FedEx Express

2023 Pilot Benefit Book

2023 PILOT BENEFIT BOOK

HOW THIS BOOK IS ORGANIZED

For a general overview of the contents of the Pilot Benefit Book, refer to the Table of Contents in the front, as well as the Table of Contents at the start of each section.

The sections in the Pilot Benefit Book are as follows:

- Who to Call
- Introduction
- Health Care Benefits
- Dental and Vision Benefits
- Disability Benefits
- Accounts
- Life Insurance
- Retirement
- Company Jumpseat
- Other Benefits and Services
- What to Do When
- Claims and Appeals

REVISION AND MAINTENANCE

This book will be updated periodically. Revised pages will be sent to pilots along with a summary sheet describing changes.

It is your responsibility to properly insert new or replacement pages in this book as soon as you receive them. The Company cannot and will not be liable for your failure to timely insert new or replacement pages in this book.

PILOT BENEFITS DIRECTORY

For Pilots and Covered Dependents Who Participate in FedEx Express Benefit Plans and Programs

Plan/Benefit	Administrator	Associated Coverage and Programs	Phone	Web
Eligibility and Enrollment				
Eligibility and Enrollment	FedEx Express Pilot Benefits Administration (PBA)	Medical, dental, vision, FSA, HSA/HRA, and life and accident insurance	866.795.6353	Email: PBA@fedex.com Pilot Benefits Online: https://fedexpilots.bswift.com
Group Health Benefits				
Active Pilot Medical Insurance **Domestic-Based Pilots** CDHP Purple, HSA & HRA CDHP Orange, HSA & HRA Buy Up Plan **Retired Pilot Medical Insurance** CDHP Purple CDHP Orange Buy Up High Deductible	Anthem Blue Cross	Member Services/ Preauthorization 24/7 NurseLine Confidential Assistance & Resources for Everyone (CARE), the Employee Assistance Program (EAP) and Mental Health & Substance Abuse International Provider Access Collect outside U.S. Coverage while Traveling Behavioral Health Resource Center AIM Specialty Pre-Cert	866.406.0982 800.700.9184 866.621.0130 (U.S.) 44.20.8987.6230 (Outside U.S.) 888.243.2358 0+610.254.8769 800.810.2583 877.657.6060 877.291.0516	www.anthem.com/ca
Prescription Drug Coverage	Express Scripts, Inc. Accredo	Retail & Mail Order Specialty Drugs	877.846.4710 800.803.2523	www.express-scripts.com www.accredo.com
Health Savings Account (HSA)	HealthEquity	Employer & Employee Contributions/Investment Options	Customer Service: 844.281.0925 Fax: 801.999.7829	https://www.healthequity.com
Health Reimbursement Account (HRA)	HealthEquity	Employer Credits	Customer Service: 844.281.0925 Fax: 801.999.7829	https://www.healthequity.com

Plan/Benefit	Administrator	Associated Coverage and Programs	Phone	Web
Medical – International Plan – **FDA-Based Pilots**	GeoBlue	**24/7 Member Services** Outside U.S. Within U.S. **CARE (EAP)** Outside U.S. Within U.S.	 +1.610.230.2406 888.304.8898 +44.20.8987.6230 866.621.0130	http://www.geo-blue.com/ GeoBlue email: customerservice@geo-blue.com
HMSA and Health Plan Hawaii (Residents of Hawaii only)	Hawaii Medical Service Association	**HMSA (PPO)** **When calling, reference Group No: 19337-1** Medical, Prescription, and EAP/Mental Health/ Substance Abuse Toll-Free **Health Plan Hawaii (HMO)** **When calling, reference Group No: 19342-1** Medical, Prescription, and EAP/Mental Health/ Substance Abuse Toll-Free	 808.948.6111 800.776.4672 808.948.6372 800.776.4672	www.hmsa.com
Dental – Domestic-Based Pilots	Cigna Dental	Dental for Pilots based in the U.S.	800.311.4725	www.cigna.com Once enrolled: www.mycigna.com
Dental – FDA-Based Pilots	Cigna Global	Dental for Pilots based in an FDA Global Toll-Free Global Direct Dial (can call collect outside the U.S.)	 800.441.2668 +1.302.797.3100	www.cignaenvoy.com
Vision – Domestic & FDA-Based Pilots	Davis Vision	Vision Within U.S. Outside U.S. (Collect)	 888.603.3339 +1.518.220.6000	www.davisvision.com

