EMPLOYEE BENEFITS GUIDE

2022

ATSG
AIR TRANSPORT SERVICES GROUP

ABX AIR | AIRBORNE GLOBAL SOLUTIONS | AIRBORNE TRAINING SERVICES | CAM CARGO AIRCRAFT MANAGEMENT | LGSTX SERVICES

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WELCOME

Our Company is committed to your health and well-being. It's just one reason we're proud to provide you and your family with valuable and significant benefits.

This Guide is an overview of our benefit plans. Please read it carefully in order to understand the benefits available to you in 2022 and use them wisely.

WHAT'S NEW FOR 2022

MEDICAL PLAN CHANGES

- 2022 Federal HSA contribution limits have been increased to $3,650 for employee only coverage and to $7,300 for all other tiers. If you are age 55 or older, an additional $1,000 may be contributed. These limits include the Company contribution of $500 for employee only coverage and $1,000 for all other tiers.

HEALTHY DIRECTIONS WELL-BEING PROGRAM

The 2022 Healthy Directions premium discount is increasing to 25% in 2022!

The switch to our new Healthy Directions platform will be complete in 2022. See page 6 for information about how to take advantage of 25% lower medical premiums and the many ways our new Healthy Directions platform supports your total well-being.

- When you fulfill the new, simple Healthy Directions requirements prior to 2/28/2022, you'll receive a discounted medical premium for all of Year 2022!
- Complete the requirements between 1/01/2022 - 11/30/2022 and receive a discounted medical premium for all of Year 2023!

UNDERSTANDING EMPLOYEE CONTRIBUTION CHANGES

The Company reviews benefit plans every year to make sure they remain comprehensive and competitive, keeping costs for you and the Company manageable.

The Company continues to carry the majority of the plan costs, but as the costs of coverage continue to rise, employee contributions for those plans may also rise.

The bi-weekly employee contributions for the 2022 medical plans can be found on page 10, and the bi-weekly rates for dental and vision plans on page 18.

ONSITE HEALTH CLINICS

Marathon Health clinics—including our own on-site clinic at the Wilmington Air Park—provide you with better access to health care and can often reduce your out-of-pocket costs.

Cincinnati Network: **Locations & Hours**

Marathon Health @ Wilmington Air Park
1261 Airport Rd.
Wilmington, OH 45177
Building 2
Mon, Wed: 7:30AM - 4:30PM
Tues, Thurs: 8AM - 7PM
Fri: 7:30AM - 11:30AM

Marathon Health @ Springdale Town Center
11568 Springfield Pike
Springdale, OH 45246
Mon, Wed, Fri: 8AM - 5PM
Tues, Thurs: 10AM - 7PM
Sat: 8AM - 12PM

Marathon Health @ Kings Mills
2188 Kings Mills Rd.
Mason, OH 45040
Mon, Tues, Thurs, Fri: 8AM - 5PM
Wed: 10AM - 7PM

Marathon Health @ Green Township
6355 Harrison Ave., Ste. 8
Cincinnati, OH 45248
Mon-Fri: 7AM - 4PM

Marathon Health @ Fourth & Main
220 E Fourth St., Ste. 130
Cincinnati, OH 45202
Mon: 7AM - 4PM
Tues-Fri: 8AM - 5PM

To schedule an appointment visit member.ourhealth.org or call 513-964-0830.

WELL-BEING PROGRAM

Healthy Directions is a voluntary well-being program that provides incentives to take specific steps to improve your health. Employees enrolled in the Company's Medical Plan can save on out-of-pocket health insurance premiums when they complete the program requirements. By participating, you also create a healthier lifestyle—and that's the most important incentive of all.

2022 - 2023 WELL-BEING INCENTIVES

Reduce your medical premiums for the entire calendar year!

When you complete the Healthy Directions program requirements shown with ** below, you'll receive a discounted medical premium for all twelve months of the following calendar year.

- **Complete the requirements from 1/1/2021 through 2/28/2022 to earn a discounted medical premium for the full year of 2022!**
- **Complete the requirements from 1/1/2022 through 11/30/2023 to earn a discounted medical premium for the full year of 2023!**

	Points Required	Required Activities	Reward
LEVEL 1	500	Online Wellness Assessment**	$10 Gift Card
LEVEL 2	1,500	Choose from a variety of activities	$25 Gift Card
LEVEL 3	3,000	Annual Physical**	Wellness Discount for 2022**
LEVEL 4	5,000	Choose from a variety of activities	$50 Gift Card

You can also earn points toward gift cards and prizes by choosing from a variety of activities and challenges focused on your whole well-being— physical, mental, emotional, and financial. The personalized OurHealth portal helps you choose activities, track your earned and unearned incentives, stay motivated, and reach your goals. The Portal has tools, information and a format that helps make managing your health fun and easy!

For desktops: login at www.member.ourhealth.org

For smartphones: download the free Marathon Health app and enter the password ATSGWELLBEING.

ELIGIBILITY & ENROLLMENT

TIP

Most of your benefit selections cannot be changed during the Plan Year unless you have a Qualifying Life Event, such as a change in your marital status.

You and your family have unique needs. That's why we offer a variety of benefit plans. When you select your benefits, consider your dependents' eligibility and your spouse's benefits through his or her place of employment.

ELIGIBILITY

If you are a full-time or part-time employee with our Company and you are regularly scheduled to work 15 hours or more per week, you are eligible to participate in the Medical, Dental, Vision, Health Savings Account (HSA), Flexible Spending Account (FSA), and additional benefits once you have completed the waiting period for the plan.

WHEN DOES COVERAGE BEGIN?

