy is cancelled
- The date you are no longer in an eligible group or your eligible group is no longer covered
- The last day of the period for which premiums are due but not paid
- The date your employment ends
- The date you retire
- The end of the month in which your Personal Leave of Absence begins, or
- The date you enter uniformed service or take uniformed services leave.

Long Term Disability insurance cannot be converted to individual insurance coverage.

Special Extension of Coverage

During Family Medical Leave

If you meet the requirements for Family Medical Leave, the company will maintain any coverage you had under this Plan prior to the leave. See the "Family Medical Leave" section for details.

During Jury Duty

Your Long Term Disability coverage continues when you are required to serve as a juror or as a court witness. Leave for employees selected for special trials of lengthy duration (over 30 days) must be individually requested through Human Resources.

Reinstatement of Coverage

If your Long Term Disability coverage terminates because you cease to meet the definition of an eligible employee, it may be reinstated immediately (without completing another 12 months of continuous service) if you return to active, full-time work in an eligible class within 12 months from the date your eligibility ceased.

Claim Procedures

Time Limit for Filing Claims

The completed claim form should be returned to The Hartford during the elimination period (180 days from the date of disability). The insurance company must receive the completed claim form no later than 90 days following the elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

How to File a Claim for Benefits

In the event a claim should occur for which benefits may be payable under this policy, The Hartford will contact you upon the ending of your Short Term Disability

Claims Are Paid By:

The Hartford
Benefit Management Services, Maitland Claim Office
P.O. Box 946790
Maitland, FL 32794-6790

Routine Questions

If there is any question about a claim payment, an explanation may be requested directly from The Hartford at: 1-800-549-6514. This number is operational between 8:00 am and 8:00pm Eastern Time, Monday through Friday. If you call outside this time frame, please leave a voicemail message and a representative will respond the next business day.

What If My Claim Is Denied?

- If your claim is denied, you will receive information providing specific reasons for the denial and an explanation of how to appeal the denial. Upon receipt of the letter, you should contact your company to schedule your return to work.

- The Hartford will notify the company that your claim has been denied. Therefore, even if you plan to appeal the decision, you should contact your employer.

Eligibility – Review and Appeal

If you, your beneficiary, or your legal representative believes that you have been improperly denied eligibility in this plan or improperly denied the opportunity to make an election change due to a qualified change in status, contact the Plan Administrator by writing to Human Resources at:

ABX Air, Inc.
Human Resources, 2061-H
145 Hunter Drive
Wilmington, OH 45177

The Plan Administrator has the sole discretionary authority to determine eligibility for benefits and to construe the terms of eligibility for the disability, life and accident plans.

If your initial request for eligibility or an opportunity to make a family status change is denied, and your written appeal is denied, you may pursue legal remedies under section 502(a) of ERISA. Before you may pursue these legal remedies however, you must first exhaust this review and appeals process. If you do take legal action, you must file suit within two years after the date of the event upon which the claims is based.

Definitions

Active Employment

You are working for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working full-time that provides for participation in this plan. Your work site must be: your employer's usual place of business, an alternative work site at the direction of your employer, or a location to which your job requires that you travel. Normal vacation is considered active employment.

Disability Earnings
The earnings that you receive while you are disabled and working

Indexed Pre-disability Earnings
Your pre-disability monthly earnings adjusted annually by adding the lesser of : 10% or the percentage changes in the Consumer Price Index..

Material and Substantial Duties
Duties that are normally required for the performance of your regular occupation and cannot be reasonably omitted or modified.

Mental Illness
Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

Monthly Earnings
Your gross monthly income in effect just prior to your date of disability. It includes your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.

Physician
A legally qualified physician is licensed to practice medicine, prescribe and administer drugs, perform surgery, and perform tasks that are within the limits of his/her medical license.

The Hartford will not recognize the employee or his/her spouse, children, parents, or siblings as a physician for any claim that is filed.

Regular Occupation
The occupation you are routinely performing when your disability begins. The Hartford will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

BUSINESS TRAVEL ACCIDENT INSURANCE PLAN

This coverage provides you with insurance protection in case of accidental death, dismemberment or paralysis occurring while you are traveling on any bona fide business for the company, 24-hours a day, anywhere in the world. You are insured for the Business Travel Accident Principal Sum as specified in the Plan Benefit section below. If you are injured as a result of a covered accident, Business Travel Accident Insurance benefits will be paid in addition to any other Life and AD&D insurance for which you may be eligible under other Plans sponsored by the company.

Eligibility and Effective Date

For Employees Only

Full-time and Part-time employees are eligible for Business Travel Accident Insurance. Eligible employees are employees regularly scheduled to work 15 hours or more per week.

Employees who are members of a collective bargaining unit are only eligible if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary, is considered as contract labor or independent contracting.

You will be covered by this Plan on the date you become an eligible employee.

You should complete the Beneficiary form and return it to the Benefits section of Human Resources.

You are covered if your business travel is authorized by the company. Coverage for each trip is automatic and begins when you leave your residence or regular place of employment, whichever occurs last, for the purpose of traveling for business. Coverage for each trip ends when you return to your residence or your regular place of employment, whichever occurs first.

You are not covered for regular commutes to and from work, or if you are using vacation days or leave of absence while traveling.

Cost

The company pays the full cost of your Business Travel Accident Insurance coverage.

Plan Benefit

Principal Sum

Your Business Travel Accident Insurance benefit (Principal Sum) is equal to two times your annual base salary, up to a maximum benefit amount of $500,000.

Adjustments in your Business Travel Accident Insurance amount due to a salary change will automatically occur on the date of the salary change.

Adjustments in your Business Travel Accident Insurance due to a change in coverage classification will occur on the date of the change, provided you are actively at work on that date. If you are absent from work on that date due to an injury, the adjustment will occur on the date you return to active work.

Benefit Amounts

Benefits will be paid for any of the following losses, which result from your covered accidental injury while you are traveling on company business.

100% of the Principal Sum will be paid for:

- Loss of life
- Loss of both hands, loss of both feet, loss of sight or a combination of any two
- Loss of hearing and one of loss of hand, loss of foot or loss of sight of one eye
- Loss of speech and one of loss of hand, loss of foot, or loss of sight of one eye
- Quadriplegia (total paralysis of both upper and both lower limbs)
- Loss of Speech and loss of hearing

75% of the Principal Sum will be paid for:

- Paraplegia (total paralysis of both lower limbs)

50% of the Principal Sum will be paid for:

- Loss of one hand or one foot
- Loss of sight of one eye
- Hemiplegia (total paralysis of upper and lower limbs on one side of the body)
- Loss of Speech or loss of hearing

25% of the Principal Sum will be paid for:

- Loss of thumb and index finger of the same hand

- Uniplegia (the complete and irreversible paralysis of one limb of the body.)

If you suffer more than one of the losses listed above as a result of any one covered accident, benefits will be paid only for the greatest loss.

The maximum amount the Plan will pay for all covered losses to all employees injured in any one covered accident is $10,000,000.

How Benefits Are Paid

Benefits for accidental dismemberment, loss of sight, speech or hearing or paralysis will be paid to you. Accidental death benefits will be paid to your beneficiary.

Payment under this Plan for accidental loss of life will be made to the person or persons you designated as beneficiary under the Life Insurance Plan unless you designated a different beneficiary for your Business Travel Accident coverage. To designate (or change) a beneficiary, complete a Beneficiary form and return it to Human Resources.

If you do not designate a beneficiary, or if your beneficiary does not survive you, your Business Travel Accident Insurance death benefit will be paid to the person or persons listed below, in the following order of priority:

- Your spouse;
- Your child(ren) equally;
- Your parent(s) equally;
- Your brother(s) and sister(s) equally;
- Your estate.

Beneficiary provisions for International Employees (who are not U.S. citizens) differ from those for employees domiciled in the U.S. If you are a non-U.S. citizen domiciled in a foreign location for the company, payments will be made to your beneficiary either directly or through a trustee designated by the company, depending on your foreign location.

Points to Note about Business Travel Accident Insurance

- Time Limit for Benefits - Business Travel Accident Insurance benefits will not be paid if loss of life, limb or sight, speech or hearing or paralysis occurs more than 365 days after the accident.

- Loss - For the purposes of this Plan, loss means with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to eyes, entire and irrecoverable loss of sight; with regard to paralysis (quadriplegia, paraplegia and hemiplegia), the complete and irreversible paralysis of such limbs; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to speech, entire and irrecoverable loss of speech; with regard to hearing, entire and irrecoverable loss of hearing in both ears.

- Annual Base Salary - For purposes of this Plan, annual base salary means your annual salary exclusive of bonuses, overtime, Profit Sharing and any other supplemental compensation. It includes compensation you elect to reduce or defer under the company benefit plans.

- Personal Deviations - Business Travel Accident Insurance coverage applies for up to three days if you make a deviation from your business itinerary for personal reasons while you are traveling on company business. This special extension of Business Travel Accident coverage does not apply if you use vacation days or leave of absence during your business trip.

- Business Travel Accident Insurance does not apply while you are commuting to and from your regular place of employment during your regular working hours.

- Exposure - If you are unavoidably exposed to the elements as a result of a covered accident and suffer one of the losses listed under Benefit Amounts, Business Travel Accident benefits will be payable.

- Disappearance - If your remains are not found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance you occupied during a covered trip, the Business Travel Accident death benefit will be payable.

- Medical Evacuation and Repatriation – Benefit amount for evacuation up to a maximum of $100,000. Hospital admission guaranty up to $5,000

Exclusions

Business Travel Accident Insurance does not cover any loss caused by or resulting from the following:

- Suicide, or any attempt thereat while sane, or self-destruction, or any attempt thereat while insane; disease; hernia; or bacterial infections, except pyogenic infections which occur through an accidental cut or wound.

- Riding as a pilot or crewmember in any aircraft unless you are a designated ABX Air, Inc. non-union Flight Management pilot riding on an ABX Air, Inc. aircraft.

- Declared or undeclared war or any act of war in the United States, Canada or your country of permanent residence or among the major powers of Europe or Asia.

- Service in the military, naval or air service of any country.

Termination of Coverage

Your Business Travel Accident Insurance will end of the day on which:

- Your employment ends, or
- You are no longer an eligible employee, or
- You start a leave of absence, or
- You take a uniformed services leave, or
- The insurance policy is terminated, if earlier.

Business Travel Accident Insurance cannot be converted to individual insurance coverage.

Claim Procedures

How to File a Claim for Benefits

Claim forms can be obtained from Human Resources.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements are submitted with the claim form.

The completed claim form should be returned to Human Resources.

When the claim has been processed, you (or your beneficiary) will be notified. Dismemberment, loss of sight, speech and hearing and paralysis benefits will be paid to you. Death benefits will be paid to your Life Insurance beneficiary unless you have designated a different beneficiary for your Business Travel Accident Insurance. If any benefits have been denied, you (or your beneficiary or authorized representative) will receive a written explanation.

Claims Are Paid By:

Chubb Group of Insurance Companies
15 Mountain View, PO Box 1615
Warren, NJ 07061

Routine Questions

If there is any question about a claim payment, an explanation may be requested directly from Chubb at: 1-888-987-5920. This number is operational 24/7

Online Services

Log on to WWW.Chubb.com/travelhelp/EB. Use Group #: N2CHUEB and Activation Code: 20130503

Eligibility – Review and Appeal

If you (or your beneficiary or your legal representative) believe that you have been improperly denied eligibility in this plan or improperly denied the opportunity to make an election change due to a qualified change in status, follow the appeal procedures and timelines described above. However, instead of contacting CHUBB in writing, contact the Plan Administrator by writing to your Company Benefits Department as follows:

ABX Air, Inc.
Human Resources, 2061-H
145 Hunter Drive
Wilmington, OH 45177

The Plan Administrator has the sole discretionary authority to determine eligibility for benefits and to construe the terms of eligibility for the disability, life and accident plans.

If your initial request for eligibility or an opportunity to make a family status change is denied, and your written appeal is denied, you may pursue legal remedies under section 502(a) of ERISA. Before you may pursue these legal remedies however, you must first exhaust this review and appeals process. If you do take legal action, you must file suit within two years after the date of the event upon which the claims is based.

GROUP UNIVERSAL LIFE INSURANCE

ABX Air, Inc. recognizes your need to make plans today to protect your family's financial future. ABX Air, Inc. has made arrangements with Prudential Insurance Company of America to underwrite and offer you a voluntary life insurance program you can purchase at group rates.

The Group Universal Life insurance plan combines life insurance coverage and a tax-deferred savings option into one simple package you can take with you when you retire or leave the company.

ABX Air, Inc. automatically deducts your insurance premiums and contributions to the cash accumulation account from your paycheck. ABX Air, Inc. has selected Mercer Health & Benefits Administration LLC (Mercer Voluntary Benefits) as the program manager.

Complete details of your coverage and the eligibility guidelines of the plan are described in your group insurance certificate, which will be sent to you by Mercer Voluntary Benefits after you become insured. What follows is a brief summary of those details.

Please refer to your certificate for further information or call Mercer Voluntary Benefits toll free at **1-800-441-5581** or visit your program website at **www.personal-plans.com/abxair**.

See "Program Definitions" section for an explanation of terms used for this Plan.

Eligibility Requirements

Employee

Full-time and Part-time employees are eligible for Group Universal Life Insurance. Eligible employees are employees regularly scheduled to work 15 or more hours per week.

Employees who are members of a collective bargaining unit are only eligible if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary, is considered as contract labor or independent contracting.

If you are a foreign national employee, check with your Benefits Department regarding your eligibility.

New employees become eligible to join the Group Universal Life Insurance Plan:

- On the first day of the month after completing 60 days of service. **Employees must enroll within 31 days of eligibility date to receive coverage without evidence of good health.**
- For any person to be insured, you, as the employee, must be actively at work on the effective date of coverage and the day the application is signed. You may not enroll a dependent child if neither you nor your dependent spouse is enrolled.

See "Enrollment" section for more enrollment details and "Effective Date" section for a description of when coverage begins.

Spouse

Your spouse is eligible for Group Universal Life Insurance if you are eligible. Your spouse cannot be on active duty in the armed services of any country or insured under any Employee Coverage of the Group Contract. Initial enrollment for Group Universal Life for dependent spouses is limited to spouses under age 70 (your spouse may remain enrolled until age 95).

If your spouse (age 69 or younger) is confined for medical care or treatment at home or elsewhere during the 90 days prior to the date you complete the enrollment form, coverage for your spouse will not take effect until the later of: a) the effective date of coverage, or b) final medical release from all such confinements.

Children

Your children include your biological children, legally adopted children and stepchildren who depends on you for support and maintenance. Your children must be unmarried, 14 days old but less than 21 years old.

A child 21 years or more is also considered a dependent if the child:

- wholly depends on you for support and maintenance; and
- is enrolled as a full-time student in a school; and
- is less than 25 years old.

If your child is confined for medical care or treatment at home or elsewhere during the 90 days prior to the date you complete the enrollment form coverage for your child will not take effect until the later of: a) the effective date of coverage, or b) final medical release from all such confinements.

Your spouse or child is not your qualified dependent while:

- on active duty in the armed forces of any country; or
- insured under any Employee Coverage of the Group Contract; or
- the spouse or child has Extended Death Protection During Total Disability under any Employee Coverage of the Group Contract after the spouse or child's insurance under that Coverage ends.

Enrollment

Q: When may I enroll?

A: You may enroll yourself, your eligible spouse and dependent children in the Group Universal Life program **within 31 days of your benefits eligibility date** (eligibility date is the first day of the month after completing 60 days of service). See the Underwriting Requirements section for amounts of coverage for which you may enroll without evidence of good health.

Unlike the rest of your benefits elections, there is no annual "Open Enrollment" period for this plan. You may enroll any time after 31 days from your benefits eligibility date. However, you or your spouse will be considered late entrants and evidence of good health will be required.

You may enroll a newly married spouse within 31 days of the date of your marriage. If you enroll after 31 days, your spouse will be considered a late entrant and evidence of good health will be required.

Q: How do I enroll?

A: Complete the Group Universal Life enrollment form found at www.personal-plans.com/abxair. Return the enrollment form to the Mercer Voluntary Benefits address on the form. Mercer Voluntary Benefits will mail confirmation of coverage to the address on the completed enrollment form. Coverage may be delayed for an incomplete enrollment form.

EFFECTIVE DATE

Q: When does the coverage go into effect?

A: *Newly eligible employee effective date:* on the first of the month after your enrollment form is processed by Mercer Voluntary Benefits, subject to the stated Eligibility and Underwriting Requirements.

Late entrant effective date: on the first of the month after medical evidence has been approved by Prudential.

Q: What happens if I am not actively at work on the effective date?

A: Coverage for you and/or your spouse and children will begin on the first of the month following your return to work, subject to the stated Eligibility and Underwriting Requirements.

If you are actively at work when you enroll but not actively at work on the effective date, and do not return to active work status within 90 days from the date you originally completed the enrollment form, you must notify Mercer Voluntary Benefits upon your return to active work status and complete a new enrollment form. You must notify Mercer Voluntary Benefits upon your return to active work status.

Q: What happens if my spouse or child is confined for medical care or treatment at home or elsewhere on the effective date?

A: Coverage for your spouse or child will not begin until final medical release from confinement. The medical release must be approved by Prudential. You must notify **Mercer Voluntary Benefits** when the medical confinement ends.

Q: What happens if I am on vacation on the effective date?

A: As long as you were actively at work on both the enrollment date and the last working day preceding your vacation (or preceding a company holiday if it falls on the effective date), you are considered actively at work on the effective date.

Q: What happens to my Group Universal Life program if I am out sick?

A: If you are on active payroll, payroll deductions for your Group Universal Life program will continue. If you are not receiving an ABX Air, Inc. paycheck, Mercer Voluntary Benefits will send a quarterly billing to your home address. *You must notify* Mercer Voluntary Benefits *upon your return to active work status.*

Coverage

How much is enough?

The amount of coverage you may need depends on your personal financial situation, and the answer to two basic questions: (1) In the event of death, will there be sufficient funds to pay your family's monthly bills? (2) How long will your survivors need the income? Please consider company-provided coverage, and other personally owned life insurance, in determining how much additional life insurance is needed.

Employee Coverage

1, 2, 3, 4, 5 or 6 times your annual base salary (rounded to next higher multiple of $10,000), not to exceed $1,000,000.

The total amount of coverage elected will be rounded up to the next higher increment of $10,000, if the multiple of your annual base salary is not evenly divisible by $10,000. For example, if your annual base salary is $23,000, 4 times annual base salary would be $92,000, which rounds up to a $100,000 term life insurance coverage amount. "Annual base salary" must be verified by your employer.

Spouse Coverage

Up to 2 times your annual base salary (elected in $10,000 increments). Minimum coverage $20,000 and not to exceed $100,000.

You can select coverage for your spouse and not elect coverage for yourself. However, if your spouse is also an eligible employee of ABX Air, Inc., coverage may be elected as an employee or spouse, but not both.

If you get married, you may enroll your spouse within 31 days of the date of your marriage. See the Underwriting Requirements section for the amounts of coverage for which you may enroll without evidence of good health. If you wait beyond 31 days, coverage for your spouse will be subject to full evidence of good health.

Dependent Children's Coverage

$10,000 is available on each child when included with employee life insurance coverage or spouse coverage, but not both. The monthly premium covers all eligible children, regardless of number.

Once one child is insured, coverage is automatic at no increase in premium for additional eligible children.

Coverage for your firstborn child may be added to your coverage (or your spouse's coverage, if you are not insured) when the child is 14 days old.

Children's Continuation Provision

Children may be covered until their 21st birthday (or 25th birthday if an unmarried, full-time student). There is an option to switch to Group Universal Life coverage within 31 days. See "Children's Continuation Provision" section.

Incapacitation Proceeds

An advance on term life insurance coverage when certain medical conditions apply. See" Incapacitation Proceeds Feature" section.

This Coverage is life insurance, which includes one or more of these three parts: term insurance, a fund and paid-up insurance. When the term insurance ends, the fund is applied to provide paid-up insurance. Paid-up insurance continues until death unless voided, if you become totally disabled, or surrendered. A benefit is payable under this Coverage if you die from any cause. The amount of the death benefit is the sum of the amounts of term insurance, fund and paid-up insurance you have at that time. But the balance and interest for any loan on your fund, due at your death, will be deducted from the death benefit to be paid. If you are totally disabled when your insurance ends, there are special provisions that may extend your death benefit protection. Under certain conditions, you may convert your term life insurance and that of your Qualified Dependent to an individual contract.