Plan/Benefit	Administrator	Associated Coverage and Programs	Phone	Web
Life Insurance Benefits				
Basic Life Optional Life Basic Accidental Death & Dismemberment (AD&D) Optional AD&D Business Travel Accident CRAF Accident	Securian Financial Group	General Information Eligibility and Benefit Questions Claims Underwriting (Evidence of Insurability) Conversion	877.491.5265 866 795 6353 888.658.0193 866.889.6221 866.365.2374	www.securian.com
Disability Benefits				
Long-Term and Supplemental Disability	The Hartford	LTD/ Supplemental LTD	800.757.0207	To file a claim: https://abilityadvantage.thehartford.com
Retirement Benefits				
FedEx Corporation Employees' Pension Plan (including the former FTL Fixed Pension Plan) Federal Express Corporation Non-Qualified Pension Plan for Pilots Federal Express Corporation Non-Qualified Section 415 Excess Pension Plan for Pilots FTL Variable Annuity Pension Plan for Pilots (VAPPP)	FedEx Retirement Service Center	Pension plans	855.604.6221 Hearing-impaired will need to call in with local relay service	http://retirement.fedex.com/
Federal Express Corporation Pilots' Retirement Savings Plan	Fidelity	Retirement plans	833.383.3339	netbenefits.com
FedEx Corporation Retirement Savings Plan (for benefits earned prior to pilot employment)	Vanguard	Retirement plans (FedEx employee accounts established *prior to* becoming a Pilot)	800.523.1188 TTY: 800.523.8004	www.vanguard.com
Other Benefits				
Adoption Benefit	LifeCare®	Adoption assistance and resources	877.543.3339	https://worklifebalance.lifecare.com **Registration code:** fedex **Member ID:** FedEx employee number Helpdesk: helpdesk@lifecare.com

Plan/Benefit	Administrator	Associated Coverage and Programs	Phone	Web
Flexible Spending Accounts (FSAs)	HealthEquity	Health Care (Full- and Limited-Purpose) and Dependent Care	Customer Service: 844.281.0925 Fax: 801.999.7829	https://www.healthequity.com
Pre-Medicare Retiree Health Reimbursement Account	HealthEquity	Annual employer credit	Customer Service: 844.281.0925 Fax: 801.999.7829	https://www.healthequity.com
Subrogation	Vengroff Williams	Health Plan Subrogation	800.813.4054	vengroffwilliams.com
Allstate Identity Protection	Allstate	Identity theft protection	855.687.2016	www.myaip.com/fedex
Legal Plan Accident Insurance Critical Illness Hospital Indemnity Long-Term Care (closed to new enrollees)	MetLife		844.463.8339	http://metlife.com/fedex
Personal Property (Home/Auto) Insurance	Farmers Travelers	Personal property insurance program for automobiles, renters, homes condominiums, boats, and recreational vehicles	Farmers: 800.438.6381 Travelers: 866.903.5054	https://www.farmers.com/ http://www.travelers.com/fedex
Work/Life Resource and Referral	LifeCare®	Resource and referral program to assist with work/life issues	877.543.3339 TTY: 800.873.1322	https://worklifebalance.lifecare.com/ **Registration code:** fedex **Member ID:** FedEx employee number Helpdesk: helpdesk@lifecare.com
Tuition Assistance Program	FedEx through Workday	Tuition reimbursement	901.434.9822	FedEx Intranet, keyword: tuition Email: education.assistance@fedex.com
Pet Insurance	Nationwide	Pet insurance	877.738.7874	www.petinsurance.com/fedex
Employee Reduced-Rate Shipping for eligible active and retired pilots	FedEx Express Revenue Services	FedEx shipping benefits	FedEx Express Revenue Services: 800.622.1147	Email: EmployeeDiscountShipping@corp.ds.fedex.com
FedEx Employees Credit Association	FedEx	Variety of banking services	Memphis area: 901.344.2500 In U.S.: 800.228.8513	www.fecca.com