Elections made during annual open enrollment become effective January 1, 2022. If you are hired in 2022, your elections become active following the plan's waiting period. *Due to IRS regulations, once you have made your choices for the 2022 Plan Year, you can't change your benefits until the next enrollment period unless you experience a Qualifying Life Event.*

ELIGIBLE DEPENDENTS

Dependents eligible for coverage in the Company's benefits plans include:

- Your legal spouse (or common-law spouse in states which recognize common-law marriages).
- Dependent children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, and foster children).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.
- Verification of dependent eligibility will be required upon enrollment.

ELIGIBILITY & ENROLLMENT

WORKING SPOUSES ARE EXCLUDED FROM COVERAGE

The Company will not offer medical plan coverage to employees' spouses who are eligible to enroll in group medical through their own employer. Spouses will remain eligible for Dental and Vision.

By enrolling your spouse in the Company medical plan, you certify that they do not have access to other coverage through their employer. Providing false information will result in disqualification of insurance and potentially disciplinary action depending on the circumstances.

REQUIRED DEPENDENT VERIFICATION DOCUMENTS

To add a child to your plan, you must submit a copy of their birth certificate. To add a spouse, you must submit a copy of your marriage certificate. Your dependents are not eligible for benefits until their dependent verification documentation has been submitted. You may upload your documents at the time you enroll for benefits, or you may fax/mail/email them to your HR department. Dependent documentation is due 10 days from the date your enrollment is completed.

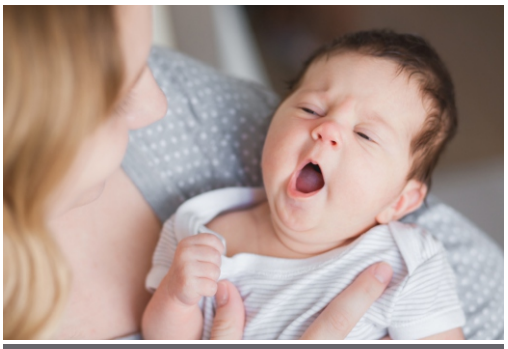
Social security numbers are required for dependent medical coverage. The Centers for Medicare & Medicaid Services (CMS) require that employer health plans report the Social Security Numbers of all covered dependents. This allows the CMS to verify that a person with Medicare or Medicaid benefits is not also receiving benefits through an employer. Therefore, in order to enroll your dependents in the Company's health plan, you are required to provide their Social Security Number to the Company. The number will only be used to report to the CMS. If you do not provide your dependents' Social Security Numbers, you cannot cover your dependents under our Plan.

CHECK TO BE SURE!

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

Log on to Self Service and click on "**BENEFITS ENROLLMENT**" then "**DEPENDENTS**." Click on your dependent's name. The Social Security Number should be in the "Tax ID" box. If it isn't, enter the Social Security Number and click the "Save" icon.

If you have a "Qualifying Life Event", you have 30 days from the date of the event to notify Human Resources. You don't need to have the Social Security Number to make this notification.



QUALIFYING LIFE EVENTS

When one of the following events occurs, you have 30 days from the date of the event to notify Human Resources and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce, legal separation or death)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid.

Your change in coverage must be consistent with your change in status.

ELIGIBILITY & ENROLLMENT

PREPARING TO ENROLL

We strive to provide employees with affordable healthcare. As a committed partner in your health, the Company absorbs a significant amount of the costs. Your share of the contributions for Medical, Dental, Vision, HSA and FSA benefits are deducted on a pre-tax basis, which lowers your tax liability.

Please note: your contributions for medical coverage will vary depending on your coverage and the number of dependents covered. In general, the more coverage you have, the higher your contribution will be.

Keep in mind, you may select any combination of coverage categories. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of the Company, must elect coverage for yourself in order to elect any dependent coverage. You have the option to select coverage from the following categories:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

Be sure to have the Social Security numbers and birth dates for any eligible dependent(s) you plan to enroll.

HOW TO ENROLL FOR BENEFITS

1. Understand Your Choices

This Guide contains very useful reference material. Keep it handy as you make your choices, and refer to it throughout the year.

2. Review Your Options with Your Family

Make sure you include any other individual who will be affected by your elections in the decision-making process.

3. Log on to EMPLOYEE SELF SERVICE

Click on the "Benefits Enrollment" tab.

4. Confirm Your Personal and Dependent Information

Click the "Dependents" tab to enter the names and Social Security Numbers of dependents you wish to cover. Social Security Numbers must be entered in order to cover your dependents!

5. Review Your Previous Coverage -or- Select New Coverage

- Click the "Benefits Enrollment" tab and check the box next to each benefit you want to enroll in. To add your dependents, check the box next to their names.
- Enter your desired HSA or FSA contribution.
- Attach any necessary Dependent Verification Documents by clicking "Attachments" and "Choose File" to upload.
- Click "Continue." Review your elections. Print a copy for your files. To complete your enrollment, you must click "SUBMIT" before exiting Employee Self Service. Done!

6. IMPORTANT! Verify Your Enrollment

Click the "IN BOX" then "My Messages" to make sure your enrollment has gone through.

MEDICAL & RX BENEFITS

Our goal is to arm you with tools and services to make wise decisions for your health and the health of your family. We offer a choice of plans so you can select the best fit for your needs.

These plans are insured by UnitedHealthcare. Visit www.myuhc.com or call UHC at 888-350-5607 for more information.

HSA PLAN

Bi-Weekly	Base Rate	Wellness Rate
Employee Only	$47.61	$35.71
Employee + Spouse	$125.96	$94.47
Employee + Child(ren)	$104.11	$78.08
Employee + Family	$186.73	$140.05

VALUE PPO PLAN

Bi-Weekly	Base Rate	Wellness Rate
Employee Only	$115.65	$86.74
Employee + Spouse	$243.34	$182.50
Employee + Child(ren)	$201.12	$150.84
Employee + Family	$360.71	$270.54

ENHANCED PPO PLAN

This plan is closed and available only to employees hired or rehired prior to January 1, 2015.