AUTOMATIC COVERAGE INCREASE

Coverage increases automatically on January 1 if a salary increase in effect as of the prior July 1 makes the employee eligible for additional coverage.

Note: Automatic Coverage Increase is not available for spouse coverage.

UNDERWRITING REQUIREMENTS For COVERAGE AMOUNT

Guaranteed *without* Evidence of Good Health

Employee:	1 or 2 times annual base salary, not to exceed $250,000
Spouse: (age 64 or younger)	$20,000
Children:	$10,000

Simplified Evidence of Good Health

Employee:	3 times annual base salary or from $260,000 to $500,000
Spouse: (age 64 or younger)	$30,000 to $100,000 not to exceed 2 times employee's annual base salary

Full Evidence of Good Health

Employee:	4, 5 or 6 times annual base salary, or from $510,000 to $1,000,000
Spouse: (age 65-69)	All coverage
Increased Coverage Amount:	Any increase in coverage amount, except for automatic increases caused by salary increases.
Late entrant:	All coverage

In any of the following situations, you must give evidence of insurability. This requirement will be met when Prudential decides the evidence is satisfactory.

- You enroll more than 31 days after you could first be covered.
- You enroll after any of your insurance under the Group Contract ends because you did not pay a required contribution.
- You wish to become insured for life insurance and have an individual life insurance contract, which you obtained by converting your insurance under a Coverage of the Group Contract.
- You have not met a previous evidence requirement to become insured under any Prudential group contract covering Employees of the Employer.

UNDERWRITER

Group Universal Life Insurance (contract form series 83500) is offered and underwritten by Prudential Insurance Company of America, Prudential Plaza, Newark, NJ 07901.

INCAPACITATION PROCEEDS FEATURE

This feature allows the insured employee and/or dependent the option to receive payments under the coverage prior to death.

The Incapacitation Proceeds feature can provide two percent of a person's term life insurance coverage monthly (minimum $400; maximum $10,000) for up to 25 months if written medical evidence is submitted

satisfactory to Prudential that the person is an Incapacitated Person and has been so for at least six consecutive months.

The condition causing the incapacity cannot be a condition for which medical care or treatment is received during the six-month period immediately before first becoming covered under the feature. This requirement will not apply if no medical care or treatment for that condition has occurred for six months or more, or if there has been a complete recovery from that condition.

An Incapacitated Person is an insured employee or dependent who is:

- Totally disabled due to sickness, injury or both for at least six months;
- In the case of the employee, unable to perform for wage or profit, the material and substantial duties of any job for which they are reasonably fitted by their education, training, or experience;
- Under the regular care of a doctor; and
- Expected to remain totally disabled for the rest of his or her lifetime.

Note that there are certain other conditions that must be met and certain circumstances under which this option may be available. Refer to your group insurance certificate for further details.

If this option is elected, the total amount of Group Universal Life coverage otherwise payable upon death, including any amount under an extended death benefit, will be reduced by the Incapacitation Proceeds. Also, any amount that could otherwise have been converted to an individual contract will be reduced by the Incapacitation Proceeds.

CHILDREN'S CONTINUATION PROVISION

Q: How long can my children keep coverage?

A: You can keep children coverage until his or her 21st birthday (or 25th birthday if an unmarried, full-time student). He or she must notify Mercer Voluntary Benefits within 31 days to switch the $10,000 dependent children's coverage (without evidence of good health) to Group Universal Life coverage with its cash accumulation option—up to $50,000—at the rates then in effect for active employees.

This option is not available for a dependent child who becomes mentally or physically handicapped while insured under the dependent children's coverage. The dependent children's term life coverage, however, can be continued at the $10,000 level until it would end for a reason other than the age limit, as described in the insurance certificate.

Coverage is also not available for children that are on active duty in the armed forces of any country; or insured under any Employee Coverage of the Group Contract; or the child has Extended Death Protection During Total Disability under any Employee Coverage of the Group Contract after the child's insurance under that Coverage ends.

COVERAGE COST

Q: How much does the life insurance cost?

A: Please refer to the Cost of Insurance Rate Table to determine the monthly cost of insurance for each $10,000 unit of life insurance coverage.

Q: May the employee increase or decrease coverage amounts?

A: Yes. Employees may increase coverage up to 6 times their annual base salary or decrease coverage to 1 times annual base salary. Any increase, except the automatic increase due to a pay increase,

will be subject to full evidence of good health. Employees must be actively at work in order to increase coverage.

NONSMOKER/SMOKER RATES

Q: Is there an advantage for nonsmokers?

A: Yes. Nonsmoker rates are available if you have not smoked or used any tobacco products for 12 consecutive months prior to the date the enrollment form is completed.

A person may qualify for nonsmoker rates at a later date if the individual has not smoked or used any tobacco products for 12 consecutive months.

Your spouse can also take advantage of the nonsmoker rates if he or she meets these same requirements.

TOTAL DISABILITY*: WAIVER OF PREMIUM*

If an employee, age 59 or younger, becomes totally disabled, the cost of insurance for the stated coverage amount shown on the insurance certificate may be waived with written proof of total disability. Please see your insurance certificate for details.

ADMINISTRATION

For your convenience, ABX Air, Inc. will process premiums through payroll deductions.

Mercer Voluntary Benefits is your program manager.

If you have any questions, please call Mercer Voluntary Benefits **toll free: 1-800-441-5581**

Mercer Voluntary Benefits responsibility is to answer all your questions and give you prompt access to accurate records. They will process your enrollment form, distribute your insurance certificate, process any claims, and provide assistance for your service needs such as:

- Changing address
- Changing beneficiary
- Changing coverage amount
- Adding coverage for your first child
- Adding coverage for a newly married spouse
- Informing you of your cash accumulation account balance
- Advising current interest rate credited to cash accumulation
- Processing withdrawals or loans from your cash accumulation account
- Arranging direct billing upon retirement or separation

Mercer Voluntary Benefits will send you an annual statement that will make it easy for you to review your program.

Termination of Coverage and Portability

Q: How do I keep Group Universal Life in force if I leave?

A: When you retire or terminate employment, you may continue your Group Universal Life program by paying premiums on a quarterly basis directly to Mercer Voluntary Benefits. The amount of insurance coverage you can continue is the amount you had on the day before you left. Contact Mercer Voluntary Benefits to arrange this.

Q: How long can I keep the coverage?

A: Until age 95, with the following exceptions:

- A U.S. permanent resident employee who forfeits U.S. permanent residency status may not keep coverage.
- A foreign national employee (except a U.S. permanent resident) who leaves employment may not keep coverage.
- A foreign national employee who returns to his/her county of citizenship to work for he company may not keep coverage.
- If a person obtains paid-up insurance, all insurance for that person, except the paid-up insurance, will end. (See the "Paid-up Life Insurance" section and your insurance certificate for details.)
- If the group contract terminates, coverage for current and former employees, dependents, spouses and adult children will end. Portability will not apply, and portability options previously exercised will terminate.

Designating Your Beneficiary

Your beneficiary is the person or persons you name to receive your Life Insurance benefit in the event of your death. The Group Universal Life Insurance Enrollment Form provides space for designating beneficiaries.

The "First Beneficiary" is your first choice of the person or persons who would receive the death benefit.

The "Second Beneficiary" is your second choice of the person or persons who would receive the death benefit (if the first is not living).

Use the reverse side of the enrollment form if you wish to list more than one person as first or second beneficiary, and also indicate the percentage of share you desire for each beneficiary.

If you wish to designate a trust or other organization as beneficiary, you are encouraged to seek guidance from your personal financial or tax adviser.

If you do not name a beneficiary, or if your named beneficiary does not survive you, your Life Insurance benefit will be paid to the person or persons in the following order of priority:

Your spouse;
Your child(ren) equally;
Your parent(s) equally;
Your brother(s) and sister(s) equally;
Your estate

The certificate owner may change beneficiaries at any time as long as the change is made in writing to and recorded by Mercer Voluntary Benefits.

The Group Universal Life Death Benefit

In the event of your death, your beneficiary will receive a death benefit equal to the life insurance coverage amount plus the cash accumulation account — all federal income-tax-free (less any funds previously withdrawn or borrowed).

Cash Accumulation Option

For each $10,000 unit of life insurance coverage you elect for yourself and/or your spouse, you are allowed to contribute additional cash, which earns tax-deferred interest. This is your cash accumulation account. How much additional cash you may contribute to your account and that of your spouse depends on the amount of life insurance coverage you and your spouse have, and your respective ages.

The Cash Contributions Rate Table shows the allowable cash accumulation contribution at each age for each $10,000 unit of life insurance coverage.

Q: Can I accumulate cash without enrolling for life insurance coverage?

A: No. IRS regulations require that Group Universal Life must be a life insurance program. As a result, the cash you contribute must maintain a specific relationship to the amount of life insurance coverage.

Q: Is automatic payroll deduction the only way to make contributions to the cash accumulation account?

A: No. You may make lump-sum contributions directly to the administrator. Call Mercer Voluntary Benefits before you do to make sure your contribution does not exceed IRS regulations.

Q: What happens to my cash if I decide to cancel my insurance coverage?

A: You will be sent the cash you have accumulated as well as the interest credited, less any outstanding loans and withdrawals. The premium you paid for your life insurance coverage will not be refunded.

USING YOUR CASH ACCUMULATION

You may use your cash accumulation account for a variety of personal needs including, buying a home or paying for a college education.

- **Pay your premium.** If you stop making premium payments, they will be automatically withdrawn from your cash accumulation account, if there is a sufficient balance, until the term insurance ends.
- **Borrow funds.** The minimum loan is $200. Under present law, loan interest is not tax-deductible. Currently, no fee is charged for a loan other than interest.
- **Withdraw cash.** You may withdraw your cash without canceling or changing your coverage amount. The minimum withdrawal is $200. Currently, no fee is charged for a withdrawal. Check your insurance certificate for details.

PAID-UP LIFE INSURANCE

Paid-up life insurance is permanent insurance that requires no further premium payments and will continue until the insured's death, unless surrendered or voided as described in your insurance certificate. This option gives the insured the choice of using all or part of the cash value in the insured cash accumulation account as a single payment to elect a paid-up death benefit. Simply stated, the

insured will pay no further premium payments for his/her life insurance coverage but will still maintain his/her cash value. When paid-up life insurance is elected all other coverages under the certificate end.

Under certain circumstances an insured Group Universal Life coverage may become a “Modified Endowment Contract,” subject to different tax rules. You should consult your tax adviser.

Prudential determines the rate for paid-up life insurance based on experience (mortality) and interest. Mercer Voluntary Benefits can tell you the rate for paid-up life insurance at any age if purchased today, or estimate a monthly cash contribution at assumed interest to prefund paid-up life insurance purchased at a future age. Contact Mercer Voluntary Benefits to request paid-up life insurance.

Group Universal Life Rate Tables

COST OF INSURANCE PER $10,000 COVERAGE UNIT

The Cost of Insurance rates are adjusted on each January 1 to account for the insured's then current age bracket.

Age* Employee/Spouse	Monthly Cost of Insurance Per $10,000 Coverage Unit Nonsmoker	Monthly Cost of Insurance Per $10,000 Coverage Unit Smoker**
Under 20	$ .58	$ .58
20-24	$ .58	$ .58
25-29	$ .70	$ .81
30-34	$ .70	$ 1.16
35-39	$ .81	$ 1.16
40-44	$ 1.63	$ 2.09
45-49	$ 2.44	$ 3.37
50-54	$ 4.65	$ 5.70
55-59	$ 7.44	$ 9.65
60-64	$ 12.91	$ 15.95
65-69	$ 18.14	$ 22.56
70-74	$ 25.93	$ 32.56
75-79	$ 36.86	$ 46.05
80-84	$ 60.47	$ 75.47
85-89	$ 88.49	$ 110.35
90-94	$ 129.77	$ 161.86

Dependent Children's Coverage: $1.45 monthly
****Use age as of January 1 of the year you enroll.***

*****Use the smoker rate if you have used any form of tobacco in the last 12 months.***
Rates may change as the insured enters a higher age category.
Also, rates may change if plan experience requires a change for all insureds.

CASH CONTRIBUTIONS PER $10,000 COVERAGE UNIT

The amount of cash you are allowed to contribute is determined by the number of $10,000 coverage units. For example, with a life insurance coverage amount of $100,000 (10 units), you would have the flexibility to contribute any cash amount up to 10 times the amount shown at your age on the Monthly Cash Contribution Table below.

Monthly Cash Contribution Table

Age Employee/Spouse Begins Level Contribution	Maximum Allowable Cash Contribution Per $10,000 Coverage Unit
17	3.85
18	4.24
19	4.67
20	5.14
21	5.66
22	6.24
23	6.87
24	7.58
25	8.35
26	9.21
27	10.15
28	11.20
29	12.36
30	13.64
31	15.06
32	16.64
33	18.38
34	20.32
35	22.48
36	24.88
37	27.55
38	30.54
39	32.08
40	33.47
41	34.93
42	36.45
43	38.04
44	39.70
45	41.43
46	43.24
47	45.14
48	46.98
49	48.52
50	50.10
51	51.73
52	53.41
53	55.13
54	56.88
55	58.66
56	60.51
57	62.40
58	64.34
59	66.32
60	68.35
61	70.43
62	72.59
63	74.81
64	77.11
65	79.47
66	81.85
67	84.32
68	86.92
69	89.67

A 2% deduction will be collected when a contribution is first received for insurance company tax obligations. For example, if a $100 contribution is made, 2 percent or $2 (currently) is collected, and the remaining $98 will be credited with current interest.

Interest is declared annually by Prudential and credited to cash contributions from date of receipt by Mercer Voluntary Benefits. The annual interest rate may vary, but will not be less than 4% per year.

Claim Procedures

How to File a Claim for Benefits

Contact Mercer Voluntary Benefits for information and forms to file any type of claim for benefits under this Plan.

Mercer Voluntary Benefits
P.O. Box 9279
Des Moines, IA 50306-9267

Telephone: 1-800-441-5581

Please follow the instructions on the claim form carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements are submitted with the claim form.

Return the completed claim form to Mercer Voluntary Benefits.

Mercer Voluntary Benefits will submit the claim to Prudential. When the claim has been processed by Prudential, you (or your beneficiary) will be notified. Incapacitation proceeds will be paid to the incapacitated person. Death benefits will be paid to your Group Universal Life Insurance beneficiary. If any benefits have been denied, you (or your beneficiary) will receive a written explanation.

Routine Questions

If there is any question about a claim, an explanation may be requested from Mercer Voluntary Benefits at 1-800-441-5581.

Claim Decisions

Final claim decisions are made by Prudential. If you have any questions about a claim that Mercer Voluntary Benefits has processed and sent to Prudential, please call toll-free at: 1(800) 524-0542. Written requests for claim information or claim appeals should be sent to:

Prudential Insurance Company of America
Group Life Claim Operations
P.O. Box 1215
213 Washington Street
Newark, NJ 07102-1215

Please include the policy number and the employee's Social Security number on all correspondence and inquiries.

Requesting a Review of Claims Denied in Whole or in Part

In the event a claim is denied in whole or in part, Prudential will notify you (or your beneficiary) in writing within 90 days after the claim was filed (180 days under special circumstances). If an extension beyond 90 days is necessary to make a decision on the claim, you (or your beneficiary) will receive a notice from Prudential indicating the reason for the delay and the date you may expect a final decision.

Prudential's notice of claim denial will include:

- The specific reason(s) for denial with reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why the material or information is necessary; and
- The steps to be taken if you (or your beneficiary) wish to have the decision reviewed.

You (or your beneficiary) or your authorized representative may request a review of the claim and may review pertinent documents. The request for review should be sent to Group Life Claim Operations at the address of the Prudential office that processed the claim within 60 days after you (or your beneficiary) receive notice of the denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments you (or your beneficiary) deem appropriate.

Prudential will reevaluate all the information, and you (or your beneficiary) will be informed of the decision in writing within 60 days after receipt of the written request for claims review. If special circumstances require an extension of time to review your claim, you (or your beneficiary) will receive written notification of the final decision as soon as possible but not later than 120 days after the request for review.

Other Information

Assignments: All assignments except collateral assignments are allowed.

Contract Holder: FLEET NATIONAL BANK, AS TRUSTEE OF THE UNIVERSAL LIFE INSURANCE TRUST FOR EMPLOYEES OF THE COMPANY.

Contract Anniversary: January 1 of each year

Employment Waiting Period: A period which begins on your first day of active service with the Employer and ends on the first day of the calendar month next following completion of 60 days of continuous full-time or part-time service with the Employer.

Cost of the Insurance: The insurance in the Book is Contributory Insurance. You will be informed of the amount of your contribution when you enroll. In no event will the amount required to provide your term insurance under the Universal Life Coverage be higher than 150% of the applicable amount under the 1980 Commissioners Standard Ordinary Mortality Table (Male, age last birthday).

Administrator: Certain functions under the Group Contract are performed by Mercer Voluntary Benefits in its role as plan Administrator.

THE COMPANY ROLE

The company is making available to employees the opportunity to enroll in the Group Universal Life program through the distribution of plan information prepared by Mercer Voluntary Benefits. The company will furnish Mercer Voluntary Benefits with necessary records and information to verify your qualification for insurance under the program. Group Universal Life is an employer-sponsored welfare benefit plan for purposes of the Employee Retirement Income Security Act Of 1974 (ERISA), as amended.

This book is not a contract; it is a brief description of the benefits of the program and contains references to concepts, which have legal, accounting and tax implications. Mercer Voluntary

Benefits comments are intended to convey a general understanding of applicable provisions, but are not intended as a legal opinion. Since Mercer Voluntary Benefits cannot serve as a tax adviser, it is recommended that you consult your personal financial adviser. Subsequent developments in the law may impact the benefits described. Please keep this summary of program provisions with your other records. In all cases, the actual insurance policy will govern.

Program Definitions

Actively at Work means that the employee is actively at work at the companies place of business or at any other place that the company requires the individual to go.

Annual Base Salary means base salary, excluding shift differential, overtime, incentive pay and other such compensation.

Cash Accumulation Account means the cash value of the fund, reduced by any cash withdrawn or outstanding loan.

Dependent Children means natural-born, legally adopted children and stepchildren who are wholly depending on you for support and maintenance. Your child cannot be covered as your dependent while covered as an employee of the company.

Eligibility Date means the date that new employees become eligible to join the Group Universal Life Insurance Plan. New employees become eligible to join on the first day of the month after completing 60 days of service.

Full Evidence of Good Health means satisfactory answers to the applicable questions in Section 4 of the enrollment form are required. The individual must also meet the Eligibility Requirements. In addition, Mercer Voluntary Benefits will send Prudential's Request for Medical Information form for completion and signature. Coverage will not become effective until the first of the month following approval by Prudential.

Guaranteed means the specified amount of coverage will be issued without evidence of good health, provided the individual meets the Eligibility Requirements.

Late Entrant means that such individual is applying for Group Universal Life coverage after a specified eligibility period to enroll has passed. (See "When may I enroll?" and "Effective Date.")

Life Insurance Coverage Amount means the specified amount of term life insurance benefit provided on your life, or the life of your spouse or your child(ren).

Simplified Evidence of Good Health means satisfactory answers to the applicable questions in Section 4 of the enrollment form are required. The individual must also meet the Eligibility Requirements. Coverage will not become effective until the first of the month following approval by Prudential.

Totally Disabled means that such individual is not able to perform for wage or profit, the material and substantial duties of any job for which the individual is reasonably fitted by education, training or experience.

VOLUNTARY ACCIDENT INSURANCE PLAN

Voluntary Accident Insurance coverage provides you (and your eligible dependents, if you enroll in the Family Plan) with insurance protection in case of accidental loss of life, dismemberment or paralysis 24-hours a day, 365 days a year, anywhere in the world. Coverage applies to accidents that occur on or off the job, at home, or while traveling.

Eligibility and Effective Date

Employees

Eligible employees are regularly scheduled full-time and part-time employees. Eligible employees are employees regularly scheduled to work 15 or more hours per week.

Employees who are members of a collective bargaining unit are only eligible if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that, at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary, is considered as contract labor or independent contracting.

New employees become eligible to join the Voluntary Accident Insurance Plan on the 61st day following date of hire.

You will be covered by the Plan on that date provided you have completed an online Self Service Enrollment form.

Dependents

Your eligible dependents are covered under this Plan on the date your coverage is effective if you are eligible and enroll each dependent for coverage.