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INTRODUCTION

As a pilot, your compensation at FedEx is more than your paycheck. It also includes a comprehensive benefits package that gives you and your family financial security during your working years and during retirement. For purposes of this book, the term “pilot” means an employee of Federal Express Corporation (the Company) whose right to participate in these benefit plans arises from the collective bargaining agreement between the Company and the Air Line Pilots Association, International (the Association). That agreement is referred to in this book as the “Collective Bargaining Agreement” or “Agreement.” Your participation in the benefit programs described in this book is provided under the terms of that Collective Bargaining Agreement. However, your continued eligibility to participate in these benefit programs depends on your next collective bargaining agreement.

Note, many of the programs described in the “Other Benefits” section are available to pilots on the same terms and conditions as available to other employees of the Company. However, the Company is not obligated to continue providing these enhanced benefits should they be unavailable or discontinued for any reason for all employees.

This book explains each benefit as simply and accurately as possible. It contains the Summary Plan Descriptions (SPDs) of the Employee Welfare Benefit Plans and the Employee Retirement Benefit Plans in which you may be eligible to participate.

The individual sections of this book summarize the highlights of the Pilots’ benefit plans. The information contained in each section is taken from the benefit plan documents and is written in summary form. The summaries do not try to cover every detail. Complete details can be found only in the formal plan documents, which govern the operations of the plans. These materials are intended to be the SPDs required under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. If there is a conflict between the summaries and the respective plan documents, the terms of the plan documents will control. If you wish to read the actual benefit plans and, if applicable, any related insurance agreements, you may review them or get a copy from Pilot Benefits Administration. This section of the book includes information about how the plans are administered and your rights under ERISA. You are not entitled to, nor denied benefits, because of a misstatement in, or omission from this book.

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Scope and Guidelines

Eligibility for each benefit plan, program, or service is determined by the Company or the applicable plan administrator. Each section of this book describes a benefit plan, program, or service, and how transferring between the Controlled Group Members affects eligibility.

Controlled Group Members include:

FedEx Corporation

Federal Express Corporation (FedEx Express)

Federal Express Virgin Islands, Inc.

FedEx Corporate Services, Inc.

FedEx Supply Chain, Inc.

FedEx Trade Networks, Inc.

FedEx Trade Networks Transport & Brokerage, Inc.

FedEx Trade Networks Trade Services, Inc.

World Tariff, Limited

FedEx Freight Corporation

FedEx Freight, Inc.

FedEx Custom Critical, Inc.

FedEx Office & Print Services, Inc.

FedEx Office Commercial Press, Inc.

FedEx Truckload Brokerage, Inc.

FedEx Ground Package System, Inc.

FedEx CrossBorder, LLC

GENCO Infrastructure Solutions, Inc.

TNT Express N.V.

The benefits programs described in this book are those of FedEx Express collectively bargained pilots.

The Benefit Program

Your benefits package is made up of many interrelated plans that help provide you and your family with increased financial security. The benefits listed below make up your benefits package and descriptions of these benefits are included in this book.