Bi-Weekly	Base Rate	Wellness Rate
Employee Only	$171.51	$128.63
Employee + Spouse	$360.84	$270.63
Employee + Child(ren)	$298.24	$223.68
Employee + Family	$534.88	$401.16

Wellness rates will not show up on Self Service. You will automatically get the discounted price if you complete the quarterly requirements.

TIP

Save money by seeing in-network physicians and taking advantage of preventive care services offered by your plan.

MEDICAL & RX BENEFITS

MEDICAL & PHARMACY (RX) BENEFITS

Waiting period: 30 days from Date of Hire.

Our medical and pharmacy benefits are provided through UnitedHealthcare. UnitedHealthcare offers a broad network of participating physicians and facilities, as well as an extensive library of online information and programs.

To view a current list of network providers and access member tools, sign in at www.myuhc.com or call UnitedHealthcare at 888-350-5607.

A partial summary of the medical coverage provided by each plan:

	HSA PLAN		VALUE PPO PLAN		ENHANCED PPO PLAN	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$1,550	$3,100	$825	$1,325	$550	$700
FAMILY	$3,100	$6,200	$1,650	$2,650	$1,100	$1,400
COINSURANCE (PLAN PAYS)	80%*	60%*	80%*	50%*	100%*	60%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAX INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$4,000	$6,200	$3,100	$6,200	$2,000	$6,400
FAMILY	$8,000	$12,400	$6,200	$12,400	$4,000	$12,800
LIFETIME MAXIMUM	Unlimited					
COPAY/COINSURANCE (YOU PAY)						
PREVENTIVE CARE	100%	Not Covered	100%	Not Covered	100%*	Not Covered
PRIMARY CARE VISITS	80%*	60%* of MNRP	$25 copay	50%* of MNRP	$25 copay	60%* of MNRP
HOSPITAL SERVICES	80%*	60%* of MNRP	80%*	50%* of MNRP	100%*	60%* of MNRP
HEALTH CARE FACILITY	80%*	60%* of MNRP	80%*	50%* of MNRP	100%*	60%* of MNRP
HOSPITAL EMERGENCY ROOM	80%* for emergencies 60%* for non-emergencies	80%* of MNRP for emergencies 60%* of MNRP for non-emergencies	80% after $200 copay for emergencies 80%* after $250 copay for non-emergencies	80% of MNRP after $200 copay for emergencies 50%* of MNRP after $250 copay for non-emergencies	100% after $200 copay 80%* after $250 copay for non-emergencies	100% of MNRP after $200 copay for emergencies 60%* of MNRP after $250 copay for non-emergencies

* After deductibles and/or Copays
MNRP = Maximum Non-Network Reimbursement Program

The Enhanced Plan is closed and available only to employees hired prior to January 1, 2015.

MEDICAL & RX BENEFITS

HOW DOES THE DEDUCTIBLE WORK?

The deductible is the amount you pay for your covered health care services before your insurance plan starts to pay.

Once you have paid the total deductible for the year, the plan pays the scheduled coinsurance benefit (80% for most in-network claims). You pay the remaining copays and coinsurance (20% for most in-network claims).

When your share of the deductible, copays and coinsurance costs equal your Annual Out-of-Pocket Maximum, your insurance really kicks in and pays 100% of all remaining costs for the rest of the year. The next year, you are back at zero and must begin paying the deductible again.

Each of our Medical Plans has an Individual and a Family deductible. The Family deductible applies to Employee + Spouse, Employee + Child(ren), and Employee + Family coverage.

The Family deductible for the HSA Plan is "non-embedded." The Family deductible for the Value PPO Plan is "embedded." The illustration at right describes the difference.

Year-to-Date Medical Expenses

Josh: $500
Lisa: $100
Mia: $900
Total: $1,500

HSA Plan
(Non-Embedded Deductible)

Family Deductible = $3,100
Deductible is NOT met

The Harmon's will continue to pay their deductible until the family's combined expenses total $3,100.

Value PPO Plan
(Embedded Deductible)

Family Deductible = $1,650
($825 per person)

Mia meets her deductible; 80% coinsurance kicks in for her future in-network expenses. Josh and Lisa will continue to pay the deductible until they each pay $825 in expenses -or- the family's payments as a whole equal $1,650.

The Harmon Family

MEDICAL & RX BENEFITS

ENHANCED PPO VS. VALUE PPO VS. HSA: WHICH IS THE BEST OPTION FOR YOU?

Do you expect to require expensive medical services in 2022? Your health and the health of your covered family members are important factors in deciding which plan is right for you. See below for an illustration of how the plans add up for a family of three in good health, and for the same family when they need additional medical care.