Your eligible dependents are:

- Your legal spouse
- Your unmarried children under age 19, including your natural children, legally adopted children, children placed for adoption, stepchildren residing with you and any other children supported solely by you and permanently residing with you, provided you are their legal guardian or you claim the children as dependents for federal income tax purposes.
- Your unmarried children from age 19 until age 23 who are registered students in full time attendance at a university or similar institution of learning and who are dependent on you for support and for whom you are entitled to an income tax exemption.
- Your unmarried child who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, provided such child was covered under this Plan at the time of disability and immediately prior to his or her 19th birthday (23rd if a student).

If you do not enroll your dependents when they are first eligible, you must wait until the next open enrollment period in the fall for a January 1 effective date, except in the event of Family/Work status changes (see Family/Work Status Changes section).

If your dependent child is an employee and eligible for Voluntary Accident Insurance coverage under the Company Plan, he or she may not be enrolled as your covered dependent.

Enrollment

Initial enrollment. Your initial enrollment election is a commitment for the remainder of the calendar year. As a new hire, you will have 60 days from hire date to complete the online Self Service Enrollment form. If you are newly eligible for this Plan due to a change in employment status, you will have 30 days from status change date to complete the online Self Service Enrollment form.

Open Enrollment. You will be given the opportunity to review your participation in the benefit plans on an annual basis each fall for a January 1 effective date. This is called an "Open Enrollment" period. Your Open Enrollment election is a 12-month commitment beginning January 1. Other than open enrollment, you may change your annual election during the year only if you meet one of the family or work status changes described below.

Family/Work Status Changes

Your benefit election is in force for the full plan year (January 1 through December 31) following the enrollment period (unless your coverage terminates).

You are eligible to change your election during the year only if you have a qualifying change in your family or work status and complete the Self Service enrollment with the documentation for the change to the Benefits Department within 30 days of the qualifying event.

Qualifying family and work status changes are:

- **Legal marital status change** due to marriage, death of a spouse, divorce, legal separation or annulment.
- **Number of dependents change** due to birth, adoption, placement for adoption or death of a dependent.
- **Employment status changes** for you, your spouse or dependent due to ending or starting employment, a strike, lockout or commencement or return from an unpaid leave of absence (including an FMLA leave); or a change in employment status with the consequence that you, your spouse or dependent becomes or ceases to be eligible for coverage (such as a switch between part-time and full-time status).
- **Residence or worksite change** (for you, your spouse or dependent) that could affect your benefits.
- **Dependent child's eligibility change** which causes a dependent to satisfy or cease to satisfy eligibility requirements due to age, student status or a similar change.
- **Change in regularly scheduled hours that affect benefits eligibility.** If your employment status changes from a position with no benefit eligibility to a full-time or part-time position with benefit eligibility, you will be allowed to make a coverage election at that time. Your employment will count toward your eligibility waiting period.

Dates for Qualifying Status Changes			
QUALIFYING STATUS CHANGE	**To change coverage, complete the Self Service Enrollment form online. The form must be completed by:**	**Proof Required**	**Disability Start/Loss Date**
Marriage:	30 days from date of marriage	A copy of the marriage certificate	Covered from the day of marriage
Divorce, legal separation or annulment	30 days from date of separation, divorce or annulment	A copy of court papers showing the date the separation, divorce or annulment was final	First of the month following the event
A newborn infant	30 days from date of birth	Birth Certificate	Covered from date of birth. *If you are out on leave, coverage begins the day you return from leave.*
A newly adopted child under the age of 18	30 days from the date of your child's placement for adoption	A copy of the final adoption papers showing the date adoption was finalized	Covered from date the child is physically placed with you for adoption & you assume financial responsibility. *If you are out on leave, coverage begins the day you return from leave.*
Change in hours that affect your benefits eligibility.	30 days from the status change	No proof required	Covered the date your status changed (provided you have satisfied the 60-day wait period.)

Cost

You pay the full cost of this coverage for yourself and for your eligible dependents if you elect the Family Plan.

Your monthly premiums, for individual or family coverage, are determined by the amount of insurance (Principal Sum) you select for yourself.

Employee Principal Sum	Bi-Weekly Cost Employee, Only Plan	Bi-Weekly Cost Family Plan
$ 25,000.00	$0.35	$0.64
$ 50,000.00	$0.69	$1.27
$ 75,000.00	$1.04	$1.91
$ 100,000.00	$1.38	$2.54
$ 125,000.00	$1.73	$3.18
$ 150,000.00	$2.08	$3.81
$ 175,000.00	$2.42	$4.44
$ 200,000.00	$2.77	$5.08
$ 225,000.00	$3.12	$5.71
$ 250,000.00	$3.46	$6.35
*$ 275,000.00	$3.81	$6.98
*$ 300,000.00	$4.15	$7.62
*$ 325,000.00	$4.50	$8.25
*$ 350,000.00	$4.85	$8.88
*$ 375,000.00	$5.19	$9.52
*$ 400,000.00	$5.54	$10.15
*$ 425,000.00	$5.88	$10.79
*$ 450,000.00	$6.23	$11.42
*$ 475,000.00	$6.58	$12.06
*$ 500,000.00	$6.92	$12.69

*Principal Sum amounts over $250,000 cannot exceed 10 times your Annual Base Salary.

Your contributions will be deducted before your withholding taxes are calculated (on a pre-tax basis), thereby reducing your income taxes and FICA taxes. You will be given an opportunity to elect pretax coverage each year during the open enrollment period.

Plan Options

Employee Only Plan: You may elect any coverage amount (Principal Sum) for yourself from $25,000 to $500,000* in increments of $25,000.

Family Plan: You may elect any coverage amount (Principal Sum) for yourself from $25,000 to $500,000* in increments of $25,000. Coverage for your eligible dependents is determined automatically, based on your family structure:

Family Structure	**Dependent's Principal Sum is Equal To:**
Spouse Only	60% of your Principal Sum**
Spouse & Child(ren) Spouse Each Child	 50% of your principal sum** 10% of your principal sum**
Child(ren), Only Each Child	 15% of your principal sum**

*Principal Sum amounts over $250,000 cannot exceed 10 times your Annual Base Salary.

**The maximum coverage amount for each spouse is $300,000 and for each dependent child is $50,000. This maximum applies even if both parents are employed and enrolled in this Plan.

Age Reductions

When you or your spouse reach age 70, that person's Principal Sum is reduced to the percentage shown in the following table:

Age at Date of Loss	Principal Sum
Age 69 or younger	100%
Ages 70 - 74	65%
Ages 75 - 79	45%
Ages 80 - 84	30%
Ages 85 and older	15%

Beneficiaries

Employees

Your beneficiary is the person or persons you name to receive the Voluntary Accident Insurance benefit payable in the event of loss of your life.

You should complete the beneficiary form and return it to the Benefits Department of Human Resources to assure Voluntary Accident Insurance benefits for loss of life are paid in accordance with your wishes.

You may change your beneficiary designation at any time. If you do not name a beneficiary, or if your named beneficiary does not survive you, Voluntary Accident Insurance benefits for loss of your life will be paid to the person or persons in the following order of priority:

1. Your spouse;
2. Your child(ren) equally;
3. Your parent(s) equally;
4. Your brother(s) and sisters(s) equally;
5. Your estate.

Family Members

If you select the Family Plan, you are the beneficiary of the Voluntary Accident Insurance benefit payable in the event of the death of your covered spouse and/or covered dependent children, unless a different beneficiary is specified on the Beneficiary form.

Schedule of Benefits

If you or your eligible dependent suffers a covered loss as the direct result of accidental bodily injury, benefits are payable as specified in the Schedule of Benefits. The benefits provided under this Plan are payable in addition to any other insurance in effect at the time of a covered accident.

Accidental Loss of Life, Dismemberment and Paralysis Benefit Amounts

Benefits will be paid for any of the following losses, which result from covered accidental injury to you or your covered dependents within 365 days of the date of the accident.

100% of the Principal Sum will be paid for:

- Loss of life

- Loss of both hands or both feet
- Loss of sight of both eyes
- Loss of one hand and one foot
- Loss of one hand or one foot and sight of one eye
- Quadriplegia (total paralysis of both upper and lower limbs)
- Loss of speech and hearing in both ears

75% of the Principal Sum will be paid for:

- Paraplegia (total paralysis of both lower limbs)

50% of the Principal Sum will be paid for:

- Loss of one hand or one foot
- Loss of sight of one eye
- Hemiplegia (total paralysis of upper and lower limbs on one side of the body)
- Loss of speech or hearing in both ears

25% of the Principal Sum will be paid for:

- Loss of thumb and index finger of the same hand

"Loss" as used above means: With regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to eyes, entire irrecoverable loss of sight; with regard to paralysis (quadriplegia, paraplegia and hemiplegia) the complete and irreversible paralysis of such limbs; with regard to thumb and index finger actual severance through or above metacarpophalangeal joints; with regard to speech, entire and irrecoverable loss of speech; with regard to hearing, the entire and irrevocable loss of hearing in both ears.

If you (or a covered dependent) suffer more than one of the losses listed above as the result of any one covered accident, benefits will be paid only for the greatest loss.

Exposure and Disappearance Benefit

Exposure - If you are unavoidably exposed to the elements as a result of a covered accident and suffer one of the losses listed above, benefits will be payable according to the Schedule of Benefits.

Disappearance - If your remains are not found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance you occupied, the benefits will be payable according to the Schedule of Benefits for loss of life.

Special Education Benefit

If you elect Family Plan coverage and lose your life as the result of a covered accident, the Plan will pay the following additional benefits.

- For your surviving dependent children:
  The Plan will pay 5% of your Voluntary Accident Insurance Principal Sum (to a maximum of $5,000) on behalf of any eligible dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the 12th grade level, or was at the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning within 365 days following the accident.
  The benefit is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his or her education.

"Institution of higher learning" includes, but is not limited to, any state university, private college or trade school.

- For your surviving spouse:
  The Plan will pay the actual cost incurred within 30 months from the date of your death (to a maximum of $2,000) to, or on behalf of, your surviving spouse who has enrolled in any professional or trades training program, for the purpose of obtaining an independent source of support and maintenance.

Common Disaster Benefit

If you elect Family Plan coverage, and both you and your spouse lose your lives as the result of the same covered accident, the benefit applicable to your spouse will automatically be increased to equal your Principal Sum to a combined maximum of $500,000. (If you and your spouse are both enrolled employees with Family Plan coverage, the combined maximum would be $1,000,000 instead of $500,000.) The increase applies only if both deaths occur within 90 days of the accident.

Coverage Limitations

- Voluntary Accident Insurance covers accidents occurring while riding as a passenger, but not as a pilot or crewmember, on any aircraft being used for the transportation of passengers unless you are a designated non-union Flight Management Pilot acting as a pilot or crewmember of a company aircraft on Company business. "Riding" includes boarding or alighting from the aircraft.

- Voluntary Accident Insurance does not provide coverage for sickness.

Exclusions

Voluntary Accident Insurance does not cover any loss caused by or resulting from:

- Suicide or any attempt thereat while sane or self-destruction or any attempt thereat while insane.
- Bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
- Disease of any kind; hernia of any kind; or bacterial infections, except pyogenic infections, which occur through an accidental cut or wound.
- Riding as a pilot or crewmember in any aircraft unless you are a designated non-union Flight Management Pilot piloting a company aircraft on Company business.
- Declared or undeclared war or any act thereof.
- Service in the military, naval or air service of any country
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage

Termination of Coverage

Your Voluntary Accident Insurance coverage will terminate at the end of the calendar month in which:

- Your employment ends,
- You are no longer an eligible employee,
- You retire,
- Your premium contributions end; or
- The Plan is terminated, if earlier.

You may qualify for an extension of coverage in certain circumstances described in the Special Extensions of Coverage section below.

Coverage for your enrolled dependents will terminate at the end of the calendar month in which:

- Your coverage terminates,
- Your dependent is no longer eligible, or
- Your dependent contributions end;

Or, if earlier, on the date your dependent child becomes eligible for coverage as an ABX Air, Inc. employee, or the Voluntary Accident Insurance policy is terminated.

Voluntary Accident Insurance can be converted to an individual insurance policy with limitations..

Special Extensions of Coverage

During Approved Disability Leave

If you are on an approved medical leave of absence for your illness or injury, your Voluntary Accident Insurance coverage for you and your dependents continues for a maximum of one year. You must continue to pay the premium to maintain this coverage during your leave.

During Family Medical Leave

If you meet the requirements for Family Medical Leave, the company will maintain or reinstate any Voluntary Accident Insurance coverage, which you had under this Plan prior to the leave. You must continue to pay the premium to maintain coverage during your leave. See the “Family Medical Leave” section for details.

During a Personal Leave Of Absence

Voluntary Accident Insurance coverage remains in effect until the end of the month in which you last worked.

During a Uniformed Services Leave Of Absence

Voluntary Accident Insurance coverage remains in effect until the end of the month in which you last worked.

During Jury Duty

Your Voluntary Accident Insurance coverage continues when you are required to serve as a juror or as a court witness. You must continue to pay the full premium to maintain coverage during this time.

Leave for employees selected for special trials of lengthy duration (over 30 days) must be individually requested through Human Resources.

After Your Death

If you die, Voluntary Accident coverage for your dependents remains in effect until the end of the month in which your death occurs.

Reinstatement of Coverage

If your Voluntary Accident coverage terminates because you cease to meet the definition of an eligible employee, coverage for you and your eligible dependents may be reinstated immediately if you return to active work in an eligible class within 12 months from the date your eligibility ceased.

If your unmarried dependent child age 19 through 22 lost eligibility because he or she was no longer a full-time student, Voluntary Accident coverage may be reinstated when the dependent child returns to full-time student status, provided you apply for reinstatement of coverage within 30 days. Coverage will be reinstated retroactive to the date the dependent child resumed attending classes.

Claim Procedures

How to File a Claim for Benefits

Claim forms can be obtained from Human Resources.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements are submitted with the claim form.

The completed claim form should be returned to Human Resources.

When the claim has been processed, you (or your beneficiary) will be notified. Dismemberment, loss of sight, speech and hearing and paralysis benefits will be paid to the insured person. Benefits payable because of your death will be paid to your Voluntary Accident Insurance beneficiary. Benefits payable because of the death of your covered dependent will be paid to you unless a different beneficiary was designated. If any benefits have been denied, you (or your beneficiary) will receive a written explanation.

Claims Are Paid By:

Cigna Group Insurance
Pittsburgh Claims Center
1600 West Carson Street, Suite 300
Pittsburgh, PA 15219

Routine Questions

If there is any question about a claim payment, an explanation may be requested directly from CIGNA at: 1-800-36-CIGNA (24462). This number is operational between 7:00 am and 7:00pm Central Time. If you call outside this time frame, please leave a voicemail message and a representative will respond the next business day.

Claim Appeals

Initial Determination

In the event a claim is denied in whole or in part, CIGNA will notify you (or your beneficiary) in writing within 90 days after the claim was filed (180 days under special circumstances). If an extension beyond 90 days is necessary to make a decision on the claim, you (or your beneficiary) will receive a notice from CIGNA indicating the reason for the delay and the date you may expect a final decision.

CIGNA's notice of claim denial will include:

- The specific reason(s) for denial with reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why the material or information is necessary; and
- The steps to be taken if you (or your beneficiary) wish to have the decision reviewed.

Claims Review and Appeal

You (or your beneficiary) or your authorized representative may request a review of the claim and may review pertinent documents. The request for review should be sent to CIGNA Group Insurance, Pittsburgh Claims Center, 1600 West Carson Street, Suite 300, Pittsburgh, PA 15219 within 60 days after you (or your beneficiary) receive notice of the denial of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments you (or your beneficiary) deem appropriate.

All the information will be reevaluated, and you (or your beneficiary) will be informed of the decision in writing within 60 days after receipt of the written request for claims review. If special circumstances require an extension of time to review your claim, you (or your beneficiary) will receive written notification of the final decision as soon as possible but not later than 120 days after the request for review.

Eligibility – Review and Appeal

If you (or your beneficiary or your legal representative) believe that you have been improperly denied eligibility in this plan or improperly denied the opportunity to make an election change due to a qualified change in status, follow the appeal procedures and timelines described above. However, instead of contacting CIGNA in writing, contact the Plan Administrator by writing to your Company Benefits Department as follows:

ABX Air, Inc.
Human Resources, 2061-H
145 Hunter Drive
Wilmington, OH 45177

The Plan Administrator has the sole discretionary authority to determine eligibility for benefits and to construe the terms of eligibility for the disability, life and accident plans.

If your initial request for eligibility or an opportunity to make a family status change is denied, and your written appeal is denied, you may pursue legal remedies under section 502(a) of ERISA. Before you may pursue these legal remedies however, you must first exhaust this review and

appeals process. If you do take legal action, you must file suit within two years after the date of the event upon which the claims is based.

Definitions

Insured Person. Includes both the insured employee and the insured dependent, as applicable.

Injury. Bodily injury caused by an accident occurring while the Voluntary Accident Insurance policy is in force as to the Insured Person and resulting directly and independently of all other causes in loss covered by the insurance policy.

Principal Sum. The coverage amount you indicated in the Voluntary Accident Insurance section of the Group Insurance Enrollment/Change form for yourself, the insured employee.

Annual Base Salary. Your annual wage or compensation paid by the company excluding bonuses, overtime, Profit Sharing and any other supplemental compensation. Annual Base Salary includes compensation you elect to reduce or defer under company sponsored benefit plans.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Account

We recognize that many of our employees are faced with rising health care costs and with child care expenses. In order to assist with these expenses, we are offering you the opportunity to participate in a Flexible Spending Account Plan.

This Plan allows you to use pre-tax dollars to pay for dependent care expenses and for health care expenses that are not reimbursed by your medical insurance plan, such as deductibles and coinsurance. By doing so, you will reduce your taxable compensation by the cost of these benefits.

With careful planning, you can avoid paying federal taxes on the amount you spend for many of the out-of-pocket heath care expenses and/or dependent care expenses you incur and put the tax savings to work for you.

Think carefully about how much you want to put into your Flexible Spending Account since the Internal Revenue Code places many restrictions on this type of program (See Important Considerations section.)

Eligibility and Enrollment

You are eligible to participate in the Medical Flexible Spending Account if you are eligible for the Enhanced PPO or the Value PPO and have been actively employed for at least one year. Your effective date will be the first of January following your 1st year anniversary.

Employees who are members of a collective bargaining unit are eligible only if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that (at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary) is considered contract labor or independent contracting.

You cannot have Medical Flexible Spending Account and a Health Care Savings Account in the same year.

Annual Enrollment

Open Enrollment. If you do not join the Health Care Flexible Spending Account Plan when you are first eligible, or do not complete the electronic enrollment form before your initial eligibility date, your next opportunity to enroll will be during next fall's Open Enrollment period. Your election made during Open Enrollment period will be effective on January 1. In the event of a qualified family/work status change, see next section below.

Your election is valid for one calendar year; your election does not carry over from one year to the next. **You must make a NEW election each year during the Open Enrollment period if you wish to continue participating in this Plan.**

How the Flexible Spending Account Works

The Flexible Benefit Plan allows you to pay for eligible unreimbursed health care expenses with pre-tax dollars. If you terminate employment during a Plan Year and your Health Care Flexible Spending Account is under-spent, you may continue your coverage under your Health Care FSA by making contributions under COBRA. Your account is under-spent when the remaining annual limit for the Plan Year, based on claims submitted before the COBRA qualifying event, is greater than the maximum COBRA premium for the remainder of the Plan Year. All contributions you make to the Health Care FSA after you terminate employment will be on an after-tax basis.

Health Care Flexible Spending Account

Your health care contributions will be credited to your Health Care FSA. You will be reimbursed for eligible health care expenses that you incur in a Plan Year up to the annual amount elected for the Plan Year. It cannot be used to reimburse you for health care expenses that you incur in the next Plan Year, except during the Grace Period. The Grace Period runs from January 1 until March 15th of the following year. If you have funds left in your account from the prior year, you can put them towards expenses through March 15th of the next year. You will not be reimbursed for any moneys left in the prior year account after March 15th, nor can it be used to compensate you in any other way. **Any money credited to your prior year Account after March 15th of the following year will be forfeited.** Therefore, conservatively estimate how much your unreimbursed health care expenses will be for the Plan Year before deciding how much to contribute to a Health Care FSA. The company reserves the right to use any amounts forfeited by employees to offset plan Administration costs.