Benefit	Benefit Plans, Programs & Services
Medical (includes Mental Health/Substance Abuse), Prescription Drug, Dental, and Vision	● Group Health Plan for Pilots including the Health Savings Account (HSA) and the Health Reimbursement Account (HRA) ● Retiree Group Health Plan for Pre-65 Pilots ● Health Care Contribution Plan*
Confidential Assistance & Resources for Everyone (CARE)	Your employee assistance program through Anthem
Long-Term Disability (LTD) (includes Supplementary Disability Benefit)	LTD Plan for Pilots
Life and Accident Insurance	● Basic Life Insurance Policy ● Pilot Optional Life Insurance Policy ● Spouse Optional Life Insurance Policy ● Child Optional Life Insurance Policy ● Retiree Optional Life Insurance Policy ● Basic Accidental Death and Dismemberment (AD&D) Policy ● Pilot Optional Accidental Death and Dismemberment (AD&D) Policy ● Business Travel Accident Insurance Policy (including CRAF Accident Insurance)
Retirement	● Pension Plan ● Non-Qualified Pension Plan for Pilots (Compensation Limit Plan) ● Non-Qualified Section 415 Excess Pension Plan for Pilots ● FTL Variable Annuity Pension Plan for Pilots ● Pilots' Retirement Savings Plan (PRSP)
Flexible Spending Accounts	● Dependent Care Flexible Spending Account Plan ● Health Care Flexible Spending Account Plan
Voluntary Benefit Plans*	● Accident Insurance ● Auto and Home Insurance ● Critical Illness Insurance ● Hospital Indemnity Insurance ● Met Life Legal Services ● Identity Theft Protection ● Pet Insurance ● Group Long-Term Care Insurance Plan (LTCI) (as of Jan. 1, 2013, this Plan is closed to new enrollees)

*These programs are available to pilots under the same terms and conditions as available to other employees of the Company.

With respect to pilot benefit plans and programs, the Company may terminate, modify, or suspend any benefit plan or program only as permitted by the terms of the Collective Bargaining Agreement. With respect to the benefit plans and programs that are available to pilots under the same terms and conditions as available to other employees of the Company, the Company may terminate, modify, or suspend these benefit plans and/or programs for any reason at any time.

Plan Administration

The individual sections of this book summarize the highlights of the Pilots' benefit plans. The information contained in each section is taken from the benefit plan documents and is written in summary form. The summaries do not try to cover every detail. Complete details can be found only in the formal plan documents, which govern the operations of the plans. These materials are intended to be the SPDs required under the Employee Retirement Income Security Act of 1974, as amended (ERISA). If there is a conflict between the summaries and the respective plan documents, the terms of the plan documents will control. If you wish to read the actual benefit plans and, if applicable, any related insurance agreements; you may review them or get a copy from Pilot Benefits Administration. This section of the book includes information about how the plans are administered and your rights under ERISA.

Plan Funding Methods

The funding method of the FedEx benefit plans can be separated into three categories:

- Trusteed plans
- Insured plans
- General asset plans

Trusteed Plans

Assets for *trusteed plans* accumulate and are invested in separate trust funds maintained by designated trust companies. Benefit payments are paid from these trust funds.

Trusteed Plans	Trustee
Flying Tiger Line Inc. Variable Annuity Pension Plan for Pilots (VAPPP)	State Street Bank and Trust Company 2 Avenue de Lafayette, 2nd Floor Boston, MA 02111
Long-Term Disability Plan for Pilots	
FedEx Corporation Employees' Pension Plan (Pension Plan)	
Federal Express Corporation Pilots' Retirement Savings Plan (PRSP)	Fidelity Management Trust Company (FMTC) Attn: Plan #74857 245 Summer Street Boston, MA 02110

Insured Plans

For *insured plans,* premiums are paid to an insurance company. Benefit payments are paid by the insurance company. The Hawaii plans and the International Plan are insured health plans.

Insured Plans	Insurance Company
Basic Life Insurance Policy for Pilots	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098
Optional Life Insurance Policy for Pilots Retiree Optional Life Insurance Plan for Pilots	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098
Basic Accidental Death and Dismemberment (AD&D) Policy for Pilots	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098
Optional Accidental Death and Dismemberment (AD&D) Policy for Pilots	
Business Travel Accident Insurance Policy for Pilots (including CRAF Accident Insurance)	
MetLife Legal Services Plan for Federal Express Corporation and Affiliated Employers (GLSP)	MetLife Legal 1111 Superior Avenue Cleveland, OH 44114-2507 1.800.GET.MET8 (1.800.438.6388) www.metlife.com/fedex
MetLife Critical Illness, Accident, and Hospital Indemnity Insurance	Metropolitan Life Insurance Company P.O. Box 80826 Lincoln, NE 68501-0826 1.866.626.7350 www.metlife.com/fedex
Group Long-Term Care Insurance Plan (LTCI) (As of Jan. 1, 2013, this Plan is closed to new enrollees.)	Metropolitan Life Insurance Company Voluntary Benefits Group 501 Route 22, Third Floor Bridgewater, NJ 08807 1.800.GET.MET8 (1.800.438.6388)
International Health Plan for FDA Pilots	GeoBlue 933 First Avenue King of Prussia, PA 19406
Hawaii Medical Service Association (HMSA)	HMSA 818 Keeaumoku Street Honolulu, HI 96814
Health Plan Hawaii (HPH)	HPH 818 Keeaumoku Street Honolulu, HI 96814

General Asset Plans

Benefit payments under general asset plans are paid by the Company directly from general assets.