2022 MEDICAL COST SCENARIOS
ATSG Family Coverage (3 family members)

Good Health Scenario

	Total Chg	ABX Enhanced PPO		ABX Value PPO		ABX HSA Choice Plus	
Medical Costs							
2022 Annual Payroll Contribution		$13,907		$9,379		$4,855	
2022 In-Network Deductible Single		$550		$825		N/A	
2022 In-Network Deductible Family		$1,100		$1,650		$3,100	
2022 In-Network MOP Single		$2,000		$3,100		N/A	
2022 In-Network MOP Family		$4,000		$6,200		$8,000	
			EE Cost		EE Cost		EE Cost
3 office visit at $100 per visit (1 per family member)	$300	$25 co-payment per visit	$75	$25 co-payment per visit	$75	Deductible + 20% co-insurance	$300
3 specialist office visits @ $150 per visit (1 per family member)	$450	$45 co-payment per visit	$135	$45 co-payment per visit	$135	Deductible + 20% co-insurance	$450
1 ER Visit (Family Member 1)	$1,500	$200 co-pay per visit	$200	$200 co-pay + 20% co-insurance	$460	Deductible + 20% co-insurance	$1,500
3 Tier 2 retail Rx @$120 each (Family Member 1)	$360	20% co-insurance (min $30/max $55)	$90	20% co-insurance (min $30/max $55)	$90	Deductible + 20% co-insurance (min $30/max $55)	$360
1 Tier 1 retail Rx @$35 each (Family Member 2)	$35	10% co-insurance (min $15/max $25)	$15	10% co-insurance (min $15/max $25)	$15	Deductible + 10% co-insurance (min $15/max $25)	$35
Total	$2,645		$515		$775		$2,645
Less Health Savings Acct - ER Contribution			N/A		N/A		-$1,000
Annual Payroll Deductions			$13,907		$9,379		$4,855
Total Annual Cost			$14,422		$10,154		$6,500
EMPLOYEE COST DIFFERENCE					**- 4,268**		**- 7,922**

Poor Health Scenario

	Total Chg	ABX Enhanced PPO		ABX Value PPO		ABX HSA Choice Plus	
Medical Costs							
2022 Annual Payroll Contribution		$13,907		$9,379		$4,855	
2022 In-Network Deductible Single		$550		$825		N/A	
2022 In-Network Deductible Family		$1,100		$1,650		$3,100	
2022 In-Network MOP Single		$2,000		$3,100		N/A	
2022 In-Network MOP Family		$4,000		$6,200		$8,000	
			EE Cost		EE Cost		EE Cost
3 preventive visits @ $88 per visit (1 per family member)	$264	Covered in full	$0	Covered in full	$0	Covered in full	$0
3 PCP office visit at $100 per visit (1 per family member)	$300	$25 co-payment per visit	$75	$25 co-payment per visit	$75	Deductible + 20% co-insurance	$300
12 specialist office visits @ $150 per visit (Family Member 2: 12 Visits)	$1,800	$45 co-payment per visit	$540	$45 co-payment per visit	$540	Deductible + 20% co-insurance	$1,800
1 ER Visit (Family Member 2)	$1,000	$200 co-pay per visit	$200	$200 co-pay + 20% co-insurance	$360	Deductible + 20% co-insurance	$1,000
1 hospital stay with surgery (facility) (Family Member 2)	$18,150	Deductible, 0% Co-insurance	$550	Deductible, 20% Co-insurance	$2,175	Deductible + 20% co-insurance	$3,630
24 physical therapy @ $127 per visit (Family Member 2: 24 visits)	$3,048	Deductible, 0% co-insurance	$0	Deductible, 20% Co-insurance	$0	Deductible + 20% co-insurance	$610
3 tier 2 retail Rx @$120 each (Family Member 2)	$360	20% co-insurance (min $30/max $55)	$90	20% co-insurance (min $30/max $55)	$0	Deductible + 20% co-insurance (min $30/max $55)	$90
9 tier 1 retail Rx @ $35 each (Family Member 2)	$315	10% co-insurance (min $15/max $25)	$135	10% co-insurance (min $15/max $25)	$0	Deductible + 10% co-insurance (min $15/max $25)	$135
12 mail order tier 3 Rx @ $385 each (4 fills) (Family Member 2: 12 Rx)	$18,480	40% co-insurance (min $120/max $170)	$460	40% co-insurance (min $120/max $170)	$0	Deductible + 40% co-insurance (min $120/max $170)	$435
Total	$43,717		$2,050		$3,150		$8,000
Less Health Savings Acct - ER Contribution			N/A		N/A		-$1,000
Annual Payroll Deductions			$13,907		$9,379		$4,855
Total Annual Cost			$15,957		$12,529		$11,855
EMPLOYEE COST DIFFERENCE					**- 3,428**		**- 4,102**

MEDICAL & RX BENEFITS

VIRTUAL VISITS

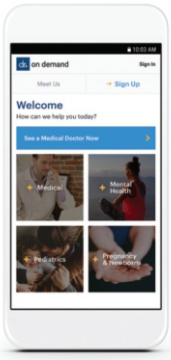
See a doctor whenever and wherever you'd like. Get access to care 24/7 with Virtual Visits.

A Virtual Visit lets you see a doctor from your mobile device or computer without an appointment.

Choose from an AmWell or Doctor on Demand network provider and pay $50 or less for the visit.

To learn more and start a visit, go to uhc.com/virtualvisits. You can also go directly to amwell.com or doctorondemand.com — or the AmWell or Doctor On Demand mobile apps. Virtual Visits are covered under your health plan benefits either way you decide to access care.

AmWell app



Doctor on Demand app

TIPS FOR REGISTERING

1. Locate your member ID number on your health plan ID card.
2. Have your credit card ready to cover any costs not covered by your health plan.
3. Choose a pharmacy that's open in case you're given a prescription.**

**Prescription services may not be available in all states.

To learn more about Virtual Visits, go to uhc.com/virtualvisits or myuhc.com.

HEALTH SAVINGS ACCOUNT (HSA)

Contributions to an HSA are tax-free, and no matter what, the money in the account is yours. Use it to pay for eligible medical expenses and receive a triple tax break.

HEALTH SAVINGS ACCOUNT
Waiting period: 30 days from Date of Hire

When you use your HSA funds for qualified medical expenses, you can net a **triple tax break**: your contributions are made pre-tax; withdrawals are tax-free; and investment growth is also tax-free.

Eligible expenses include your deductibles and copayments, doctors' office visits, dental expenses, eye exams, prescription expenses and LASIK surgery. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov.