Requests for reimbursement of expenses must be submitted for reimbursement and paid within 90 days after the end of the Plan Year. The Plan will only reimburse health care expenses that were incurred during a period in which you were contributing to your Health Care FSA.

Health Care Expenses

- You may be reimbursed for eligible health care expenses that were **incurred** during the Plan Year and Grace Period and during the period you were contributing to the Health Care FSA.
- **The date an expense is incurred is the date you (or your eligible dependent) receive health care services.** The date you are billed for a health care service or the date you paid for a health care service is not the date the expense is incurred.
- Health care expenses must be for you, your spouse or for your eligible dependents. Dependents generally include any member of your family who received half of his or her support from you.
- Health care expenses are generally medical expenses you can deduct on your Federal income tax return.

Expenses eligible for reimbursement include, but are not limited to, the following expenses:

Acupuncture
Childbirth classes
Contact lenses & solutions
Medical aids (crutches, Orthopedic shoes, etc.)
Chiropractor Deductibles
Dental
Eyeglasses
Prescription drugs co-payments
Coinsurance amounts
Hearing aids & batteries
Transportation expenses (related to medical care)

Expenses that are not eligible for reimbursement include, but are not limited to, the following expenses:

- Expenses reimbursed by an insurance provider or another Plan
- Cosmetic Surgery/Procedures
- Long Term Care Services
- Insurance Premiums
- Over-the-counter medications w/o a physician's prescription

If you have any questions regarding eligible or ineligible expenses, please contact the Plan Administrator.

IMPORTANT CONSIDERATIONS

Think carefully about how much you want to put into your Flexible Spending Account Plan since the Internal Revenue Code places many restrictions on this type of program.

Forfeitures - "Use it or Lose it"

Paying eligible expenses with before-tax dollars can mean significant tax savings. But you must be careful not to over budget on your expected costs. Under IRS regulations, if you have any money left in your Flexible Spending Account at the end of the plan year and next year grace period and you didn't incur an expense during the plan year/grace period to offset it; you will lose the money in your account. But, if you budget wisely, you should not have any forfeitures. (Any forfeited money is used to reduce the cost of plan administration). ***Note: There is no refund of the remaining balance to you.***

Social Security

Since you pay less FICA tax when you use a Flexible Spending Account, you or your family may receive a slightly lower Social Security benefit when you retire, or if you become disabled or die.

IRS Rules

For more information about eligible expenses, see the appropriate IRS publication:

- Publication 502 , Eligible Medical Expenses

Both publications are available from any IRS Forms Office, by calling 1-800-TAX-FORM, or by visiting www.irs.gov and entering publication number into the search box in the left hand column.

Discrimination

Due to the tax advantages available under this Plan, certain highly paid employees are prohibited from disproportionately benefiting under the Plan. In some circumstances it may be necessary to reduce contribution elections for such individuals. You will be notified if it is necessary to reduce/restrict your contribution amount to meet these requirements.

When Coverage Ends

Your Flexible Spending Account participation ends:

- On the last day of the month in which you elect to stop participating (during an annual enrollment period or because of a change in family status, cost or coverage change)
- On the date you stop working for the company, or you are no longer an eligible employee
- On the date the Plan is discontinued by the Company.

If your participation ends and you still have money in your Flexible Spending Account, you have until March 31 of the following year to claim benefits from the account for expenses incurred to the end of the month you were a Plan participant.

How to File a Claim

This section will explain how to file a claim for benefits from your Health Care FSA and/or your Dependent Care FSA.

You may submit a claim for benefits after you have incurred an eligible expense. Remember the date you receive medical or dependent care service is the date you incur an expense. ***The date you are billed for an expense or the date you paid for an expense is <u>not</u> the date you incurred the expense.***

You must complete a Reimbursement Form and forward the claim to:

United HealthCare
P.O. Box 981178
El Paso, TX 79998-1178
Fax (915) 781-1085
Telephone (877) 311-7849

Reimbursements from a Health Care FSA

At any time during the Plan Year, the maximum reimbursement you may receive from your Health Care FSA is the total amount of money you elected to contribute to your Account for the full Plan Year. ***You will be reimbursed for expenses that were incurred during the Plan Year and Grace Period and during a period you were contributing to the Health Care FSA.*** If you terminate employment, or stop your contributions to the Plan during an unpaid leave of absence you may not receive reimbursement for expenses incurred during the period you were not contributing to the Plan.

For example:

You terminate employment on May 1st and your contributions through payroll reduction to your Health Care FSA cease. On May 15th you purchase a pair of eyeglasses. This expense is not eligible for reimbursement because the expense was incurred after you stopped contributing to the Plan. However, if you elected to continue your contributions under COBRA and sent in an after-tax contribution to remain a participant, then the expense would be eligible for reimbursement up to the amount that is in your Account because you were contributing to the Health Care FSA at the time you incurred the expense.

Excess Expenses

Any expenses that remain at the end of the Plan Year for either a Health Care FSA or a Dependent Care FSA will not be carried over to the next Plan Year. You will not receive reimbursement for these excess claims.

Please note:

You are not permitted to use money from one account to pay for other types of expenses. You are permitted to use the money from your account(s) only for the designated purpose. For example, medical expenses cannot be claimed from the Dependent Care FSA.

Reimbursements

You may submit reimbursement requests at any time.

Claims Review

The Plan Administrator has designated United HealthCare to make all determinations as to the right of any person to a benefit under the Flexible Benefit Plan. If you have questions on the status of a claim for benefits from your Account, you can obtain information by calling at (877) 311-7849, or by writing United HealthCare at P.O. Box 981178 El Paso, TX 79998-1178. United HealthCare will notify you of any denial of a claim for benefits under this Plan in writing and the notice will be delivered or mailed to you within a reasonable period of time-usually within 90 days after the claim is received. The 90-day period may be extended no more than 180 days if required by special circumstances, and in such cases, you will be notified before the end of the initial 90-day period for the reasons for the extension.

The notice will set forth the specific reasons for the denial, pertinent plan provisions, additional material needed to be supplied by you, and an explanation of the claims review procedure written to the best of the plan administrator's ability in a manner that may be understood without legal or actuarial counsel.

If you dispute the propriety of United HealthCare's denial of any FSA reimbursement, the Plan Administrator will assume full responsibility for making a final and binding decision. The Plan Administrator has absolute and final authority regarding administration, construction, interpretation and application of the provisions of their Plan.

Claims Appeal

If you or someone acting on your behalf wants to appeal the denial of benefits, you or your representative must write a letter appealing the decision, normally within 60 days of the denial of the benefit by the Plan Administrator. In your letter, state why you think your claim should not have been denied. Also, include any documents, additional information or comments you think might be helpful.

In this manner, the Plan Administrator intends to afford a reasonable opportunity to any participant whose claim for benefits has been denied for review of the decision denying the claim. Your appeal will be reviewed and you will be notified in writing of the decision promptly. Normally, this decision will be made within 60 days of receipt of your appeal, but this period may be extended no more than 180 days if special circumstances require additional time, and in such cases you will be notified before the end of the initial 60-day period of the reasons for the extension.

Effective on the first day of the first plan year beginning on or after July 1, 2002, special rules apply to claims filed under Group Health Plans, including Health Care Spending Accounts. All claims will be decided within a reasonable time period, no longer than 30 days after it is received. This time period may be extended by 15 days in situations outside the control of the Administrator, including those situations that involve incomplete claims. If an extension is necessary, you will receive a notification, including the reason for the extension and the expected date of a decision by the Administrator. In such cases, you will be notified before the end of the initial 30-day period. You will be given 45 days to complete an incomplete claim. The Administrator reserves the right to require additional information if necessary to decide your claim.

A written notice will be provided to you if your claim is denied in whole or in part. The notice will outline the specific reasons for the denial, pertinent plan provisions, additional material needed to be supplied by you and an explanation as to why this material is needed, and an explanation of the claims review procedure written to the best of the plan administrator's ability in a manner that may be understood without legal or actuarial counsel. If your claim is denied, you may submit an appeal to the Plan Administrator asking for a review of your denied claim. This appeal must be in writing and received within 180 days of the initial claim denial. If an appeal is not filed within this time frame, you lose the right to appeal. Additionally, you lose your right to file suit in court.

An appeal will be decided by the Plan Administrator within a reasonable length of time not exceeding 60 days after it is received. Any decision will be sent to you in writing. The same individual who denied your initial claim will not be responsible for deciding your appeal. The Plan Administrator reserves the right to request additional information as needed. If the appeal process confirms the initial denial of your claim, you will receive a written notice of the denial. The notice will set forth the specific reasons for the denial, pertinent plan provisions, your right to review pertinent information and documents at your request and at no charge to you, an copy of any criterion the Plan Administrator relied upon to reach a decision and a description of such criterion, and your right to file suit under ERISA § 502(a)

Dependent Care Flexible Spending Account

A Dependent Care Account allows you to pay for work-related dependent care expenses with before-tax dollars. If you set up a Dependent Care Account, you will fund it with before-tax dollars deducted from your paycheck. With careful planning, you can avoid paying federal taxes on the amount you spend for many of the dependent care expenses you incur and put the tax savings to work for you.

Think carefully about how much you want to put into your Dependent Care Account since the Internal Revenue Code places many restrictions on this type of program (See Important Considerations section.)

Eligibility and Effective Date

You are eligible to participate in the Dependent Care Account Plan if you are a full-time or part-time employee.

Employees who are members of a collective bargaining unit are only eligible if the collective bargaining agreement provides for participation in this Plan.

You are not eligible to enroll if you are working in a capacity that (at the sole discretion of the Plan Administrator and without regard to any government agency or other determination to the contrary) is considered contract labor or independent contracting.

New employees become eligible to join the Dependent Care Account Plan on the first day of the month after completing 60 days of service.

- You will be covered by the Plan as soon as you become eligible, but you must complete the Self Service enrollment form **within 60 days from date of hire.**

How the Dependent Care Account Works

You can set up a Dependent Care Account if you and your spouse both work, you work and your spouse attends school, you work and your spouse is actively seeking employment, or you are a single head-of-household.

You can contribute up to $5,000 a year if you are married and file a joint tax return. You can contribute $2,500 if you are married filing a separate tax return or you single/head of household. The contributions are deposited in to a Dependent Care Account with before-tax dollars to pay for qualified dependent care expenses you expect in the coming year (January through December 31).

Qualified Dependents

A qualified dependent must meet the IRS dependent definition and be:

- A child under age 13 who you claim as a dependent on your federal income tax return, or
- A child under age 13 for whom you are a custodial parent described under the Internal Revenue Code, or
- A spouse or other dependent (including a parent) who is physically or mentally incapable of self-care, regularly spends at least eight hours each day in your home, and you claim as a dependent on your federal income tax return.

Annual Enrollment

Open Enrollment. If you do not join the Dependent Care Account Plan when you are first eligible, or do not complete the electronic enrollment form ***before*** your initial eligibility date, your next opportunity to enroll will be during next fall's Open Enrollment period. Your election made during Open Enrollment period will be effective on January 1. In the event of a qualified family/work status change, see next section below.

Your election is valid for one calendar year; *your election does not carry over from one year to the next.* You must make a NEW election each year during the Open Enrollment period if you wish to continue participating in this Plan.

Family/Work Status Change

Your benefit election is in force for the full plan year (January 1 through December 31) following the enrollment period (unless your coverage terminates).

You are eligible to change your election during the year only if you have a qualifying change in your family or work status and submit an enrollment form with the change to Human Resources within 30 days of the qualifying event.

Think carefully about setting up an account! Changes can be made only during an annual open enrollment period or if you have a change in family or work status that affects the amount or eligibility for reimbursement or dependent care expenses. Qualifying changes in family or work status are:

- Change in legal marital status due to marriage, death of a spouse, divorce, legal separation or annulment.
- Change in number of dependents due to birth, adoption, placement for adoption or death of a dependent.
- Change in employment status for you or your spouse due to ending or starting employment, a strike, lockout or commencement or return from an unpaid leave of absence (including an FMLA leave); or a change in employment status with the consequence that you or your spouse becomes or ceases to be eligible to participate (such as a switch between part-time and full-time status).
- A change in residence or worksite (by you, your spouse or dependent).
- An event which causes a dependent to cease to be a dependent due to age or a similar change.

Any change in your Account election must be on account of, and correspond with, your change in family status that affects qualified dependent care expenses and **must be made within 30 days of the change.**

Other events that would allow you to change your Account election are:

- If the cost of your dependent care assistance changes significantly, you may change your election accordingly. Election changes are not permitted for cost changes imposed by a provider who is your relative.

- If your dependent care assistance is significantly curtailed (as determined by the Plan Administrator; for example a reduction in hours of the care provider), or ceases altogether, you may revoke your election and, if other dependent care assistance is available, change your election accordingly.

- If, during the plan year, a new dependent care assistance plan is offered, you may change your election to elect the new benefit.

- If your spouse participates as an employee in a dependent care assistance plan sponsored by your spouse's employer and that plan has a different period of coverage than this plan (or if it permits mid-year election changes due to qualified changes in status), and your spouse elects a coverage change, you may change your election under this Plan. Your election change must be prospective only and must be on account of, and must correspond with, the change made under your spouse's plan.

Eligible Dependent Care Expenses

The eligible dependent care expenses must be work-related, meaning the care must be necessary for the employee and/or the employee's spouse to work, to look for work, or to attend school full-time, or if they are physically unable to care for their children. If your spouse has no earned income, you cannot use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, or is a full-time student for at least five months during the Plan Year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. .

- Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent who is a child under age 13, if you claim a deduction for that dependent on your federal income tax return; or

- A spouse or dependent under federal tax law who is physically or mentally incapable of caring for himself or herself.

- Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

    - Expenses for care at a day care center that complies with all applicable state and local regulations.

    - Expenses for care provided by a housekeeper, babysitter or other person in your home.

    - Expenses for care provided by a relative who cares for your dependents, so long as that relative is over the age of 19 and is not your dependent.

    - Expenses for care for an elderly or incapacitated dependent, either in your home or outside your home. The dependent must spend at least 8 hours each day in your home if you are claiming reimbursement for care outside your home.

- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you cannot use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.

Limits on Amounts to a Dependent Care Account

Because of the tax savings the Dependent Care Account offers, the Internal Revenue Code limits when and how much you can contribute to the account to pay eligible expenses.

- You cannot put more than your salary or your spouse's salary (whichever is smaller) into a Dependent Care Account
- If you and your spouse file separate federal income tax returns, you are each limited to contributing $2,500 a year to the Dependent Care Account
- If you and your spouse file a joint tax return and you both participate in flexible spending account programs where you work, your combined before-tax expense reimbursements are limited to $5,000 a year.

Dependent Care Account or Tax Credit

You have two tax-saving choices for dependent care expenses: reimbursement through the Dependent Care Account or the dependent care tax credit allowed by the federal government on your annual income tax return. The difference is:

- The Dependent Care Account reduces your taxable income, so your tax is lower, while
- The tax credit reduces the amount of income tax you pay at the end of the year.

With this Plan, you use your before-tax dollars in your dependent care account to reimburse yourself for the cost of dependent care expenses. Each month you increase your spendable income by the amount that would otherwise be withheld to pay taxes on your contributions to the Dependent Care Account. With the tax credit, you wait for the savings until you file your tax return.

You cannot use the Dependent Care Account and the tax credit for the same expense. Also, the Dependent Care Account will reduce the amount you can take the tax credit on dollar for dollar. You must decide which method is best for you.

Exclusions and Limits

You cannot use the Dependent Care Account to reimburse yourself for:

- The cost of food, entertainment, overnight camp, supplies, clothing or education--unless those costs are part of your dependent's care (for example, if a nursery school provides lunch and some education that cannot be separated from the cost of daycare)
- Household services, unless part of the daycare is provided in your home
- Education expenses for a child in first grade or above and kindergarten expenses if the education expense can be separated from the after-school day care expense
- Transportation
- Care provided by a person you claim as a dependent on your tax return or by your child or stepchild under age 19, even if they are no longer dependent on you
- Expenses for a dependent child when you are divorced or legally separated and the child is in your custody for less than half the year
- Amounts paid by your spouse's employer toward dependent care
- Amounts you claim for the dependent care tax credit on your federal income tax return
- Expenses incurred for services received before the plan year starts or ends.

Important Considerations

Think carefully about how much you want to put into your Dependent Care Account since the Internal Revenue Code places many restrictions on this type of program.

Forfeitures - "Use it or Lose it"

Paying eligible expenses with before-tax dollars can mean significant tax savings. But you must be careful not to over-budget on your expected costs. Under IRS regulations, if you have any money left in your Dependent Care Account after March 15th following the end of the plan year and you didn't incur an expense during the plan year and grace period to offset it, you will lose the money in your account. But, if you budget wisely, you should not have any forfeitures. (Any forfeited money is used to reduce the cost of plan administration). ***Note: There is no refund of the remaining balance to you.***

No Contribution Changes Mid-Year Unless. . .

Once you decide how much to put into your account, *you cannot change your decision for the rest of the year, unless* you have a change in family status or there is a change that affects the cost of dependent care or the eligibility of dependent care expenses for reimbursement from your account.

Consider Summer Vacations

When calculating your annual expenses be sure to consider periods when your dependent will not be enrolled in daycare such as holidays or spring and summer vacations.

Social Security

Since you pay less FICA tax when you use a Dependent Care Account, you or your family may receive a slightly lower Social Security benefit when you retire, or if you become disabled or die.

IRS Rules

For more information about eligible expenses, see Publication 503, Child and Dependent Care Expenses, available from any IRS Forms Office by calling 1-800-TAX-FORM, or by visiting www.irs.gov and entering 503 into the search box in the left hand column.

Discrimination

Due to the tax advantages available under this Plan, certain highly paid employees are prohibited from disproportionately benefiting under the Plan. In some circumstances, it may be necessary to reduce contribution elections for such individuals. You will be notified if it is necessary to reduce/restrict your contribution amount to meet these requirements.

When Coverage Ends

Your Dependent Care Account participation ends:

- On the last day of the month in which you elect to stop participating (during an annual enrollment period or because of a change in family status, cost or coverage change)
- On the date you stop working for the company or you are no longer an eligible employee
- On the date the Plan is discontinued by the Company.

If your participation ends and you still have money in your Dependent Care Account, you have until March 31 of the following year to claim benefits from the account for expenses incurred to the end of the month you were a Plan participant.

Claim Procedures

Requesting a Reimbursement

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from a Flexible Spending Account. In addition, expenses which are incurred during one Plan Year can not be reimbursed during another Plan Year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as monthly. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least $25, except for reimbursement with respect to the last month of the Plan Year. Amounts below $25 will be accumulated and processed with future payments.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

For expenses incurred during the Plan Year, requests for withdrawal will be accepted and processed through March 31 of the following year.

Claims are Paid by:

United HealthCare
P.O. Box 981178
El Paso, TX 79998-1178
Fax (915) 781-1085
Telephone (877) 311-7849

In accordance with IRS regulations, amounts contributed to your HCSA or DCSA during the Plan Year but remaining in your account at the end of the processing period (March 31 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan Year. These amounts are forfeited and applied as directed by the Employer in accordance with the Plan.

Claim Denial Process

If your claim is denied for reimbursement, you will receive a written notice from United HealthCare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. United HealthCare will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, United HealthCare will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Questions and Appeals

If you have a question or concern about a claim reimbursement determination, you may informally contact a United HealthCare Customer Service representative before requesting a formal appeal. The Customer Service telephone number is shown on your ID card. If the Customer Service representative cannot resolve the issue to your satisfaction, you may request a formal appeal as described below.

If you wish to request a formal appeal of a denied claim for reimbursement, you should contact Customer Service to obtain the United HealthCare address where the appeal should be sent. Your appeal should be submitted in writing to that address and should include your name and identification number from the ID card, a description of the claim determination that you are appealing, the reason you believe your claim should be reimbursed, and any written information to support your appeal.

Your first appeal request must be submitted in writing to United HealthCare within 180 days after you receive the denial.

A qualified individual who was not involved in the initial benefit decision being appealed will be designated to decide the appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for reimbursement.

The first level appeal will be conducted and you will be notified by United HealthCare of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If you are

not satisfied with the first level appeal decision, you have the right to request a second level appeal from United HealthCare. Your second level appeal request must be submitted in writing to United HealthCare within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by United HealthCare of the decision in writing within 30 days from receipt of a request for a second level appeal.

United HealthCare has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.

PRETAX PREMIUM PLANS

For employees eligible for the listed individual coverages and not covered under a negotiated contract, the company pays all of the cost of Life Insurance, AD&D Insurance, Long Term Disability Insurance and Business Travel Accident Insurance, and most of the cost of health care coverage and Short Term Disability coverage.