General Asset Plans	Company
Confidential Assistance & Resources for Everyone (CARE)—the employee assistance program	Federal Express Corporation
Group Health Plan for Pilots Retiree Group Health Plan for Pilots	
Non-Qualified Pension Plan for Pilots (Compensation Limit Plan)	
Health Care Contribution Plan	
Dependent Care Flexible Spending Account Plan for Pilots	
Health Care Flexible Spending Account for Pilots	
Non-Qualified Section 415 Excess Pension Plan for Pilots	

Plan Identification

The IRS has assigned employer identification number 71-0427007 to FedEx Express Corporation. Each FedEx benefit plan is also assigned a plan number by FedEx. The plan numbers and plan administrators for the various pilot benefit plans are listed in the following table. The plan administrator and, in some cases, the plan's claims paying administrator has the authority and discretion to interpret the plan provisions and to determine eligibility to receive benefits under the plans, as provided under the plan documents and the Collective Bargaining Agreement.

Plan	Plan Number	Plan Administration
FedEx Corporation Employees' Pension Plan (Pension Plan)	002	**Postal Mail:** FedEx Retirement Service Center* PO Box 661087 Dallas, TX 75266-1087 For Overnight Delivery send to: FedEx Retirement Service Center MS-55 2701 East Grauwyler Rd Irving, TX 75061 1.855.604.6221 **retirement.fedex.com**
Flying Tiger Line Inc. Variable Annuity Pension Plan for Pilots (VAPPP)	004	
Federal Express Corporation Non-Qualified Pension Plan for Pilots	N/A	
Federal Express Corporation Non-Qualified §415 Excess Pension Plan for Pilots	N/A	
Federal Express Corporation Pilots' Retirement Savings Plan (PRSP)	007	Fidelity Investments, Inc. Attn: Plan #74857 100 Crosby Pkwy KC1F Covington, KY 41015 1.833.383.3339 netbenefits.com
Federal Express Corporation Group Health Plan for Pilots (Medical, Prescription Drug, Mental Health/ Substance Abuse, Eligibility, Dental, Vision)	527	FedEx Express Pilot Benefits Administration 3620 Hacks Cross Road Building B-3 Memphis, TN 38125-8800 1.866.795.6353
Federal Express Corporation Business Travel Accident Insurance Policy for Pilots	503	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098
Federal Express Corporation Accidental Death and Dismemberment Insurance Policy including Optional AD&D for Pilots	504	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098
Federal Express Corporation Basic Life Insurance Policy for Pilots	511	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098
Federal Express Corporation Optional Life Insurance Policy for Pilots, Spouse, and Children	514	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098