If you withdraw money for non-medical expenses, you'll owe taxes and a 20% penalty. However, after age 65 you can withdraw money to pay for non-medical expenses without penalty, but the funds will be taxed as income (similar to a traditional pre-tax IRA).

Eligibility
You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan, such as our HSA Medical Plan.
- You are not covered by your spouse's health plan, health care flexible spending account (FSA) or health reimbursement account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare.

Individually-Owned Account
The HSA Plan provides you with an HSA through Optum Bank. You own and administer your Health Savings Account. You determine how much you'll contribute to the account (change requests are processed on a monthly basis). Your account comes with a debit card you can use to pay for doctor visits, prescriptions, and other eligible medical expenses. HSAs allow you to save and roll over money if you do not spend it in the calendar year. The money in your HSA stays with you, even if you change plans or jobs. **There are no vesting requirements or forfeiture provisions.**

TIP

Funds in your HSA roll over from year to year, allowing you to save money for future medical expenses.

HEALTH SAVINGS ACCOUNT (HSA)

2022 HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2022, contributions (which includes any employer contribution) are limited to the following:

2022 HSA FUNDING LIMITS	
INDIVIDUAL	$3,650
FAMILY	$7,300
CATCH-UP CONTRIBUTION (AGE 55+)	$1,000

2022 HSA COMPANY CONTRIBUTIONS

The Company will increase your savings by making contributions to your HSA. In order to receive the Company contribution, you must open a Health Savings Account before January 1. If you are hired in 2022, you must open your HSA within 60 days of hire to receive the Company contribution. The entire Company contribution will be deposited after your first paycheck of 2022.

2022 HSA COMPANY CONTRIBUTIONS	
INDIVIDUAL	$500
FAMILY	$1,000

HSA: HOW TO ENROLL

- You must elect the HSA Medical Plan and complete all HSA enrollment materials.
- You must open a Health Savings Account with Optum Bank. If you are electing this benefit for the first time, go to www.optumbank.com and open your account (group number 703940). Optum will notify us that the account has been successfully established and is ready to receive both employee and employer contributions.
- The Company will deposit your HSA contributions once your account information has been provided and verified.
- Each year, you must designate the amount you wish to contribute. Your prior contribution designation does not carry over from year to year.
- In order to receive the Company contribution, you must open your Health Savings Account before January 1, 2022. If you are hired in 2022, you must open your HSA within 60 days of hire to receive the Company contribution. The Company will deposit the entire Company contribution after your first paycheck of 2022.

FLEXIBLE SPENDING ACCOUNTS (FSA)

TIP

Use it or lose it!

Manage your account wisely and take advantage of the 2½ month FSA Grace Period.

If you contributions from the prior year remaining in your FSA on March 15, you forfeit the money.

MEDICAL FSA

Waiting period: one year from Date of Hire

Our Medical FSA allows you to save money on taxes by contributing money pre-tax for eligible medical, dental, and vision expenses that aren't covered by your health care plan or elsewhere.

Eligible expenses include deductibles, coinsurance, copayments and other out-of-pocket expenses. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov.

2022 Contribution Limit: $2,750

ELIGIBILITY

You are eligible to open and fund a Medical FSA if:

- You are not enrolled in the Company's HSA Medical Plan
- You are not making contributions to a Health Savings Account (HSA)

DEPENDENT CARE FSA

Waiting period: 60 days from Date of Hire

Our Dependent Care FSA allows you to save money on taxes by contributing money pre-tax for dependent care services such as day care, preschool, summer camps or before- and/or after-school programs. It can also be used for elder daycare when an elderly or disabled parent is considered a dependent and you're covering more than 50 percent of their maintenance costs.

The annual contribution limit for a Dependent Care FSA is based on the account holder's tax filing status. Generally, joint filers have double the limit of single or separate filers. However, even if each spouse has access to a separate FSA through his or her employer, they are still subject to the mandated maximum limits.

2022 Contribution Limits:
Account holder is single: $2,500
Account holder is married and filed a separate tax return: $2,500
Account holder is married and files a joint return or filed as single/head of household: $5,000

ELIGIBILITY

You are eligible to open and fund a Dependent Care FSA if:

- You have been employed by the Company for at least 60 days from date of hire.

DENTAL & VISION BENEFITS

Dental and vision checkups can detect serious health issues in their early stages. Routine care is important for your teeth, eyes, and overall health.

DENTAL & VISION BENEFITS

Waiting period: 30 days from Date of Hire.

- *Dental coverage is through MetLife Dental. For more information or to find a dentist in the network visit online.metlife.com or call MetLife Dental at 800-942-0854.*
- *Vision coverage is through EyeMed. For more information or to find a network vision provider, log in to eyemedvisioncare.com or call EyeMed at 866-939-3633*

NETWORK PROVIDERS

Your Plan's in-network dentists and vision providers have agreed to charge lower fees, which helps keep money in your pocket. If you choose to use a provider who is not in your Plan's network, your out-of-pocket costs may be higher, and you are subject to any charges over the Reasonable and Customary (R&C).

DENTAL & VISION PREMIUMS

Your premium contributions will be deducted from your paycheck on a pre-tax basis. Your coverage tier will determine your biweekly premium.

2022 DENTAL & VISION PREMIUMS		
Bi-Weekly Premiums	Enhanced Plan	Basic Plan
EMPLOYEE ONLY	$ 8.40	$ 5.11
EMPLOYEE + SPOUSE	$16.82	$10.02
EMPLOYEE + CHILD(REN)	$18.07	$10.12
EMPLOYEE + FAMILY	$28.12	$15.78

TIP

Daily cleaning and regular visits to the dentist will help prevent unwanted health concerns, saving you time and money in the long run.