You pay the full cost of Group Universal Life Insurance and Voluntary Accident Insurance. Your share of the cost for health care coverage, Short Term Disability coverage and Voluntary Accident Insurance will be paid on a pretax basis. You may also make salary reductions for eligible dependent care or medical expenses on a pretax basis if you enroll in the Flexible Spending Account (FSA) or the Health Savings Account (HSA).

- When you make payments through the Pretax Premium Plan, you will not pay income tax or FICA taxes on your contributions to the Plan for health care coverage, Short Term Disability coverage, Voluntary Accident Insurance, or salary reductions under the FSA or HSA if you are enrolled. Most states also allow your contributions to reduce your state income taxes.

- If your compensation is less than the Social Security wage base, your FICA taxes will be lower. This may slightly reduce your Social Security benefit.

- Pretax premiums (and salary reductions under the FSA or HSA if you are enrolled) will not reduce your compensation for purposes of your salary-related benefits—Life and AD&D insurance, Short Term Disability Benefits, Long Term Disability insurance, Business Travel Accident insurance, Group Universal Life Insurance, Voluntary Accident Insurance, and Capital Accumulation Plan (CAP/401k).

- Your cost for Group Universal Life Insurance will be paid on an after-tax basis.

The Pretax Premium Plan is a “cafeteria” plan under Section 125 of the Internal Revenue Code.

For employees subject to a collective bargaining agreement, the terms of your collective bargaining agreement apply.

CONTINUATION COVERAGE PRIVILEGE (COBRA)

Complying with the Consolidated Omnibus Budget Reconciliation Act (COBRA), the company permits covered employees and dependents to temporarily continue health coverage (through "COBRA coverage") at group rates if coverage ends for certain reasons. Covered participants may continue coverage under all health plans in which they were enrolled at the time of the event causing loss of coverage. This notice informs you of your COBRA rights and obligations. **Both you and your spouse should read this carefully.**

Qualifying Events

If you are a **covered employee**, you have a right to choose continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (unless due to gross misconduct).

If you are the **covered spouse** of an employee, you have the right to choose continuation coverage if you lose group health coverage due to one of the following qualifying events:

- Termination of your spouse's employment (unless due to gross misconduct) or reduction in your spouse's hours of employment;
- Death of your spouse;
- Your spouse becomes entitled to Medicare; or
- Divorce or legal separation from your spouse.

A **covered dependent child** of an employee has the right to continuation coverage if group health coverage is lost due to one of the following qualifying events:

1. Termination of the employee parent's employment (unless due to gross misconduct) or reduction in the employee parent's hours of employment;
2. Death of the employee parent;
3. The employee parent becomes entitled to Medicare;
4. Employee parent's divorce or legal separation;
5. Ceasing to be a "dependent child" as defined under this Plan.

If an **employee on a Family Medical Leave** terminates employment during the leave or fails to return from the leave, the employee and covered family members may be eligible to continue coverage for up to 18 months from the earlier of the last day of the leave period or the date of termination.

Maximum Period of COBRA Coverage

The maximum period of COBRA coverage is 18 months if you lose group health coverage because of a termination of employment or reduction in hours, or 24 months if you are on a uniformed services leave. For all other qualifying events, the maximum period of COBRA coverage is 36 months.

Second Qualifying Event: The 18-month maximum period can increase to 36 months for dependents who have another qualifying event during the first 18 months of COBRA coverage. If the second event is legal separation, divorce or loss of dependent child eligibility, you must notify Human Resources within 60 days of the second qualifying event to qualify for the additional coverage.

Disability Extension: The 18-month maximum period can increase to 29 months if the employee or a covered family member is totally disabled. To qualify for this additional coverage, during the first 18 months of COBRA coverage you must present proof that the Social Security Administration determined the individual to be totally disabled at the time of termination/hours reduction or any time during the first 60 days of COBRA coverage. You must provide Human Resources with a copy of the Social Security determination letter (indicating entitlement to Social Security disability benefits) within 60 days of the date of the determination and within the initial 18 month period. The extension will be available to the disabled individual and covered family members.

Notice Requirements

You or a family member has the responsibility to notify Human Resources **within 30 days** of a divorce, legal separation, death, or a child's loss of dependent status. If you fail to notify Human Resources during the 30-day notice period, family members who lose coverage will not be able to elect COBRA coverage. If Human Resources is properly notified, the company will send a COBRA Explanation and COBRA Election Notice to the affected individuals. Similarly, Human Resources will send you a notice of your right to elect COBRA upon the occurrence of any other qualifying event. You and your dependents must keep Human Resources informed of any change of address.

Electing COBRA Coverage

When you become eligible for COBRA coverage, you will have 60 days to complete and return your election form to Human Resources. This 60-day period runs from either the date active coverage ends or the date Human Resources provides you with notice of your right to elect COBRA coverage (whichever is later). If you do not return the COBRA election form by that date, you forfeit your right to COBRA coverage. Each covered participant has an independent right to elect COBRA coverage. Example: A covered spouse or child could elect COBRA coverage when an employee terminates, even if the employee does not elect coverage.

Paying For COBRA Coverage

If you elect COBRA coverage, you will have 45 days from the date of your election to make your initial payment. Your initial payment must include the cost of coverage from the date you lost coverage through the last full month before you pay. After your initial payment, premiums are due on the first day of each month. Premium payments (except the initial payment) are subject to a 30-day grace period. If your premiums are not sent by the specified due date, your coverage will end and you cannot reenroll in COBRA coverage. **It is your responsibility to make your payments on time. You will not receive reminders or past due notices (even for your initial**

payment.) . **Your payments should be sent to: ABX Air, Inc., 145 Hunter Drive, 2061-h Wilmington OH, 45177**

Generally, your cost for COBRA coverage will not be more than 102% of the applicable premium. However, during an 11-month disability extension (if the disabled individual is covered) the cost may increase to 150% of the applicable premium. "Applicable premium" means the total cost of coverage for active employees (the companies share plus your share). Current COBRA rates are included in COBRA enrollment materials and are not the same as active employee rates. Please contact Human Resources for rate information.

Changes to Your Coverage

COBRA coverage is identical to the coverage provided under the plan to similarly situated active participants or family members. Any Plan changes which apply to active participants will also apply to COBRA participants. Any increase in premiums, other than an increase due to a mid-year election change, which is effective for active participants' mid-year, will not apply to COBRA participants until the beginning of the next year. You have the same right to change benefits or add dependents as active participants. In general, added dependents do not have COBRA rights, so their coverage ends when yours does. However, the former employee's child born or adopted during the COBRA coverage period will have the same COBRA rights as a child who was covered at the qualifying event.

When COBRA Coverage Ends

Your COBRA coverage will end before your maximum period of COBRA coverage if:

1. You (employee, spouse, or child) don't pay the required premium on time
    - You (employee, spouse, or child) become entitled to Medicare (after the date of the COBRA election)
    - You (employee, spouse, or child) become covered under another group health plan as an employee, spouse, dependent child or otherwise (after the date of the COBRA election) unless the other plan limits or excludes coverage for your preexisting health condition
    - The company no longer provide any group health coverage, or
    - COBRA coverage is extended because of Social Security disability, but the disabled family member (employee, spouse, or child) loses entitlement to Social Security disability benefits. (Coverage will end on the last day of the month following the month Social Security determines the family member is no longer disabled. The first 18 months of COBRA coverage are available regardless of when Social Security disability benefits are lost.)

Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Social Security and the COBRA Disability Extension

A disabled qualified beneficiary may be entitled to an extension of up to 11 months to an 18-month COBRA coverage period, a total of up to 29 months. (See the "Maximum Period of COBRA Coverage" section above). Qualified beneficiaries are entitled to up to 18 months of COBRA continuation coverage for the qualifying events of termination of employment (including retirement) or reduction of work hours. If the disabled individual qualifies for the extension, it is

available to his or her family members covered under COBRA due to the same qualifying event as well.

To qualify for the disability extension, the disabled qualified beneficiary must be determined by the Social Security Administration to have been disabled as of the date of the qualifying event, or within the first 60 days of continuation coverage due to the event. The Social Security Administration will send a letter of disability determination which must be provided to the Benefits section of Human Resources within 60 days of the date of the determination and within the first 18-month continuation coverage period.

Social Security disability benefits begin after a waiting period of five full calendar months. The individual must have been disabled throughout this period. Being disabled means that the individual is so severely impaired, physically or mentally, that he or she cannot perform any substantial gainful work. The impairment must be expected to last at least 12 months or to result in earlier death.

The disabled individual should file an application for Social Security benefits as soon as possible after disability occurs. By filing promptly, the application can be processed during the waiting period. The application process can be started by a telephone call to the Social Security Administration (1-800-772-1213). A certified copy of the disabled individual's birth certificate is required.

Medicare generally becomes available automatically after the individual has been entitled to Social Security disability benefits for two years. There are special rules for end-stage renal disease (kidney failure).

For a disabled individual, the 29-month COBRA continuation coverage period should make medical coverage available during the five-month waiting period for Social Security benefits and the 24-month waiting period before Medicare eligibility.

FAMILY MEDICAL LEAVE

The Family and Medical Leave Act of 1993 (FMLA) allows eligible employees to take up to 12 weeks of unpaid, job protected leave for certain family and medical reasons during any 12-month period. When an FML is taken for a period of 12 weeks or less, you will be returned to your same or an equivalent position for which you are qualified.

The company uses the "rolling year" method for Family Medical Leave (FML) eligibility calculations. A rolling 12-month period is measured backward in time from the date an employee first uses any FML.

Eligibility

To be eligible for Family Medical Leave, you must:

- Have worked for the company for at least one year, and
- Have worked at least 1,250 hours over the previous 12 months

Basic Leave Entitlement

You may request a Family Medical Leave for any of the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth
- To care for your child after birth, or placement for adoption or foster care
- To care for your spouse, child, or parent who has a serious health condition
- To care for a family member (spouse, child, parent, or next of kin) who is injured while serving on active military duty
- For a serious health condition that makes you unable to perform your job

FML will be unpaid except in certain circumstances you may use sick leave or vacation time during your leave (see Pay While On Family Medical Leave below).

Military Family Leave Entitlement

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

30-Day ADVANCE NOTICE AND MEDICAL CERTIFICATION

You are required to provide advance notice and medical certification of your leave. Your FML request may be denied if these requirements are not met.

- You must provide 30 days advance notice to your manager when the leave is foreseeable.
- You must provide medical certification to support your FML request because of a serious health condition. The company may require a second or third opinion (at the companies expense) and a fitness for duty report to return to work. Medical certification must be provided within 15 days after the FML form is sent to you or the company may delay the commencement of your leave until certification is submitted.

Application for Family Medical Leave

If you are considering a family medical leave, contact Human Resources for an FML application form. You are required to provide your manager with 30 days advance notice that you want to take an FML, or tell your manager immediately if your leave is caused by a sudden, unexpected event.

Restriction

Key Employees

For Family Medical Leave purposes, you are a key employee if you are a salaried employee and among the highest paid 10 percent of employees within 75 miles of your worksite at the time you request the leave.

A key employee is entitled to all the benefits of the FMLA with the exception of job restoration in the event of the birth of a child, placement of an adopted or foster child, and the serious health condition of a family member.

If you take approved medical leave for your own serious health condition, you will be reinstated to your prior position or an equivalent position for which you are qualified, if you return to work within 8 weeks. The company will notify you at the start of your leave if there will be restrictions on reinstatement

Pay while on Family Medical Leave

FML is an unpaid leave of absence. However, in certain circumstances paid time may be substituted for unpaid time during an approved FML:

- For birth or placement of an adopted or foster child or the serious health condition of a spouse or parent: you may *elect* to use earned vacation and/or sick leave hours while on FML.
- For your own serious health condition or for the care of a sick child: Accrued sick leave hours *must* be used. You may *elect* to use earned vacation time.

Effect of Family Medical Leave on Your Benefits

Medical, Dental, and Vision Plans

The company will maintain any medical, dental and vision coverage which you had before you went on family or medical leave. You must continue to pay your share of the premium, if any.

If you return to work following a qualified Family Medical Leave, you may change your coverage election as described in the "Family/Work Qualified Status Changes" section of each of these plans.

Life Insurance, AD&D Insurance, Short Term Disability, and Long Term Disability Plans

The company will maintain any Life, AD&D, Short Term Disability and Long Term Disability Insurance coverage you had under these Plans before you went on family or medical leave. You must continue to pay your share of the premium, if any.

Business Travel Accident Insurance Plan

When you return to work, the company will reinstate any Business Travel Accident Insurance coverage you had under this Plan before you went on family or medical leave.

Group Universal Life Insurance

You may continue any Group Universal Life Insurance which you had under this Plan for yourself and your dependents before you went on family or medical leave. You must continue to pay the premium to maintain coverage. Marsh@WorkSolutions will send a quarterly billing to your home address.

If you elect not to continue coverage during your leave, upon your return you will be eligible to reenroll for the amounts of Group Universal Life Insurance which you had under this Plan for yourself and your dependents immediately prior to your leave. You will not be required to provide additional evidence of good health to reinstate your prior amounts of coverage.

If you have a balance in your cash accumulation account when you choose not to continue coverage, it must be used to obtain paid-up insurance or distributed to you as cash. If the cash accumulation value is distributed to you as cash, it will be subject to tax to the extent it exceeds your investment in the contract.

Voluntary Accident Insurance

You may continue any Voluntary Accident Insurance which you had under this Plan for yourself and your dependents before you went on family or medical leave. You must continue to pay the premium to maintain coverage.

If you elect not to continue coverage during your leave, upon your return you will be eligible to reenroll for the amounts of Voluntary Accident Insurance which you had under this Plan immediately prior to your leave.

New York's Paid Family Leave

New York's Paid Family Leave provides job-protected, paid time **off for employees who work in New York** so they can:

- **Bond** with a newly born, adopted or fostered child
- **Care** for a close relative with a serious health condition, or
- **Assist** with family situations when a family member is deployed abroad on active military service

Participants can continue their health insurance while on leave and are guaranteed the same or comparable job after their leave ends. To keep their health benefits participants must continue to pay their premium while on Paid Family Leave.

Benefits

Time. Eligible employees can take Paid Family Leave for up to eight weeks in 2018. Leave can be taken either all at once or in full-day increments. You may take the maximum time-off benefit in any given 52-week period.

Pay. Benefits are a percentage of participants average weekly wage, capped at that same percentage of the New York State Average Weekly Wage, as calculated annually by New York State's Department of Labor.

Eligibility

All eligible employees are entitled to participate in Paid Family Leave.

- **Full-time employees:** Employees who work in New York a regular schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment
- **Part-time employees:** Employees who work in New York a regular schedule of less than 20 hours per week are eligible after working 175 days, which do not need to be consecutive

To enroll or to receive more information contact your Human Resources Department

Uniformed Services Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) allows eligible employees to take unpaid, job protected leave to perform uniformed service (service in the U.S. Armed Forces, National Guard or Commissioned Corps of the Public Health Department). You may continue health coverage (as described below) for up to the shorter of 18 months or the period of your service under USERRA).

When you return from leave, you will be reinstated to your same or an equivalent position for which you are qualified, as long as your service did not exceed 5 years and you notify the company within a reasonable timeframe upon completion of your leave. A "reasonable" timeframe is dependent on your length of service:

- Less than 31 days: by the beginning of the first regularly scheduled work period after the end of the duty, plus travel time and an 8 hour rest period

- 31 to 180 days: Application for reemployment must be submitted within 14 days after completion of duty.

- 181 days up to 5 years: Application for reemployment must be submitted no later than 90 days after completion of military duty.

- Service connected injury or illness: Reporting deadlines are extended for up to 2 years.

Applying for Uniformed Services Leave

If you are considering a uniformed service leave, you should contact your manager or the Benefits department in Human Resources.

Effect of Uniformed Services Leave on Your Benefits

Medical, Dental, and Vision Plans

* If your uniformed services leave is less than 31 days, your medical, dental and vision coverage continues during the leave. You must continue to pay your share of the premium to maintain coverage for you and your dependents.
* If your uniformed services leave is 31 days or more, your medical, dental and vision coverage remains in effect until the end of the month in which you last worked. You may enroll in the health care COBRA continuation coverage program at your expense.

When you return to work, the company will reinstate any medical, dental and vision coverage which you had under this Plan before you went on uniformed services leave. Your coverage will be effective the day you return to work if you return directly from a qualified uniformed services leave.

If you return to work following a qualified uniformed services leave, you may change your coverage election as described in the “Family/Work Status Changes” section of each of these plans.

Life Insurance, AD&D Insurance, Short Term Disability, and Long Term Disability Plans

During a uniformed service leave of absence:

* Your Life Insurance coverage remains in effect until the end of the month in which you last worked. You may be eligible to convert all or part of your Life Insurance coverage to an individual life insurance policy. See “Conversion Privilege” in the Life Insurance section for details.
* Your AD&D Insurance coverage remains in effect until the end of the month in which you last worked.
* Your Short Term Disability coverage ends on the day you begin a uniformed services leave.
* Your Long Term Disability coverage ends on the day you begin a uniformed services leave.

When you return to work, any Life, AD&D, Short Term Disability and Long Term Disability Insurance coverage you had under these Plans before you went on uniformed services leave will be reinstated. Your coverage will be effective the day you return to work if you return directly from a qualified uniformed services leave.

Business Travel Accident Insurance Plan

When you return to work, any Business Travel Accident Insurance coverage you had under this Plan before you went on uniformed services leave will be reinstated.

Group Universal Life Insurance

You must continue to pay the premium to maintain coverage during your leave. Marsh@WorkSolutions will send a quarterly billing to your home address.

If you elect not to continue coverage during your leave, upon your return the amounts of Group Universal Life Insurance, which you had under this Plan for yourself and your dependents immediately prior to your leave, will be reinstated. You will not be required to provide additional evidence of good health to reinstate your prior amounts of coverage.

If you have a balance in your cash accumulation account when you choose not to continue coverage, it must be used to obtain paid-up insurance or distributed to you as cash. If the cash accumulation value is distributed to you as cash, it will be subject to tax to the extent it exceeds your investment in the contract.

Voluntary Accident Insurance

During a uniformed services leave of absence your Voluntary Accident Insurance coverage remains in effect until the end of the month in which you last worked.

When you return to work, any Voluntary Accident Insurance which you had under this Plan for yourself and your dependents before you went on uniformed services leave will be reinstated.

Retirement Plans

Your USERRA rights under the Retirement Income Plan, Profit Sharing Plan, Defined Contribution Retirement Account and Capital Accumulation Plan will be discussed in the section below titled "Other Information on Your Retirement Plans."

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Company provides medical, dental and vision coverage to employees' dependent children as long as they meet the eligibility requirements of the plans. In accordance with federal law, the Company also provides medical, dental and vision coverage to certain dependent children (called alternate recipients) if the Company is directed to do so by a Qualified Medical Child Support Order (QMCSO).

Under this law, courts or authorized state agencies may require an employee, in certain events such as a divorce, to provide medical, dental and vision coverage to a child who might not otherwise be covered. In addition to requiring the employee to provide coverage for the child, the law authorizes the Company to take the applicable payroll deduction.

- A QMCSO is a "medical child support order" that is "qualified" under the ERISA requirements.

- A medical child support order:

  Is any decree, judgment, or order (including approval of settlement agreement) from a state court of competent jurisdiction or a state agency with jurisdiction over the child's support

  Recognizes the child as an alternate recipient for plan benefits

  Provides, based on a state domestic relations law (including a community property law), for the child's support or health plan coverage

  Specifically refers to the plan which will provide coverage.

- A medical child support order is "qualified" if it specifies:
    - The employee's name and last known address
    - Each alternate recipient's name and address
    - A reasonable description of the type of coverage the alternate recipient is entitled to or the manner in which the type of coverage is to be determined
    - The coverage effective date
    - How long the child is entitled to coverage
    - Each plan subject to the order.

- When the Company receives a medical child support order, it will promptly notify both the employee and the alternate recipient that the order has been received and what procedures the Plan will use to determine if the order is qualified. Then the Company will decide, based on the Plan's written procedures and within a reasonable period, whether the order is qualified. Once the decision is made, the Company will notify the employee and alternate recipient by mail.