Plan	Plan Number	Plan Administration
Federal Express Corporation Employee Assistance Program for Pilots – (CARE)	529	FedEx Express Pilot Benefits Administration 3620 Hacks Cross Road Building B-3 Memphis, TN 38125-8800 1.866.795.6353
Federal Express Corporation Health Care Flexible Spending Account Plan for Pilots	524	FedEx Express Pilot Benefits Administration 3620 Hacks Cross Road Building B-3 Memphis, TN 38125-8800 1.866.795.6353
Federal Express Corporation Dependent Care Flexible Spending Account Plan for Pilots	516	FedEx Express Pilot Benefits Administration 3620 Hacks Cross Road Building B-3 Memphis, TN 38125-8800 1.866.795.6353
Federal Express Corporation Retiree Group Health Plan for Pilots (Medical, Prescription Drug, Mental Health/Substance Abuse, Eligibility, Dental, Vision)	528	FedEx Express Pilot Benefits Administration 3620 Hacks Cross Road Building B-3, Memphis, TN 38125-8800 1.866.795.6353
FedEx Corporation Health Care Contribution Plan	517	FedEx Express Pilot Benefits Administration 3620 Hacks Cross Road Building B-3 Memphis, TN 38125-8800 1.866.795.6353
Federal Express Corporation Long-Term Disability Plan for Pilots	523	FedEx Express Pilot Benefits Administration 3620 Hacks Cross Road Building B-3 Memphis, TN 38125-8800 1.866.795.6353
Federal Express Corporation Group Long-Term Care Insurance Plan As of Jan. 1, 2013, this Plan is closed to new enrollees.)	521	FedEx Services Benefits Administration 90 FedEx Parkway 1st Floor, Vertical Collierville, TN 38017-8711 1.901.263.5202 Memphis area
MetLife Legal Services Plan for Federal Express Corporation and Affiliated Employers Plan	522	FedEx Services Benefits Administration 90 FedEx Parkway 1st Floor, Vertical Collierville, TN 38017-8711 1.901.263.5202 Memphis area

Plan	Plan Number	Plan Administration
Federal Express Corporation Adoption Assistance Plan	505	LifeCare® Attn: FedEx Adoption Subsidy Administrator 2 Armstrong Road Shelton, CT 06484 1.877.543.3339

*FedEx Corporation is the Plan Administrator for the above plans. However, the Company has delegated administrative functions to the FedEx Retirement Service Center for the Pension Plan, the non-qualified plans and the VAPPP; and to Fidelity for the PRSP.

Plan Year

The plan year for most benefits begins on June 1 and ends on May 31 of each year. For the following plans, however, the plan year begins January 1 and ends on December 31:

- Federal Express Corporation Pilots' Retirement Savings Plan (PRSP)
- Flying Tiger Line Inc. Variable Annuity Pension Plan for Pilots (VAPPP)
- Federal Express Corporation Dependent Care Flexible Spending Account Plan for Pilots
- Federal Express Corporation Health Care Flexible Spending Account Plan for Pilots
- Federal Express Corporation Health Care Contribution Plan
- Federal Express Corporation Group Long-Term Care Insurance Plan
- MetLife Legal Services Plan for Federal Express Corporation and Affiliated Employers
- Federal Express Corporation Business Travel Accident Insurance Policy for Pilots
- Federal Express Corporation Optional Accidental Death and Dismemberment Insurance Policy for Pilots
- Federal Express Corporation Basic Life and Basic Accidental Death and Dismemberment Insurance Policy for Pilots
- Federal Express Corporation Optional Life Insurance Policy for Pilots
- Federal Express Corporation Adoption Assistance Plan

Your Rights Under ERISA

As a participant in the FedEx benefit 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 Plans and Benefits*
  - Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts and copies 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 (EBSA).
  - Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and updated SPDs. 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.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 62) 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 a year. The plan must provide the statement free of charge.

- *Continue Group Health Plan Coverage*
  - Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- *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 or any other person, may terminate 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.

- *Enforce Your Rights*
  - If your claim for a pension or 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 Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan 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 after all levels of review have been exhausted. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 may 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 (for example, if it finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance With Your Questions—If you have any questions about your plan(s), 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, listed in your telephone directory or write:

Division of Technical Assistance and Inquiries
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.

HIPAA Notice of Privacy Practices for Protected Health Information for the FedEx Corporation Group Health Plan for Pilots

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.

1. **Background.** This is your Health Information Privacy Notice on behalf of the Federal Express Corporation Group Health Plan for Pilots (the "Plan"). **Please read it carefully.** You have received this Notice because of your participation in the Plan maintained by Federal Express Corporation ("FedEx" or the "Plan Sponsor"). This notice will explain your rights under the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH ACT"). The Plan and the Plan Sponsor strongly believe in protecting the confidentiality and security of information received about you during the course of administering the Plan.