DENTAL & VISION BENEFITS

2022 SCHEDULE OF DENTAL BENEFITS

Plan Feature	Enhanced Plan	Basic Plan
ANNUAL DEDUCTIBLE	$25 per person	None
LIFETIME DEDUCTIBLE	None	$50 per person
ANNUAL MAXIMUM BENEFIT	$2,000 not including orthodontia	$1,500
DIAGNOSTIC/PREVENTIVE SERVICES Exams, cleanings, x-rays, fluoride application, etc.	$100% of R&C* deductible does not apply	80% of R&C* after the deductible
BASIC RESTORATIVE SERVICES Fillings, extractions, surgery, endodontics, periodontal procedures such as bone and gum surgeries, etc.	80% of R&C* after the deductible	
MAJOR RESTORATIVE SERVICES Onlays, crowns, bridges, etc.	50% R&C* after the deductible	
ORTHODONTIA & BRUXISM TREATMENT	50% R&C* up to $1,000 lifetime maximum (deductible does not apply)	Not covered
EMERGENCY TREATMENT	Same as any other covered expense	

* Reasonable & Customary

2022 SCHEDULE OF VISION BENEFITS

EYE EXAM	Reimburses up to $50
GLASSES, FRAMES OR CONTACTS	Reimburses up to $100
SAFETY FRAMES AND LENSES	Reimburses up to an additional $100 for safety frames; $0.00 copay on most safety lenses

LIFE & DISABILITY BENEFITS

For Full-Time Employees Only
These benefits are not subject to Open Enrollment
Waiting period Life, AD&D, Voluntary STD, Group Life and Voluntary Accident: 60 days from Date of Hire
Waiting period LTD: one year from Date of Hire

The following plans are insured by MetLife

LIFE AND AD&D INSURANCE

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

Your company-paid Life and AD&D coverage also includes Will Preparation, Funeral Planning, Estate Resolution, Grief Counseling and Travel Assistance Services at cost to you. See page 22 for more information.

LONG TERM DISABILITY (LTD)

LTD is automatically provided to full-time employees with one year of full-time service at no cost to you.

VOLUNTARY SHORT TERM DISABILITY (STD)

If you have not previously elected Short Term Disability and wish to do so at this time, you will be subject to Evidence of Insurability. Please contact Human Resources for more information.

VOLUNTARY TERM LIFE INSURANCE

During your new hire enrollment period, you may purchase Term Life Insurance for yourself, your spouse, and/or child without Evidence of Insurability (certain limitations apply).

To purchase coverage after your new hire enrollment period, you must complete MetLife's Evidence of Insurability approval process to qualify for coverage.

- Coverage for yourself of up to six times your annual salary ($500,000 maximum) in $1,000 increments is available. *During the new hire enrollment period, Evidence of Insurability is required for amounts over $200,000.*
- Spouse coverage up to a maximum of 50% of the amount of coverage you have purchased for yourself ($100,000 maximum) is available in $25,000 increments. Child Life Insurance of $10,000 is available for your child(ren). To purchase Spouse and/or Child Life Insurance, you must be enrolled for Voluntary Term Life coverage for yourself. *During the new hire enrollment period, Evidence of Insurability is required for Spouse coverage over $25,000.*
- Each Term Life plan also includes Accidental Death and Dismemberment (AD&D) insurance coverage equal to the amount of life insurance coverage.

VOLUNTARY TERM LIFE		
MONTHLY RATES PER $1,000 of COVERAGE		
AGE	EMPLOYEE	SPOUSE
< 30	$0.095	$0.076
30 - 34	$0.115	$0.083
35 - 39	$0.125	$0.101
40 - 44	$0.135	$0.124
45 - 49	$0.185	$0.163
50 - 54	$0.265	$0.235
55 - 59	$0.465	$0.394
60 - 64	$0.695	$0.692
65 - 69	$1.305	$1.198
70+	$2.095	$2.214
	CHILD COVERAGE	
Flat Rate	$0.212	