- If the medical child support order is a QMCSO, the Company will notify the employee and each alternate recipient specified in the QMCSO of the Plan's procedures, and allow the alternate recipient an opportunity to designate a representative to receive copies of any notices due under the QMCSO.
    - Coverage for the alternate recipient will commence on the date specified in the QMCSO. This is not necessarily the first day of a calendar month.
    - The employee is allowed to make a new health care coverage election if necessary to accommodate a QMCSO.
    - If a dependent contribution is required, specific authorization from the employee is not required for the payroll deduction to be established. Any applicable payroll deduction will

be taken retroactively on an after-tax basis to the alternate recipient's effective date. Subsequent deductions will be taken on a pre-tax basis.

- The Plan pays the provider if the claim is assigned.

- If the medical child support order is not a QMCSO, the Company will notify the participant and each alternate recipient within a reasonable period of the specific reasons that the medical child support order does not qualify as a QMCSO and the procedures for submitting a corrected medical child support order

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Certificate of Coverage

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), if you and/or a covered family member lose coverage under a company sponsored health plan option you will be sent, within a reasonable period of time, a "Certificate of Coverage".

This is an important document and you should keep it in a safe place. The Certificate of Coverage will be important proof of coverage under one plan that you may need to reduce any subsequent plan's pre-existing condition limitation period which might otherwise apply to you and/or your family.

Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information (PHI), includes virtually all individually identifiable health information held by the Plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the following plan: ABX Air, Inc. Cafeteria Plan #501 which includes the following HIPAA covered self-insured benefits: medical, dental and vision. The plans covered by this notice may share health information with each other to carry out Treatment, Payment, or Health Care Operations (TPO). These plans are collectively referred to as the Plan in this notice, unless specified otherwise. References to ABX Air, Inc. as Plan Sponsor includes the following participating employers: Air Transport Services Group, Inc., ABX Air Inc., ABX Material Services, Inc., Airborne Maintenance & Engineering Services, Inc., Airborne Global Solutions, LGSTX, and CAM.

The Plan's duties with respect to health information about you

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

How the Plan may use or disclosure your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment activities, and Health Care Operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share health information about you with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

- Health care operations include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to review the effectiveness of wellness programs.

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan may share your health information with the company.

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to the company for plan administration purposes. The company may need your health information to administer benefits under the Plan. The company agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources, Labor Relations, and Finance staff are the only employees who will have access to your health information for plan administration functions. Here is how additional information may be shared between the Plan and the company as allowed under the HIPAA rules:

- The Plan, or its Insurer or HMO, may disclose "summary health information" to the company if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information have been removed.
- The Plan, or its Insurer or HMO, may disclose to the company information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that the company cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the company from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the

	individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the Plan has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Plan has already made.

Your individual rights

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

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

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

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

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations. If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested; or
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for up to 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information. The Plan also may charge reasonable fees for copies or postage. If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your

request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings). If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

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

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below. You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

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

Changes to the information in this notice

The Plan must abide by the terms of the Privacy Notice currently in effect. This notice takes effect on September 1, 2003, which is the effective date of the Cafeteria Plan. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised Privacy Notice. Revisions will be provided to Plan participants in conjunction with periodic benefits updates that are sent to either the work location or home address.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, you may contact the HIPAA privacy unit of the medical, dental or vision plan provider or you may contact the HIPAA compliant manager in your Benefits Department.

Contacts

For more information on the Plan's privacy policies or your rights under HIPAA, contact the Benefits Department at (937) 366-2157.

The following is a list of key offices you may need to contact to exercise your rights under the HIPAA privacy rule for different benefit plans sponsored by the company.:

Medical Plan – United Health Care	United Healthcare Customer Service-Privacy Unit PO Box 740815 Atlanta, GA 30374-0815	Phone: 1-888-350-5607 Group #703940
Dental Plan – MetLife Dental	MetLife Attn: HIPAA Privacy Unit P.O. Box 981282 El Paso, TX 79998	Phone: 1-800-942-0854 Group #302073
Vision Plan – EyeMed Vision Care	EyeMed Vision Care Attn: HIPAA privacy Unit PO Box 498488 Cincinnati, OH 45249-8488	Phone: 1-866-723-0513 Group #9681974

RETIREMENT PLANS

Overview

ABX Air, Inc. (also referred to in this summary as the "Company") is committed to helping you meet your retirement income needs. To help with this important goal, the Company offers the Capital Accumulation Plan. The Capital Accumulation Plan and Social Security work together to provide you long-term financial security when you retire.

Additionally, certain employees hired prior to 1/1/2000 may have an account balance under the Profit Sharing Plan and certain employees hired prior to 9/1/2005 may have an account balance under the Retirement Income Plan. Starting with the year 2000, Company contributions to the Profit Sharing Plan ceased. Company contributions were redirected to significantly increase the Retirement Income Plan benefit formula for all eligible employees. In September of 2005, the Retirement Income Plan was frozen to all new entrants; and in January of 2010, it was frozen for all participants. In January of 2010, those formerly eligible for the Retirement Income Plan were allowed to participate in the Plan.

The following summary highlights the nature of the Plan.

The **Plan** allows you to:

- Save part of your current income (on a pre-tax basis or an after-tax (Roth) basis) for retirement in a tax-deferred investment account
- For certain employees who begin participating in the Plan on or after January 1, 2016, receive Company matching contributions
- For certain employees who participated in the Plan prior to January 1, 2016, receive a deferred contribution paid by the Company
- Rollover money from another eligible retirement plan

The **Social Security Program** provides a base level of retirement benefits for all employees and is paid for equally by you and the Company through Social Security (FICA) payroll taxes.

Qualified Plans

This is a brief description of the Company sponsored retirement plans and how each plan operates. This information is a summary only. Due to the complexity of laws and regulations underlying programs such as these, the official plan document of each plan is the controlling document and must govern in all cases.

All qualified retirement plans are strictly governed by federal law that specifies certain minimum requirements affecting how the plans are set up and operated, including the rights of participating employees (see "Statement of ERISA Rights" section of this booklet).

Retirement Income Plan

Participation

The Retirement Income Plan (referred to as "Retirement Income Plan" throughout the remainder of this document) was closed to new entrants on September 1, 2005 and accrual of benefits ceased for all participants on January 11, 2010.

Your Benefits

Your benefit under the Retirement Income Plan is paid for by the Company and determined under the formula (A times C) + (B times D) where the terms have the following meaning:

A. The number of the participant's years of credited service up to a maximum of 25 years

B. The number of the participant's years of credited service which exceeds 25 years

C. An amount equal to 2% of the participant's average monthly compensation

D. An amount equal to .5% of the participant's average monthly compensation

Your benefit shall be determined as of January 11, 2010. Years of service or average monthly compensation earned after January 11, 2010 will not be counted in determining the participant's accrued benefit. You are credited with a year of credited service for each year, and fraction thereof, of employment with the Company. Your average monthly compensation is your compensation for the 5 highest consecutive years during your last 10 years of employment, divided by 60.

If you were hired before 1/1/2000 and have a balance in the ABX Profit Sharing Plan, your overall retirement benefit level is determined by the Retirement Income Plan formula and is paid through a combination of the Profit Sharing Plan and the Retirement Income Plan. In general, Profit Sharing Plan benefit offsets the Retirement Income Plan benefit. Specifically, your Retirement Income Plan benefit level will be actuarially adjusted to reflect the value of any benefits provided by your Profit Sharing account at the time you separate from service.

Example Employee with a Vested Profit Sharing Balance	
Benefit determined by the Retirement Income Plan Benefit Formula at normal retirement age 65	$1,250/mo
1) Amount to be paid from the Profit Sharing Plan (Your PS account balance converted to monthly amount)	- $750/mo
2) Amount remaining to be paid from the Retirement Income Plan	= $500/mo.

If your Profit Sharing account balance exceeds the benefit level produced by the Retirement Income Plan formula, you would receive your Profit Sharing account balance and no benefit would be payable from the Retirement Income Plan.

More information as to how the Profit Sharing balance offsets the Retirement Income Plan benefit can be found in prior years Employee Handbooks or you may contact your Retirement Benefit Representative in the Human Resources department.

Payment of Benefits

Benefits from the Retirement Income Plan are paid after you leave employment with the Company under one of the following circumstances:

Normal Retirement: Your Normal Retirement Age is the attainment of age 65. Your retirement benefits will be paid no later than 60 days after the close of the calendar year in which you retire under the Retirement Income Plan's normal retirement provisions, provided you complete the required paperwork.

Postponed Retirement: You can continue to work after you reach age 65 and defer payment of your benefits. Your retirement benefits will be paid to you when you actually retire. However, your additional pay and service after January 11, 2010 will not be recognized under the Retirement Income Plan's benefit formula.

Early Retirement: You may retire as early as age 55 if you have 10 years of service with the Company. Since early retirement means you are likely to receive benefits for a longer period of time, your retirement benefit from the Retirement Income Plan will be adjusted to account for the extended payment period. Specifically, annuity amounts from the Plan will be adjusted downward at a rate of ½ % for each month (6% per year) that you elect to commence payment of your annuity prior to your normal retirement age. If you are considering early retirement, you may want to contact your Benefit Representative in Human Resources for further details.

- If you leave employment with the Company at any age prior to age 65 and you have less than 10 years of service, annuity payments to which you may be entitled from the Retirement Income Plan can be paid at your normal retirement age of 65.

- If you leave employment with the Company prior to age 55 and you have 10 years of service or more, annuity payments to which you may be entitled from the Retirement Income Plan can be paid at any time after you reach the early retirement age of 55.

- Employees hired prior to 1/1/2000 may have a vested Profit Sharing account balance which can be paid prior to the above retirement dates. See the Profit Sharing Plan-Payment of Benefits section.

Benefits upon Death, Disability or Termination of Employment

Death. If you die after becoming eligible for early retirement and before you actually retire and you are married, a survivor benefit (calculated under the Plan's early retirement rules and in the form of a 50% joint and survivor annuity) will be paid to your spouse.

If you are married and die before becoming eligible for early retirement, Plan benefits are determined as if you terminated on the day of your death, but elected to retire on your earliest retirement age, then died the next day.

If you are not married or fully vested at the time of your death, no benefits will be paid from the Plan.

Disability. If you become permanently disabled while employed by the Company, your Retirement Income Plan benefits will be determined as if you left the Company for any other reason. Permanent disability will be established by Social Security certification.

Termination of Employment. If you terminate your employment at the Company or you are fired, you are eligible to receive the vested portion of your retirement benefits. If you are in a lay-off status, your vested retirement benefits cannot be paid out until you resign employment.

If you are eligible for Retirement Income Plan benefits, payment will be deferred until you reach normal retirement age 65. However, you may elect to take a reduced benefit prior to age 65, but no earlier than age 55 with at least 10 years of service (See "Early Retirement" under "Retirement Income Plan-Payment of Benefits" section).

If the lump sum value of the Retirement Income Plan benefit is $1,000 or less, your benefit will be cashed out and mailed to you after you leave employment with the Company.

If you leave the company prior to retirement and you have a benefit payable to you, remember to update your address with the Human Resources Department. This will enable the company to contact you about benefits that are due to you.

Form of Payment

Benefits from the Retirement Income Plan are paid in one of the following forms:

Unmarried Participants. If you are not married when your benefit payment commences, you will be paid a single life annuity. A single life annuity pays benefits for your lifetime, with no further benefits paid to any beneficiary after your death.

Married Participants. If you are married when your benefit payment commences, you will be paid a 50% joint and survivor annuity. A joint and survivor annuity pays you a benefit for your lifetime and pays a pre-selected percent of your benefit to your spouse after your death for the lifetime of your spouse. You can elect an annuity form other than a 50% joint and survivor annuity provided you obtain written notarized consent from your spouse. Your spouse's consent must be in writing, must acknowledge the effect of your election and must be witnessed and notarized by a notary public or a plan representative. Options are: Single Life Annuity or 100%, 75% or 50% Joint and Survivor Annuity.

If the amount of your monthly benefit is less than $250.00 at your date of commencement, you may elect to cash out your benefit in a single lump sum payment rather than receive annuity payments.

Time of Payment

Once you are eligible to start your benefit, please contact the Human Resources Department. You will receive a "Distribution Election for Retirement Income Plan" form, along with other necessary forms to start your benefit. Complete the forms and return it to the Human Resources Department.

If you are entitled to a benefit, your first monthly payment from the Retirement Income Plan will begin within approximately 60 days of your elected date of commencement with all payments retroactive to the start date.

Your start date is the later of: the date you elect, the date you are first eligible for an annuity, or the first day of the month following your application processing date.

Vesting

The term "vesting" or "vested" means your percentage of ownership in an employer provided retirement benefit. If you are not 100% vested, you will not receive the value of your benefits.

You become 100% vested in your Retirement Income Plan benefit after you are credited with 5 years of service with the Company. You are credited with one year of service for vesting purposes for each year of employment during which you complete at least 1,000 hours of service. *If you terminate employment with the Company prior to being credited with 5 years of service, your benefit under the Retirement Income Plan will be forfeited.*

If you terminate employment due to attainment of age 65 (or more), your account automatically becomes 100% vested regardless of your years of service.

In general, all service with ABX Air, Inc. Companies will be credited for vesting purposes, but special offsets for any prior Profit Sharing distributions (see above) or other retirement benefits may apply.

If you are rehired before you incur 5 consecutive one-year breaks in service, your forfeited benefits may be reinstated (restored).

A one-year break in service is each 12-month period commencing with the anniversary date of your employment during which you are credited with less than 501 hours. For determining a break in service, you may receive credit for hours not worked or for paid or unpaid absences such as: vacations, holidays, illness, jury duty, maternity leave, etc. Be sure to notify the Human Resources Department if you are rehired by any eligible company.

Funding of Your Benefits

Your benefits under the Retirement Income Plan are paid by the Company. You are not permitted or required to contribute to the Retirement Income Plan.

Notify the Company if You Move

If you leave the company and do not immediately request a distribution of your account, remember to update your address with the Human Resources Department. This will enable you to be contacted with information on your benefit.

Profit Sharing Plan

Participation

Prior to 1/1/2000 certain employees may have been eligible to receive benefits under the Profit Sharing Plan. The following information is specific to those participants that still have an account balance under that Plan. For additional information, please refer to your employee benefits handbook from 1999 or prior years, or contact Human Resources.

Your Benefits

Your benefit under the Profit Sharing Plan is your account balance. However, if you were hired before 1/1/2000 and have an account balance in the Profit Sharing Plan, your overall retirement benefit level is determined by the Retirement Income Plan formula and is paid through a combination of the Profit Sharing Plan and the Retirement Income Plan. In general, you Profit Sharing Plan benefit offsets the Retirement Income Plan benefit. Specifically, your Retirement Income Plan benefit level will be actuarially adjusted to reflect the value of any benefits provided by your Profit Sharing Plan benefit at the time you separate from service.

Your Profit Sharing Plan account balance is credited quarterly with your share of the investment earnings gains/losses and plan expenses. Your account may also receive a proportionate share of funds that have been forfeited by participants who have left the Company before being fully vested (See Vesting section below).

Payment of Benefits

When you leave employment with the Company, you may elect to receive distribution of your Profit Sharing Plan account balance in any of the forms of payment discussed below.

The full value of your Profit Sharing Plan account can be paid to you or your beneficiary under any of the following circumstances:

Death. Your Profit Sharing Plan account automatically becomes 100% vested if your death occurs while you are an employee. It will be paid to your surviving spouse or your designated beneficiary if you have no surviving spouse or if your spouse consented to a different beneficiary.

Disability. If you become permanently disabled, your benefits will be determined as if you left the Company for any other reason (see below) except, your Profit Sharing Plan account automatically becomes 100% vested regardless of your years of service. Permanent disability will be established by Social Security certification.

Termination of Employment. If you leave employment with the Company or are fired, you are eligible to receive your Profit Sharing Plan account balance if you are 100% vested. If you are in a lay-off status, your Profit Sharing Plan account balance cannot be paid out until you resign employment.

Vested Profit Sharing account balances shall be paid under the same options available to retirees. Your vested account balance in the Profit Sharing Plan will be based on the market value of your account at the end of the quarter prior to termination.

Form of Payment

You can elect to receive your benefits from the Profit Sharing Plan in one of the following forms:

Lump Sum. You may choose a single cash payment equal to the fair market value of your Profit Sharing Plan account.

Annuity. You may choose to have your Profit Sharing Plan account paid to you under one of the annuity options described under the Retirement Income Plan. When you leave employment take the opportunity to discuss the payment options with Employee Benefits in the Human Resources Department before you make your selection.

If you are married, your spouse must consent to the distribution in the form of a lump sum or a single life annuity.

Time of Payment

You may request a "Distribution Election for Profit Sharing Plan" form after you leave the Company. Complete this form in full and return it to Employee Benefits in the Human Resources Department.

Lump Sum Distribution. If you choose to have your Profit Sharing Plan account paid to you in a lump sum, your application will be processed as of the last day of the month following receipt of your application by the Benefits Department in Human Resources. Lump sum distributions are processed as soon as administratively possible after your application is processed. The normal processing time is 5 to 6 weeks after your application processing date.

> Example: You return your completed application form to Human Resources by 2/20/17. Your processing date is 2/28/17 and your expected distribution date is 5-6 weeks later.

Please be aware that if the value of your Profit Sharing Plan account is more than $1,000, these funds cannot be distributed unless your distribution election forms are completed and returned.

The Company will automatically distribute your Profit Sharing Plan account if it has a balance of $1,000 or less if no distribution election form is received. Under $1,000 distributions occur once a year, usually in the calendar year following the year of termination and participants who are affected will receive notification of the payout. Any cash distribution that is not rolled over to an IRA or an employer's eligible retirement plan will be subject to a 20% federal tax withholding.

Annuity Payments. If you choose to have your Profit Sharing Plan account paid to you as an annuity, your monthly annuity payment will begin within 60 days of your elected date of commencement with all payments retroactive to the start date. Your start date is the later of: the date you elect, the date you are first eligible for an annuity, or the first day of the month following your application processing date. You must be age 65, or age 55 with 10 years of service, to be eligible to elect an annuity.

Vesting

The term "vesting" or "vested" means your percentage of ownership in an employer provided retirement benefit. If you are not 100% vested when you leave the Company, you will not receive the value of your Profit Sharing Plan benefits.

You become 100% vested in your Profit Sharing Plan account after you complete 3 years of service with the Company and certain of its affiliates. You are credited with one year of service for vesting purposes for each year of employment during which you complete at least 1,000 hours of service (400 hours of

service for Crew Members). If you terminate employment due to attainment of age 65 (or more), disability or death, your account automatically becomes 100% vested regardless of your years of service.

If you leave the Company before you are 100% vested in your Profit Sharing Plan account, you forfeit your account. Profit Sharing Plan forfeitures are redistributed to remaining Profit Sharing Plan participants.

If you receive a distribution of your Profit Sharing Plan account and are rehired before you incur 5 consecutive one year breaks in service, your forfeited amounts may be reinstated (restored) if you repay the full amount of your Profit Sharing Plan account distribution. A one-year break in service is the 12-month period beginning on the anniversary date of your commencement of employment during which you are credited with less than 501 hours of service (201 hours for a Crew Member). For determining a break in service for participants other than Crew Members , you may receive credit for hours not worked or for paid or unpaid absences such as: vacations, holidays, illness, jury duty, maternity leave, etc. Be sure to notify Human Resources if you are rehired by any eligible company.

Investment of Your Account

The Profit Sharing Plan establishes a general investment fund in which Company contributions are invested in investments selected by the Retirement Advisory Committee.

Special Retirement Fund Investment Option. The Company recognizes the different investment needs and concerns for those participants that are nearing retirement. Profit Sharing Plan participants nearing retirement are typically more concerned with short term investment strategies and preserving their account balance than with achieving a high rate of return. The Special Retirement Fund option was established to allow participants to incorporate this conservative investment strategy into their overall retirement planning.

At the time of the production of this handbook, the Special Retirement Fund is comprised of money market securities. Investments are managed by the Northern Trust Company and are overseen by the Retirement Advisory Committee. The investment fund is determined by the Retirement Advisory Committee and may be changed at any time.

To be eligible to have your Profit Sharing Plan account invested in this special option, you must:

- Have completed 5 years of service with the Company and have attained age 55.
- Declare your intent to retire within 18 months.

If you meet the eligibility criteria above and wish to elect this option, contact your Employee Benefits Department to obtain the Special Retirement Fund Option Request Form. This form should then be completed and returned to the Benefits Department.