LIFE & DISABILITY BENEFITS

VOLUNTARY ACCIDENT INSURANCE

This plan is insured by MetLife

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

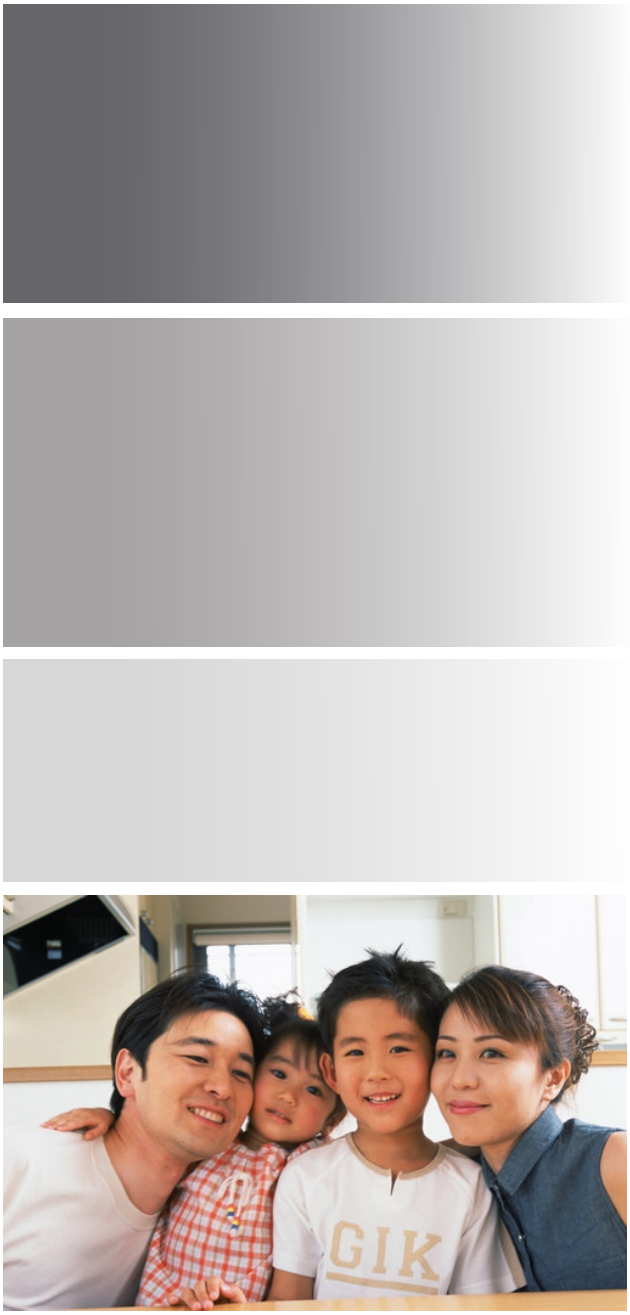
VOLUNTARY ACCIDENT RATES

2022 Bi-Weekly Rates

Employee Principal Amount	Single	Family
$ 25,000	$0.43	$0.53
$ 50,000	$0.85	$1.06
$ 75,000	$1.28	$1.59
$ 100,000	$1.71	$2.12
$ 125,000	$2.13	$2.65
$ 150,000	$2.56	$3.18
$ 175,000	$2.99	$3.72
$ 200,000	$3.42	$4.25
$ 225,000	$3.84	$4.78
$ 250,000	$4.27	$5.31
$ 275,000	$4.70	$5.84
$ 300,000	$5.12	$6.37
$ 325,000	$5.55	$6.90
$ 350,000	$5.98	$7.43
$ 375,000	$6.40	$7.96
$ 400,000	$6.83	$8.49
$ 425,000	$7.26	$9.02
$ 450,000	$7.68	$9.55
$ 475,000	$8.11	$10.08
$ 500,000	$8.54	$10.62

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

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



LIFE & DISABILITY BENEFITS

The following MetLife Advantages℠ services are included with your company-provided Life and AD&D insurance plan:

Will Preparation Services — Having a will ensures your final wishes are clear and prevents unnecessary stress. MetLife offers legal resources through Hyatt Legal Plans to help you create or update a binding will at no cost to you. Meet with any of more than 14,000 participating plan attorneys either in-person or by phone as many times as needed to prepare, update or revise a will, living will and/or powers of attorney. To get started, call Hyatt Legal Plans at 800-821-6400, give the company name, **customer number 5959764** and the last 4 digits of the policyholder's social security number.

Funeral Discount and Planning Services — Losing a loved one is one of life's most difficult experiences. This service helps you make decisions about funeral arrangements during a difficult time. It includes discounts on funeral services through the largest network of funeral homes and cemetery providers, compassionate experts to guide you through the pre-planning process, and counselors who assist with personalizing funeral arrangements in a non-sales environment.

Grief Counseling Services — Whether you're coping with a loss or a major life change, your MetLife coverage includes professional counseling through LifeWorks US to support you and your family 24/7. Grief takes many forms. It could be that a loved one has died, you've finalized a divorce, or you've received a serious medical diagnosis. Perhaps you need confidential legal or financial consultations. Counseling sessions are tailored to your individual needs. LifeWorks also offers self-help resources online to help you through the grieving process. To speak with a LifeWorks Counselor call **888-319-7819** or visit metlifegc.lifeworks.com, **User Name: metlifeassist Password: support**

Estate Resolution Services — Settling an estate can be a complex and lengthy process, but it doesn't have to be. With your MetLife Life and AD&D coverage, you and your beneficiaries are provided with expert legal guidance, either over the phone or in person. To find a participating plan attorney, call Hyatt Legal Plans at **800-821-6400** and provide the company's name, **customer number 110008** and the last four digits of the policyholder's social security number.

Travel Assistance Services — Professional help is just a phone call away. You and your covered family members can contact AXA representatives 24/7 for emergency medical, travel and personal assistance services, wherever you are in the world. For more information, call **800-454-3679** or visit webcorp.axa-assistance.com **User Name: axa Password: travelassist**

RETIREMENT BENEFITS

TIP

Review your life circumstances and long-term financial goals each year. The results may call for an adjustment to your 401(k) investment mix.

It's never too early—or too late—to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. Our Capital Accumulation/401(k) Plan provides you with the opportunity to save toward your long-term financial goals.

CAPITAL ACCUMULATION/401(K) PLAN

Waiting period: 60 days from Date of Hire
Fidelity Investments is the record keeper and trustee of the 401(k) plan.

Eligible employees hired after 1/1/2016 can invest for retirement while receiving certain tax advantages. Beginning July 1, 2018, the Company will match $1.00 for every $1.00 you save up to 5% of your annual salary.

Eligibility
You may start making pre-tax contributions to your 401(k) account after 60 days of continuous employment. Employees are automatically enrolled at 3% of gross pay.

Contributing to the Plan
You designate a percentage of your income to contribute through pre-tax payroll deductions. The maximum allowable pre-tax contribution is set each year by the IRS. For 2022, the pre-tax contribution limit is $20,500. You may contribute an additional $6,500 if you are age 50 or over for a total of $27,000.

Visit www.401k.com or call (800) 835-5095 to enroll, make changes, or request more information.

After you have completed the eligibility period, you may enroll in the 401(k) and change your contributions at any time. This benefit is not subject to the Annual Open Enrollment restrictions.

GLOSSARY

Health insurance has a language all its own. Understanding how your insurance plan works is something every American needs to master. These terms are important to know to get the most our of your health care coverage.

COINSURANCE — The percentage you pay for the cost of covered health care services, usually after you have paid your full deductible. For example, once you have paid your deductible, you may pay 20% of the cost of services until you reach your out-of-pocket maximum. Your insurance plan pays the other 80%.

COPAY — A set dollar amount you pay for doctor visits, prescriptions and other health care services. The copay amount is determined by your insurance plan.

DEDUCTIBLE — The amount you pay for your health care services before your insurance starts to help out. Only services that are covered by your health insurance "count" toward your deductible. However, some preventive care services—like your annual physical and exams—are completely free to you. For those services, your plan pays the whole cost, even if you haven't paid your deductible.

HEALTH SAVINGS ACCOUNT (HSA) — A personal savings account for qualified health care expenses. You can only have an HSA if you're in a High-Deductible Health Plan (HDHP). HSAs can help you build a health care nest egg. When you need health care in the future, you can use the account to pay for qualified health care expenses. You don't pay taxes on the contributions, earnings or withdrawals, as long as you use the account for qualified health care. Your HSA funds are yours. They roll over from year to year, and the account goes with you if you change jobs. At ABX Air, you also receive company contributions to your HSA.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) — A medical plan option that typically offers lower premium payments in exchange for a higher deductible.

GLOSSARY

IN-NETWORK — a group of doctors, labs, hospitals, and other providers that your plan contracts with for discounted costs. When you use in-network providers, you'll almost always pay less because of the discount, and also because your copays and coinsurance are often lower.

OUT-OF-NETWORK — any doctor, lab, hospital or other provider who is not contracted with your insurance company. If you choose an out-of-network doctor, you will almost always pay more because you will not receive a discounted rate, and also because your copays and coinsurance are usually higher.

OUT-OF-POCKET MAXIMUM — this is a "cap" on your costs for the year. In a worst-case-scenario year when you need a lot of care, your plan pays for 100% of year health care once you hit this cap. This is the true insurance part of your health insurance. It protects you financially, especially if you get really sick or seriously injured and need special (and expensive) care. This limit does not include your premiums, charges beyond the Reasonable & Customary, or health care your plan doesn't cover.

PREMIUM — The amount you pay for your health insurance out of your paycheck bi-weekly. Your premium is an indicator of the value of your plan and depends on a variety of factors, including: the cost of health care in your area; whether your plan also covers a spouse and/or child(ren); which services are covered; and how much you pay for health care services for the year before you reach your annual out-of-pocket maximum. For this reason, you need to consider all the factors when you choose a health plan — not just your biweekly premium cost.

REASONABLE & CUSTOMARY ALLOWANCE (R&C) — the amount your insurance company will pay for a medical service based on what providers in the area usually charge for the same or similar medical service.

SUMMARY OF BENEFITS AND COVERAGE — your insurance carrier or plan sponsor will provide you with a clear summary of your benefits and plan coverage.

REQUIRED LEGAL NOTICES

IMPORTANT LEGAL NOTICES

The following notices are mandated by federal law.

November 1, 2021

Women's Health and Cancer Rights Act Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 888-350-5607.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact your plan administrator at 888-350-5607.

Notice of Special Enrollment Rights for Medical Plan Coverage

As you know, if you have declined enrollment in ABX Air's medical plans for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

ABX Air will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the ABX Air group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan.

For more information about this notice or your prescription drug coverage, contact:
ABX Air, Inc.
Benefits Department
145 Hunter Dr., Wilmington, OH 45177
937-382-5591
www.abxair.com
11/1/2021

REQUIRED LEGAL NOTICES

Important Notice to Employees from ABX Air About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the ABX Air medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2022. This is known as "creditable coverage."

Why this is important. *If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2022 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.*

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with the companies of ATSG (covered by the ABX Air Cafeteria Plan), and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage
You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the ABX Air prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2022. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the ABX Air plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop ABX Air coverage, Medicare will be your only payer. You can re-enroll in the ABX Air plan November 8, 2021 - November 28, 2021 or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the ABX Air plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with ABX Air and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this ABX Air coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

REQUIRED LEGAL NOTICES

ABX Air HIPAA Privacy Notice

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

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

The Plan's duties with respect to health information about you

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

How the Plan may use or disclose your health information

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

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing “behind the scenes” plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

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

How the Plan may share your health information with ABX Air

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to ABX Air for plan administration purposes. ABX Air may need your health information to administer benefits under the Plan. ABX Air agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The Human Resources Department are the only ABX Air employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and ABX Air, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose “summary health information” to ABX Air, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to ABX Air 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 ABX Air cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by ABX Air from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

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

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

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

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

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

Your individual rights

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

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

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

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

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

Right to receive confidential communications of your health information

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

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

Right to inspect and copy your health information

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

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

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

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

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

Right to amend your health information that is inaccurate or incomplete

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

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

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

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

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

Right to obtain a paper copy of this notice from the Plan upon request

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

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2022. 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 via your employer's intranet site.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact your Human Resource Department.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Your Human Resource Department.

BENEFIT CONTACTS

BENEFITS TEAM (please contact your provider first)
abx.benefits@abxair.com

MEDICAL
UnitedHealthcare - group #703940
888-350-5607
www.myuhc.com

DENTAL
MetLife Dental - group #231454
800-942-0854
www.metlife.com/mybenefits

VISION
EyeMed Vision Care - group #9681974
866-939-3633
www.eyemedvisioncare.com

HEALTH SAVING ACCOUNT
Optum Bank - group #703940
www.optumbank.com

FLEXIBLE SPENDING ACCOUNT (FSA) and FMLA
Contact your Human Resource Department

GROUP LIFE and AD&D, GROUP LTD, VOLUNTARY STD, VOLUNTARY TERM LIFE, and VOLUNTARY ACCIDENT
MetLife - group #11008-1-G
www.metlife.com/mybenefits

CAP/401(k) Plan
Fidelity
800-835-5095
www.401k.com