Important: *Once your account balance is moved to the Special Retirement Fund you are unable to move it again.* This option is designed for employees who are planning to retire within the next 18 months. Therefore, this decision must be carefully evaluated prior to completing the form. If you do not retire within 18 months, the Retirement Advisory Committee may transfer your account balance out of the Special Retirement Fund.

Requests will be effective the first day of the quarter following receipt of the signed form by the Benefits Department in Human Resources. For example, if the form was received by Benefits on December 10, it will be effective January 1. As an alternative, you may request an effective date which is in the future. For example, you may complete and return the form to Benefits on December 10 and request an effective date of April 1. Retroactive effective dates cannot be elected.

A special earnings rate is applied to your account during the first quarter it is transferred to the Special Retirement Fund. Your account will earn interest at the short-term money market rate from the first day of the quarter until the date it is actually transferred to the Special Retirement Fund. As soon as the transfer is made, your account will be credited with actual earnings from the Special Retirement Fund.

Notify the Company if You Move

If you leave the company and do not immediately request a distribution of your account, remember to update your address with the Human Resources Department. This will enable you to be contacted with information on your benefit.

Capital Accumulation Plan

Overview

The Capital Accumulation Plan is a qualified retirement plan commonly referred to as a 401(k) plan. A 401(k) plan like ours creates individual accounts for you and each participant. Money goes into your account. As a participant, you may elect to contribute a portion of your compensation to the Capital Accumulation Plan (401(k) Contributions). In addition, the Company may make additional contributions to the Capital Accumulation Plan on your behalf. Information regarding the Capital Accumulation Plan, including eligibility, participation, contributions, investments, vesting and distributions are described on the following pages.

Eligibility

You are eligible to make 401(k) Contributions to the Capital Accumulation Plan if:

- You have completed 60 days of service with any eligible company
- You are a regularly scheduled full-time or part-time employee
- You are not covered by a union-negotiated agreement unless that agreement specifically requires participation in this plan
- You are not employed as a special project worker
- You are not covered under any other 401(k) plan sponsored by the Company

Automatic Enrollment

If you are a new employee and you satisfy the eligibility conditions listed above, the Company will automatically enroll you in the Capital Accumulation Plan upon completion of 60 days of service. It is not necessary for you to complete an enrollment form.

Your Benefits—401(k) Contributions

401(k) Contributions. You can elect to make 401(k) Contributions after 60 days of employment. When you elect to make 401(k) Contributions you authorize the Company to reduce the compensation you would regularly receive by a specified percentage. This percentage is then deducted from your paycheck as soon as administratively possible after you elect to make 401(k) Contributions and is deposited in your Capital Accumulation Plan account. You may elect to make Pre-Tax 401(k) Contributions and/or Roth 401(k) Contributions to the Capital Accumulation Plan.

- **Pre-Tax 401(k) Contributions**. You do not pay federal income taxes (or, in many states, state income taxes) on compensation you contribute to the Capital Accumulation Plan as Pre-Tax 401(k) Contributions for the year in which you make the contribution. Instead, your Pre-Tax 401(k) Contributions and earnings on your Pre-Tax 401(k) Contributions are taxable when they are distributed from the Capital Accumulation Plan.

Example: Tax-Deferral with Pre-Tax 401(k) Contributions		
	With Pre-Tax 401(k) Contribution	**Without Pre-Tax 401(k) Contribution**
Your annual salary	$25,000	$25,000
If you contribute 6% of compensation to the plan	- 1,500	- 0
Your taxable income is	$23,500	$25,000
x federal income tax rate of 15%	x 15%	x 15%
Your estimated federal taxes	$ 3,525	$ 3,750
TAXES DEFERRED: (3,750 - $3,525)	$ 225	

*Note: Some states and localities may impose income taxes on 401(k) Contributions when made.

- **Roth 401(k) Contributions**. You pay federal income taxes and state income taxes on compensation you contribute to the Capital Accumulation Plan as Roth 401(k) Contributions for the year in which you make the contribution. However, your Roth 401(k) Contributions are not taxable when they are distributed from the Capital Accumulation Plan. In addition, if certain conditions are satisfied, the earnings on your Roth 401(k) Contributions are also not taxable when distributed form the Capital Accumulation Plan.

  There are two requirements that must be satisfied for the distribution of your Roth 401(k) Contributions and earnings on your Roth 401(k) Contributions to not be taxable:

  - Distribution must be made at least 5 years after the first day of the calendar year in which you first made Roth 401(k) Contributions to the Capital Accumulation Plan. Special rules apply for determining this 5-year period if you make Roth Rollover Contributions.
  - Distribution must be a "qualified distribution." A "qualified distribution" is a distribution made to you after you reach age 59 ½ or become disabled or made to your beneficiary after your death.

Once you designate a 401(k) Contribution as either a Pre-Tax or Roth 401(k) Contribution, you may not later change its designation. You may, however, change your designation with respect to future 401(k) Contributions.

Automatic Contributions. Unless you elect otherwise, eligible employees who are newly hired or re-hired, the Company will withhold 2% of your compensation as a Pre-Tax 401(k) Contribution as soon as you are eligible to begin participation in the Capital Accumulation Plan.

If you are currently not eligible to participate in the Capital Accumulation Plan, but your status changes so that you become eligible to participate, the Company will withhold 2% of your compensation as a Pre-Tax 401(k) Contribution as soon as you are eligible to begin participation in the Capital Accumulation Plan.

You may elect to have your 401(k) Contributions treated as Roth 401(k) Contributions instead of Pre-Tax 401(k) Contribution. You may also elect to make 401(k) Contributions in a different percentage or not at all. To make 401(k) Contributions in a different percentage or to elect out of automatic 401(k) Contributions, contact Fidelity Investment Company ("Fidelity") at 1-800-835-5095 or log on to NetBenefits at www.401k.com. Changes to your 401(k) Contribution percentage or catch-up contribution

percentage (See Catch-Up 401(k) Contributions below) will take effect as soon as administratively possible, generally within one to two payroll cycles.

If you are not newly hired or re-hired and have not elected to make 401(k) Contributions to the Capital Accumulation Plan, the Company may commence automatic contributions in the future. The Company will provide notice to you prior to commencing automatic contributions. You will be able to elect to treat automatic 401(k) Contributions as Roth 401(k) Contribution or to make 401(k) Contributions in a different percentage or to opt out of automatic 401(k) Contributions.

Amount of 401(k) Contributions. You may contribute from 1% to 75% of your compensation to the Capital Accumulation Plan. For this purpose, compensation means your base salary plus overtime, commissions, and most bonuses and excludes severance pay, cost-of-living differentials, auto allowances, moving expenses, expatriate premiums, housing allowances, post differentials, distributions from any deferred compensation plan (other than an unfunded nonqualified plan),and contributions to nonqualified deferred compensation plans. In some circumstances, the amount you defer may be limited by the Internal Revenue Service or if you contribute the maximum permitted by law. See Contributions Limits later in this booklet to learn more about these limits.

Catch-Up 401(k) Contributions. You may be eligible to make an additional Pre-Tax or Roth 401(k) Contribution, referred to as a Catch-Up 401(k) Contribution, if you are age 50 or older or you are expected to turn age 50 any time during the calendar year. You can make Catch-Up 401(k) Contributions even if your 401(k) Contributions are limited under federal law. (See Contribution Limits, below). You do not have to satisfy these limits before you start making Catch-Up 401(k) Contributions. Your Catch-Up 401(k) Contribution is a separate election from your normal 401(k) Contribution election. Any Company match does not apply to the Catch-Up 401(k) Contribution. To make a Catch-Up 401(k) Contribution election or get more details, contact Fidelity at 1-800-835-5095 or log on to NetBenefits at www.401k.com.

Your Benefits—Company Contributions

The Capital Accumulation Plan provides for two types of Company Contributions:

- Company Defined Contributions
- Company Matching Contributions

Eligibility for Company Defined Contributions. If you were hired on or after September 1, 2005 and prior to January 1, 2016 or rehired prior to January 1, 2006, you will receive Company Defined Contributions if you satisfy the eligibility requirements for making 401(k) Contributions, listed above, and satisfy the following additional requirements:

- You complete one year of service;
- You are employed on December 31st of the year for which the Company Contribution relates; and
- You are not an employee of Airborne Maintenance and Engineering Services, Inc.

A year of service under the Capital Accumulation Plan means completing at least 1,000 hours of service during the 12-month period beginning on your date of hire (if you do not complete at least 1,000 hours of service during this first 12-month period, your hours are determined on a calendar year basis in each subsequent year). Salaried employees are credited with 190 hours for each month during which they complete at least one hour of service.

Amount of Company Defined Contributions. If you are eligible to receive Company Defined Contributions, each year the Company will make a Company Defined Contribution to your account in the Capital Accumulation Plan equal to 5% of your compensation. Compensation means your base salary plus overtime, commissions, and most bonuses and excludes severance pay, cost-of-living differentials, auto allowances, moving expenses, expatriate premiums, housing allowances, post differentials, distributions from any deferred compensation plan (other than an unfunded nonqualified plan),and contributions to nonqualified deferred compensation plans.

Eligibility for Company Matching Contributions. If you were hired on or after to January 1, 2016 you will receive Company Matching Contributions if you satisfy the eligibility requirements for making 401(k) Contributions, listed above, and you make Pre-Tax or Roth 401(k) Contributions.

Amount of Company Matching Contributions. If you are eligible to receive Company Matching Contributions, each year the Company will make Company Matching Contributions equal to 100% of the first 3% of your compensation contributed to the Capital Accumulation Plan as a Pre-Tax or Roth 401(k) Contribution (and not Catch-Up 401(k) Contributions) and 50% of the next 2% of your compensation contributed to the Capital Accumulation Plan as a Pre-Tax or Roth 401(k) Contribution (and not Catch-Up 401(k) Contributions). In other words, the Company will contribute $1.00 for every $1.00 you defer up to the first 3% of your compensation and 50 cents for every $1.00 you defer on the next 2% of compensation. Compensation means your base salary plus overtime, commissions, and most bonuses and excludes severance pay, cost-of-living differentials, auto allowances, moving expenses, expatriate premiums, shelter allowances, post differentials, distributions from any deferred compensation plan (other than an unfunded nonqualified plan),and contributions to nonqualified deferred compensation plans.

If you are employed on December 31st, the Company will make an annual adjustment to the amount of Company Matching Contributions equal to the difference, if any, between (i) your actual Company Matching Contributions made during the year and (ii) Company Matching Contributions determined using your annual compensation. Often these amounts will be the same and no annual adjustment will be necessary.

Your Benefits—Rollover Contributions

Rollover Contributions. Upon hire you may rollover money from another eligible retirement plan or an Individual Retirement Account (IRA) into the Capital Accumulation Plan before you have completed 60 days of service or at a later date.

Note: In-service withdrawals may be taken from your Rollover Contributions account. Loans are not available from Rollover Contributions.

For more details about rolling over eligible contributions into the Capital Accumulation Plan, please contact Fidelity at 1-800-835-5095 or log on to NetBenefits at www.401k.com.

Payment of Benefits

The full value of your Capital Accumulation Plan account can be paid to you when you leave ABX Air, Inc. under any of the following circumstances:

Retirement: If you retire from the Company at or after age 65, you will receive the full value of your Capital Accumulation Plan account balance regardless of your years of service.

Death: If you die while an employee of the Company (or while in qualified military service), your Company Retirement or Matching Contributions account becomes 100% vested if not already fully vested. Your spouse or your beneficiary (if you have no spouse or your spouse properly consents to your

designation) will be entitled to receive the entire value of your accounts under the Capital Accumulation Plan.

Disability: If your employment terminates because of permanent disability that prevents you from performing the regular duties of your job, your Company Retirement or Matching Contributions account becomes 100% vested if not already fully vested. You will be entitled to receive the full value of your account under the Capital Accumulation Plan. Permanent disability will be established by Social Security certification.

Termination of Employment: If you leave the Company for any reason other than those stated above, you will be entitled to receive the full value of your Pre-Tax and Roth 401(k) Contributions, your Rollover Contributions account, and the vested portion of your Company Retirement or Matching Contributions account.

Form of Payment

All Capital Accumulation Plan accounts will be distributed to you in lump sum payment(s). Partial payments are available. You will have the option of having these funds paid to you or transferred directly to an IRA or an eligible retirement plan in order to defer income taxation and avoid early withdrawal penalties.

Time of Payment

Contact Fidelity Investment at 1-800-835-5095 or www.401k.com to initiate a distribution of your Capital Accumulation Plan account balance. Upon confirming your distribution election with Fidelity, allow a minimum of ten business days for receipt of your distribution check.

Before a distribution can be requested, Fidelity must receive your employment status change from the Company and any contributions and/or loan repayments from your final paycheck.

Note: The Company will automatically distribute Capital Accumulation Plan accounts when the combined vested account balance is $1,000 or less once a year if no distribution election is requested, usually in the calendar year following the year of termination. Any cash distribution that is not rolled over to an IRA or employer's eligible retirement plan will be subject to a 20% federal tax withholding.

Vesting

The term “vesting” or “vested” means percentage of ownership of your CAP/401(k) account. The vested portions of your accounts belong to you and cannot be forfeited even if you leave the Company. If you leave the Company before you are 100% vested in your Company Defined Contribution or Company Matching Contribution accounts, you forfeit the non-vested portion of your account. Forfeitures will be

401(k) Contributions and Rollover Contributions. Your Pre-Tax and Roth 401(k) Contributions and Rollover Contributions accounts are always 100% vested.

Company Defined Contributions. Your Company Defined Contributions account becomes 100% vested after you complete 3 years of service. You are credited with one year of service for vesting purposes on each anniversary of your date of hire in which you are employed by the Company. If you terminate employment due to attainment of age 65 (or more), disability or death, your Company Defined Contributions account automatically becomes 100% vested regardless of your years of service.

Company Matching Contributions. You gradually become vested in your Company Matching Contribution account through your years of service as follows:

Completed Years of Service	Percent Vested
1	20%
2	40%
3	60%
4	80%
5	100%

You are credited with a year of service for vesting on each anniversary of your date of hire in which you are employed by the Company. If you terminate employment due to attainment of age 65 (or more), disability or death, your Company Matching Contributions account automatically becomes 100% vested regardless of your years of service.

If you are rehired before you incur five consecutive one-year breaks in service, your forfeited amounts may be reinstated (restored) if you repay the amount of the Company Matching Contribution or Company Defined Contribution account previously distributed to you.

Loans

- Loans may be taken from the Employee Pre-Tax 401(k) Contribution account (including earnings on your deferrals). Loans are not available from your Roth 401(k) Contributions account.
- Loans are not available from your Rollover Contributions account; however, you may make a withdrawal from this account (see Withdrawals While Employed section below).
- The minimum loan amount is $1,000 and the maximum is $50,000 (reduced by the highest outstanding balance of any loan that you have taken within the prior 12-month period). The total balance of the loan may not exceed 50% of your employee deferral account balance.
- You will be charged a loan set-up fee of $35.00.
- The loan must be repaid within a maximum of 5 years.
- The interest rate on loans is established at January 1st each year at prime rate + 1%.
- The loan is repaid with after-tax dollars via automatic payroll deduction. Your loan payments including the interest go back into your Pre-Tax 401(k) Contribution account.
- You may have one loan outstanding at a time.
- Loans may not be initiated while on Leave of Absence.

If a loan repayment is not repaid when due and is treated as in default, the outstanding balance of the loan, including any accrued interest, will become taxable to you. In addition, if you terminate employment before the loan is repaid, you will be required to immediately repay the outstanding balance of the loan; if

you do not do so, your vested account balances will be reduced by the outstanding balance of the loan. Distributions to you or your beneficiaries can be made only after a loan is settled. A loan payment is treated as being in default if a missed payment has not been repaid by the end of the calendar quarter following the calendar quarter in which the payment was due.

You have the option to repay the balance of your loan early. Contact Fidelity Investments to ask for a payoff amount of your Capital Accumulation Plan loan. A new loan cannot be requested until your loan payoff check has cleared the bank, and the Fidelity system has been updated to give you access to new loan information.

To obtain loan information or to apply for a loan, contact Fidelity at 1-800-835-5095 or log on to NetBenefits at www.401k.com.

Withdrawals While Employed (In-Service Withdrawals)

Withdrawals from your 401(k) Contributions account are generally permitted when you turn age 59 ½, terminate your employment, retire, become permanently disabled or experience severe financial hardship.

There are two circumstances under which you could receive a withdrawal while you are an employee: a Hardship Withdrawal or an Age 59½ Withdrawal. The IRS refers to these as "in-service withdrawals." In addition, you are permitted to receive a withdrawal from your Rollover Contributions account.

Hardship Withdrawal: You can receive a hardship withdrawal from your Pre-Tax 401(k) Contributions account to meet an immediate and severe financial hardship. Hardship Withdrawals from the Roth 401(k) Contributions account is not available. A severe financial hardship is currently defined by the IRS regulations as:

- Purchase of, avoidance of foreclosure of, or avoidance of eviction from your principal place of residence
- Medical expenses incurred or to be incurred by you, your spouse or dependents
- Costs of post-secondary education (including tuition, room and board and related expenses) for the next 12-months for you, your spouse or your dependents
- Payments for burial or funeral expenses for you, your deceased parents, spouse, children or dependents
- Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under Section 165 of the Code (determined without regard to whether the loss exceeds 10% of the Participant's adjusted gross income).

The amount requested may not exceed your Pre-Tax 401(k) Contributions account (excluding earnings) and the maximum amount available can be no more than your Pre-Tax 401(k) Contributions account balance. Amounts eligible for withdrawal do not include any earnings on your deferrals after December 31, 1988 or any Company Matching Contributions or earnings on those funds.

The amount of the hardship withdrawal is subject to 20% federal tax withholding. The amount withdrawn must be added to your taxable income for that year and may also be subject to a 10% federal tax penalty for early withdrawal. You will be issued a 1099-R form by Fidelity for year-end tax reporting. No more than one hardship withdrawal may be granted in a 12-month period. Your ability to make Pre-Tax or Roth 401(k) Contributions will be suspended for a six-month period commencing after you receive a hardship distribution.

Age 59½ Withdrawal: Upon reaching age 59½, you can withdraw the balance of your Pre-Tax 401(k) Contributions account and any qualified Roth 401(k) Contributions without demonstrating financial

hardship. The amount you withdraw must be included in your taxable income for that year. Any amount paid directly to you and not rolled over to an IRA or other eligible retirement plan will be subject to 20% federal tax withholding.

Rollover Contributions: You may take an in-service withdrawal of up to 100% from your Rollover Contributions account. No demonstration of financial hardship is required.

Contact Fidelity Investments at 1-800-835-5095 or log on to NetBenefits at www.401k.com to find out more details about the qualifications and provisions of a withdrawal from your 401(k) Contributions or Rollover Contributions account.

Investment of Your Account

Your Pre-Tax and Roth 401(k) Contributions, Company Matching Contributions and Rollover Contributions accounts are held in a trust account for you. While it is held in trust, your money is invested in one or more of the Capital Accumulation Plan's investment funds based on your investment election.

The Company Defined Contribution will be deposited into your account and automatically invested in a State Street Target Fund that corresponds to the date on which you would turn age 65.

The State Street Target Funds are "one-stop" investing because a professional manager divides the money in the fund among a variety of investments. The manager invests more conservatively as a retirement date approaches. You don't need to keep your company contribution in the State Street Target Fund into which it is initially contributed. You can move the company contribution to another 401(k) Plan investment. Log on to NetBenefits at www.401k.com or call Fidelity at 1-800-835-5095 for a complete list of your investment options.

Investment Fund Choices

You can invest your Pre-Tax and Roth 401(k) Contributions and Rollover Contribution accounts (the money you contribute to the Plan and rollovers) in any one or a combination of several professionally managed investment funds. You can change the investment of your future contributions, or transfer existing balances among funds at any time by contacting Fidelity at 1-800-835-5095 or log in to NetBenefits at www.401k.com.

If you do not choose an investment fund, your 401(k) Contributions and Rollover Contributions will be invested in the age appropriate State Street Target Fund.

The value of your investments will be affected by changes in stock and bond market prices and interest rates. Each fund varies by expectation of investment return and risk. Generally, the higher the investment return, the higher the risk. When you make your investment decision, you should keep in mind your own investment philosophy and personal situation. ABX Air, Inc. strongly encourages you to view your Capital Accumulation Plan retirement funds with a long-term investment philosophy and avoid the temptation of reacting to short term market shifts.

ERISA Section 404(c) Statement

The Company intends that the Plan qualifies as a "404(c) plan" within the meaning of the Employee Retirement Income Security Act of 1974, as amended (ERISA) and the "regulations thereunder." This means that the Company intends that none of the Company, each participating employer, the Retirement Advisory Committee, the Trustee, or any other plan fiduciary will be liable for any loss that results from your exercise of control over the investment of your Capital Accumulation Plan account.

Because you are ultimately responsible for your investment decisions, the Company's goal is to provide you with the ability to:

- Choose from several investment options, each with materially different risk and return characteristics, at least one of which will provide for a high degree of safety and capital preservation.
- Make investment decisions regarding your accounts.
- Vote proxies.

Also, you can receive or have access to the following information, as updated:

- A description of the investment alternatives available under Capital Accumulation Plan, including a general description of the investment objectives, risk and return characteristics, and type and diversification of assets comprising each alternative,
- A description of any transaction fees or expenses charged to your accounts, and information on fund costs and fees that reduce your rate of return (expense ratios),
- Fund prospectuses, annual reports, and semiannual reports, and
- Investment education and advice through Fidelity's Portfolio Planner.

Investment Fund Management

The investment funds are managed by Fidelity and other professional investment managers. Founded in 1946, Fidelity is one of the largest investment management organizations in the country. Fidelity manages more than $978 billion for more than 58 million individual and institutional accounts.

To obtain investment fund information, fund prospectuses, or other investment information for the Capital Accumulation Plan, contact Fidelity at 1-800-835-5095 or log on to NetBenefits at www.401k.com.

Notify the Company if You Move

If you leave the company and do not immediately request a distribution of your account, remember to update your address with the Human Resources Department. This will enable you to be contacted with information on your account.

Accessing Your Capital Accumulation Plan Account

Access your Capital Accumulation Plan account by contacting Fidelity at 1-800-835-5095. Fidelity Representatives are available to answer questions about the Plan or any of the investment options offered from 8:30 am to 8:00 p.m. in your local time zone. Or you can use Fidelity's automated telephone system, virtually 24 hours a day, seven days a week.

You can also access your Capital Accumulation Plan account as well as find many helpful planning tools by accessing the Fidelity NetBenefits website at www.401k.com.

In order to access your Capital Accumulation Plan account information you will need to establish a Personal Identification Number (PIN).

Other Information On Your Retirement Plans

Taxation of Benefits

Generally, all amounts [except the value of your Roth account] distributed to you from the Plan are subject to federal income tax in the year of receipt. In addition, if you receive a lump sum distribution or an installment distribution of less than 10 years, 20% of the taxable amount distributed to you will be withheld for the payment of federal income tax. Subject to certain limitations, you can roll over a lump sum distribution or an installment distribution of less than 10 years to a traditional IRA, a qualified plan, a Section 403(b) (tax-sheltered annuity) plan or a governmental 457 plan, and postpone the federal income tax on the amounts rolled over until subsequently distributed from the transferee IRA or other plan. If the rollover is made directly from the Trustee of the Plan to the other plan or IRA, you may also avoid the mandatory 20% withholding on the taxable amount of the rollover. You may also make a rollover after receiving a distribution from the Plan by transferring it to an eligible retirement plan or IRA within 60 days, but the taxable amount of your distribution will be subject to 20% withholding. However, distributions made to you on account of your financial hardship, and certain miscellaneous distributions, cannot be rolled over. You may also make a direct rollover of amounts that are not Roth contributions to a Roth IRA; but in such case the total amount of the direct rollover will be subject to federal income tax as further described below.

Roth contributions are after-tax contributions and are not subject to federal income tax when distributed. Earnings on Roth contributions are nontaxable if the earnings are distributed after the participant attains age 59½, dies or becomes disabled, and after the Roth contribution 5-year participation requirement has been met. The 5-year participation period is the 5-year period beginning on the calendar year in which you first make a Roth contribution to the Plan and ending on the last day of the calendar year that is 5 years later. For example, if you make your first Roth contribution under this Plan on November 30, 2007, your participation period will end on December 31, 2011. It is not necessary that you make a Roth contribution in each of the 5 years. Roth contributions may be rolled over to a Roth IRA or directly rolled over to a plan meeting the requirements of Section 401(k) or Section 403(b) of the Code that accepts Roth contributions. Earnings on Roth contributions may also be rolled over (either directly or indirectly) to a Roth IRA or to a plan meeting the requirements of Section 401(k) or Section 403(b) of the Code that accepts Roth contributions.

If you are a beneficiary who is a surviving spouse, you have the right to make a rollover distribution similar to the above rules. If you are an individual beneficiary who is not a surviving spouse, your rollover rights are limited to making a direct rollover to an IRA in the name of the deceased. Mandatory withholding at the rate of 20 percent does not apply to a taxable distribution to a nonspouse beneficiary.

If you have not attained age 59½ at the time you receive a distribution from the Plan, the taxable amount of your distribution may be subject to a 10% federal income tax penalty. However, the 10% penalty will not apply to taxable distributions (a) to your beneficiary upon your death; (b) to you if as a result of your disability; (c) to you after your separation from service after attainment of age 55; or (d) for certain other distributions.

You will receive more information about these rules before you receive a distribution from the Plan. As the Retirement Advisory Committee cannot provide you with personal tax advice, you should contact your tax advisor prior to receiving a distribution from the Plan.

Participation upon Rehire

If you leave the Company for any reason and are later rehired, your eligibility to rejoin each Plan will depend upon your vested status when you terminate employment as well as how long you were gone.

In general, your participation commences on your rehire date. Any previously forfeited benefits may be restored if you pay back any distributions you received within 5 years after the date of your rehire. If you terminate employment with a zero percent interest in your account, your nonvested interest will automatically be restored to your account upon your rehire.

Required Distributions

If you are a participant in any of these retirement plans upon attainment of age 70½ and are not still employed by the Company, the law requires that you begin receiving payments from each Plan. If you are a participant in any of these retirement plans upon attainment of age 70½ and are still employed by the Company, the law allows you to waive distribution until actual retirement from each Plan.

Limitations on Benefits

Federal law imposes restrictions on the amount you can contribute to and can be paid from the retirement plans. These limitations include:

- The maximum compensation that can be taken into account for benefit purposes is $275,000 in 2018. This amount is adjusted for cost-of-living changes.

- The total 401(k) Contributions (Pre-Tax and Roth) that you can make to the Capital Accumulation Plan are limited to not more than $18,500 for 2018 (plus $6,000 for 2018 catch-up contribution if age 50 or older) per year. This limit is adjusted for changes in the cost-of-living. If your 401(k) Contributions exceeds this limit, you should notify the Company by March 1 of the following calendar year and the excess will be distributed to you.

- The combined total of Company Contributions and 401(k) Contributions cannot exceed the lesser of 100% of your compensation, or $55,000 (plus $6,000 for 2018 catch-up contribution if age 50 or older). This limit is adjusted for change in the cost-of-living.

- The maximum benefit that can be provided through the Retirement Income Plan is $220,000 in 2018. This amount is adjusted for cost-of-living changes.

If you are affected by these limits, your 401(k) Contributions, Company Contributions, or benefits may be reduced. You will be notified if you are affected by these limits.

Naming Your Beneficiary

A beneficiary(s) should be named when you enroll in the retirement programs and can be changed whenever necessary by completing the beneficiary election form on www.401k.com. If you are married, you cannot name a person other than your spouse as your primary beneficiary unless your spouse consents to the designation and the consent is notarized. However, in the Retirement Income Plan, your spouse is required to be named your beneficiary.

USERRA Rights

If you are no longer an active employee of the Company as a result of entering into military service, your 401(k) Contributions will cease if you are not paid by the Company during your period of military service. If you return to active employment with the Company after entering into military service and your reemployment rights are protected by law, you will be given the opportunity to make 401(k) Contributions, and receive Company Contributions attributable to your period of military service. For example, if your period of military service was six months, you may elect to allocate six months of your future 401(k) Contributions to your period of military service, and receive Company Matching Contributions on such amounts. You will also be given credit for your period of military service in determining whether you are to be credited with a year of service for vesting purposes and in determining whether you are entitled to receive an allocation of Company Defined Contributions.

How to File A Claim

Generally, you do not need to file a formal claim for retirement benefits. You should apply for benefits in accordance with the procedures set forth in this summary. However, if you believe you are not being provided with the benefits to which you are entitled, you, or your representative, may make a request to:

Retirement Advisory Committee Secretary
c/o Benefits Dept.
145 Hunter Drive
Wilmington, Ohio 45177

The Retirement Advisory Committee will generally respond to your letter within 30 days, but will inform you if any extensions are needed.

If any part of your claim is denied, in whole or in part, you will be given the reason and an explanation of what you should do to request review of the claim.

(a) the specific reason or reasons for the denial;

(b) the specific reference to the pertinent Plan provision(s) on which the denial is based;

(c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) an explanation of the plan's claim review procedure and the time limits applicable to such procedures and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review.

In the case of an adverse determination of a claim for disability benefits, the information provided to the claimant shall also include, to the extent necessary, the information set forth in Department of Labor Regulation 2560.503 1(g)(1)(v).

How to Appeal a Claim

If you are not satisfied with the Committee's explanation, you may request a review of your claim within 90 days after receiving notice of denial (180 days in the case of a claim for disability). You will be given a full and fair review of your claim within the next 60 days (45 days in the case of a claim for disability) unless special circumstances require an extension. The Committee will notify you in writing of its final decision and, the reasons for it, and the specific plan provisions on which it is based.

Protection of Your Benefits

Your Retirement Income Plan benefit is insured up to certain limits by an agency of the federal government. Pension benefits under the Retirement Income Plan are insured by the Pension Benefit Guaranty Corporation (PBGC) if the Plan terminates. Each year the Company pays premiums to the PBGC. Generally, the PBGC guarantees most vested normal retirement age benefits, early retirement benefits, and certain survivor's pensions. However, the PBGC does not guarantee all types of benefits under covered Plans, and the amount of benefit protection is subject to certain limitations. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on Plan provisions that have been in place for fewer than five years at the time the Plan terminates; (3) benefits that are not vested because you have not worked long enough for the Company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC insurance protection and its limitations, and the benefits it guarantees, ask the Plan Administrator or the PBGC. Inquiries to the PBGC should be addressed to the Office of Communications, PBGC, 2020 K Street N.W., Washington, D.C. 20006. The PBGC Office of Communications may also be reached by calling (202) 326-4040. Contact the PBGC's Technical Assistance Division; 1200 K Street N.W.; Suite 930; Washington, D.C. 20005-4026 or call 1 202 326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1 800 877 8339 and ask to be connected to 202 326 4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

The Pension Benefit Guaranty Corporation does not insure Profit Sharing or the Capital Accumulation Plans because your benefit is the amount in your accounts in each plan; but if the Company were to terminate these plans, your accounts would be fully vested.

Assignment of Benefits

Benefits provided under these plans are for you and your beneficiary's personal security. Accounts or benefits cannot be assigned to someone else in order to settle a debt, nor can they be used as collateral to secure a loan outside of the plan. The only exception is that each plan is required to comply with the terms of a Qualified Domestic Relations Order.

Qualified Domestic Relations Orders

Generally, benefits under these plans may not be attached by any creditor. However, there is exception for a Qualified Domestic Relations Order (QDRO) which could create a right to all or part of your benefit on the part of a spouse, former spouse, child or other dependent of yours as a result of a judgment or court order requiring child support, alimony payments, or other marital property settlements. This right will exist only if the order is determined to be qualified. You will be notified in the event of such an order. Once the determination is made, distribution of your account balances and/or the division of your Retirement Income Plan benefit will be made in accordance with the court order and the terms of the plan.

Contact the **QDRO Administrator at 800-571-9801** for information and to obtain a model QDRO document. In addition, the Company has established procedures for reviewing domestic relations orders. If you would like to review a copy of such procedures, please contact the Retirement Advisory Committee. The Qualified Domestic Relations Order procedures will be provided at your expense.

Plan Documents

This explanation is intended to acquaint you with your retirement programs' most important provisions, benefits and limitations. Official Plan documents are on file at the Human Resources Department. You may examine them at any time. You may request copies for your personal use. Since there is a reasonable charge for reproducing the documents, it is recommended that participants who wish to obtain copies first inquire as to what the cost will be.

Amendment and Termination

The Company reserves the right to terminate or amend each of the plans. If the Profit Sharing or Capital Accumulation Plan is terminated, you will be 100 percent vested in your account under each plan and you will be entitled to receive a distribution of your account if permitted by law.

If the Retirement Income Plan is terminated, all participants affected by the plan termination will be 100% vested. In addition, assets of the Retirement Income Plan will generally be used to provide retirement benefits through the purchase of one or more annuity contracts from an insurance company. After all benefits have been paid and all legal requirements have been met, the Retirement Income Plan will turn over any excess plan funds to the Company.

COMPLIANCE WITH EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The information furnished in this book constitutes the Summary Plan Description required by Federal Law. To comply with the law, the following additional plan information is also furnished:

Plan Information

Plan Names and Numbers:	ABX Air, Inc. Cafeteria Plan Plan No. 501
	ABX Air, Inc. Profit Sharing Plan Plan No. 001 Capital Accumulation Plan Plan No. 002 ABX Air, Inc. Retirement Income Plan Plan No. 004
Name and Address of Employer:	ABX Air, Inc. 145 Hunter Drive Wilmington, OH 45177
Employer ID. No.	91-1091619
Plan Sponsor:	ABX Air, Inc. 145 Hunter Drive Wilmington, OH 45177
Type of Plan:	Medical Benefits Dental Benefits Vision Benefits Life and Accidental Death and Dismemberment Insurance Short and Long Term Disability Insurance Business Travel Accident Insurance Group Universal Life Insurance Voluntary Accident Insurance Flexible Spending Account Profit Sharing -Defined Contribution Plan Capital Accumulation Plan – Defined Contribution Plan Retirement Income - Defined Benefit Plan
Plan Administrator – Health and Welfare Plans:	ABX Air, Inc. 145 Hunter Drive Wilmington, OH 45177

Type of Administration - Health and Welfare Plans:

- **Medical benefits** for the PPO options described in this booklet are paid by United HealthCare and funded through the Cafeteria Plan. United HealthCare is responsible for reviewing claims and determining whether they are payable under the terms of the Plan; United HealthCare does not insure these benefits.
- **Dental benefits** are paid by Metropolitan Life Insurance Company (referred to as MetLife) and funded through the Cafeteria Plan. MetLife is responsible for reviewing claims and determining whether they are payable under the terms of the Plan; MetLife does not insure these benefits.
- **Vision benefits** are paid by EyeMed Vision Care and funded through the company Cafeteria Plan. EyeMed Vision Care is responsible for reviewing claims and determining whether they are payable under the terms of the Plan; EyeMed Vision Care does not insure these benefits.
- **Life and Accidental Death and Dismemberment** benefits are insured by and claims paid by, The Hartford.
- **Short and Long Term Disability benefits** are insured by, and claims paid by, The Hartford.
- **Business Travel Accident benefits** are insured by, and claims paid by, CHUBB.
- **Flexible Spending Accounts** are administered by United HealthCare a third-party administrator.
- **Group Universal Life Insurance benefits** are insured by, and claims paid by, Prudential Insurance Company of America, Newark, NJ. The program is administered by Marsh@WorkSolutions, a third-party administrator. The group insurance contract is held by a trust on behalf of the Plan.
- **Voluntary Accident Insurance benefits** are insured by, and claims paid by, CIGNA.

See “Claims Procedure” sections throughout this handbook for appropriate addresses of the Claims Administrator.

Plan Administrator for the Retirement Plans:

Plan Administrator for the Profit Sharing Plan is:

Retirement Advisory Committee
ABX Air, Inc., Inc.
145 Hunter Drive, Wilmington, OH 45177
800-736-5095

For the Capital Accumulation Plan is:

Retirement Advisory Committee
ABX Air, Inc., Inc.
145 Hunter Drive, Wilmington, OH 45177
800-736-5095

For the Retirement Income Plan is:

Retirement Advisory Committee
ABX Air, Inc., Inc.
145 Hunter Drive, Wilmington, OH 45177
800-736-5095

The Retirement Advisory Committee has the responsibility to make all rules and regulations regarding the administration of each plan, and to decide all questions and issues arising out of the operation of the plan.

Retirement Plan Funding and Trustee:

For the Retirement Income & Profit Sharing Plans, Trust Agreement with:

The Northern Trust Company
50 South La Salle Street, Chicago, IL 60603

For the Capital Accumulation Plan, Trust Agreement with:

Fidelity Management Trust Company
82 Devonshire Street
Boston, MA 02109

The Trustee holds the assets of each plan in Trust. Plan assets may only be used for the exclusive benefit of plan participants and to defray the reasonable expenses of the plan.

Insurance Policies:

Life No. 395260 and AD&D Policy No. S07320 (The Hartford)

Short and Long Term Disability Policy No.: 395260 (The Hartford)

Business Travel Accident Policy – CHUBB

Group Universal Life Insurance Policy – Prudential 96945

Voluntary Accident Insurance Policy – CIGNA

Agent for Service of Legal Process:

For disputes arising under the Capital Accumulation Plan, Profit Sharing Plan, or Retirement Income Plan, service of legal process may be made on the Plan Administrator, a Plan Trustee or on the Secretary of the Corporation at ABX Air, Inc. (See the "Plan Administrator" section for addresses.)

For disputes arising under the **Life, AD&D, and Short or Long Term Disability** insurance contracts, service of legal process may be made upon The Hartford at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

For disputes arising under the **Business Travel Accident** insurance contracts, service of legal process may be made upon CHUBB at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside. For disputes arising under the **Voluntary Accident** insurance contracts, service of legal process may be made upon CIGNA at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

For disputes arising under the **Group Universal Life** Insurance contract, service of legal process may be made upon Prudential Insurance Company of America at one of its Home Offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

Plan Year:

The Cafeteria Plan's fiscal records are kept on a plan year basis beginning January 1 and ending on the following December 31.

The Profit Sharing Plan's fiscal records are kept on a plan year basis beginning January 1 and ending on the following December 31.

The Capital Accumulation Plan's fiscal records are kept on a plan year basis beginning January 1 and ending on the following December 31.

The Retirement Income Plan's fiscal records are kept on a plan year basis beginning January 1 and ending on the following December 31.

Collective Bargaining Agreements:

Certain employees who are subject to collective bargaining agreements are eligible to participate in these plans. To determine if these provisions apply to you, refer to the bargaining agreement or contact your Benefits Department.

Statement of ERISA Rights

As a participant in the above described plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

For the Retirement Income Plan, obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge. For the Profit Sharing Plan, you are entitled to receive a statement at least once a year and free of charge. For the Capital Accumulation Plan, you are entitled to receive a statement on a quarterly basis, although information about your accounts may be available on line.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA. If your claim for a pension or welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 (as adjusted for cost-of-living) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are

successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272 or log onto its Web site at http://www.dol.gov/ebsa.

Authority of Fiduciaries

In carrying out their respective responsibilities under the plans, the Plan Administrator, the Claims Administrator (i.e., those responsible for reviewing claims to determine eligibility for payment under the terms of the plan), the insurance companies, and other plan fiduciaries shall have full and absolute discretionary authority to administer and interpret the terms of the Plans and to determine eligibility for and entitlement to Plan benefits. Benefits under this Plan will be paid only if the Plan Administrator, or its delegate, decides in its discretion that the applicant is entitled to them. Any interpretation or determination made under such discretionary authority will be given full force and effect and shall be binding on the participants, employees, their dependents and all interested parties, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Note: The Life, AD&D, and Short and Long Term Disability benefits described in this summary plan description (SPD) are provided under insurance contracts with The Hartford. The Business Travel Accident benefits described in this summary plan description (SPD) are provided under insurance contracts with CHUBB. Voluntary Accident Insurance benefits described in this SPD are provided under insurance contracts with CIGNA. The Group Universal Life Insurance benefits described in the SPD are provided under an insurance contract with Prudential Insurance Company of America. These insurance contracts are on file with the Plan Administrator and are available for your review. If the SPD and the insurance contracts conflict, the insurance contracts will govern plan administration and benefit payments

IMPORTANT LEGAL NOTICES

The following notices are mandated by federal law.

January 1, 2018

SBC

In compliance with health care reform, the company provides an SBC for each medical plan for which you are available to help you compare your coverage options. SBC 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 Medical section of this document for deductibles and coinsurance information applicable to the Plan option in which you enrolled.

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.

145 Hunter Drive
Wilmington, OH 45177
(937) 382-5591
www.abxair.com