   This Notice describes how the Plan protects the Protected Health Information ("PHI") obtained about you relating to your health coverage, and how the Plan may use and disclose this information. PHI includes individually identifiable information which relates to your past, present, or future health and treatment or payment for health care services. This Notice also describes your rights with respect to your PHI and how you can exercise those rights.

   The Plan is required to provide this Notice to you under HIPAA. For additional information regarding the Plans' HIPAA Privacy Policy or general privacy policies, you may consult the Privacy Policies and Procedures Statement maintained by Federal Express Corporation. You may submit questions to the Plan there or you may write directly to Kelly Romito, HIPAA Privacy Officer, Federal Express Corporation, 3620 Hacks Cross Road, Building B, 2nd Fl., Memphis, TN 38125.

   This Privacy Notice is effective as of October 1, 2018.

2. **Legal Requirements.** The Plan is required by law to:

   a. Maintain the privacy of your PHI;

   b. Provide you this Notice of the Plan's legal duties and privacy practices with respect to your PHI; and

   c. Follow the terms of this Notice.

   The Plan reserves the right to change the terms of this Notice and to make the new Notice applicable to all PHI the Plan maintains.

The Plan protects your PHI from inappropriate use or disclosure. The Plan, the employees of the Plan Sponsor responsible for the administration of the Plan, and all companies that help maintain and administer the Plan, are required to comply with the Plans' requirements that protect the confidentiality of PHI. These entities and individuals may only look at your PHI when there is an appropriate reason to do so, such as to administer health care services under the Plan.

The Plan will not disclose your PHI to any company for their use in marketing their products to you. However, as described below, the Plan may use and disclose PHI about you for business purposes relating to your health coverage.

3. **Use and Disclosure of PHI.** The main reasons for which the Plan may use and may disclose your PHI are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures, together with some examples.

   a. **For Payment.** The Plan may use and disclose PHI to pay for benefits under your health coverages. For example, the Plan may review PHI contained on claims to reimburse providers for health services rendered to you and your family. The Plan may also disclose PHI to insurance carriers and third-party administrators to coordinate benefits with respect to a particular claim. Additionally, the Plan may disclose PHI to another health plan or an administrator of an employee welfare benefit plan for various payment related functions, such as eligibility determination, audit and review, or to assist you with your inquiries for coverage or disputes.

   b. **For Treatment.** The Plan may use and disclose PHI for purposes of your treatment. Treatment means the coordination or management of health care and related services by one or more health care providers, including, for example:

      i. The coordination or management of health care by a health care provider with a third party.

      ii. Consultation between health care providers relating to a patient; or

      iii. The referral of a patient from one health care provider to another. However, PHI that is genetic information (including family medical histories) may not be used or disclosed for underwriting purposes (except with regard to long-term care insurance).

   c. **For Health Care Operations.** The Plan may also use and disclose PHI for insurance operations or to administer self-insured programs. These purposes include evaluating a request for health insurance requested by you. The Plan may also disclose PHI to Business Associates, if they need to receive PHI to provide a service and have agreed to abide by specific HIPAA rules relating to the protection of PHI. Examples of Business Associates are billing companies, data processing companies, or companies that provide general administrative services. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition in order to make an informed business decision regarding any such prospective transaction. However, PHI that is genetic

information (including family medical histories) may not be used or disclosed for underwriting purposes (except with regard to long-term care insurance).

d. **Where Required by Law or for Public Health Activities.** The Plan may disclose PHI when required by federal, state, or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases or providing PHI to a governmental agency or regulator with health care oversight responsibilities. The Plan may also release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

e. **To Avert a Serious Threat to Health or Safety.** The Plan may disclose PHI to avert a serious threat to someone's health or safety. The Plan may also disclose PHI to federal, state, or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

f. **For Health-Related Benefits or Services.** The Plan may use PHI to provide you with information about benefits available to you under your current coverages or policies and, in limited situations, about health-related products or services that may be of interest to you, including treatment alternatives, subject to limits imposed by law. The Plan may use or disclose PHI to send you reminders about your benefits or case, such as appointment or refill reminders.

g. **For Law Enforcement or Specific Government Functions.** The Plan may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons, or similar process. The Plan may disclose PHI about you to federal officials for intelligence, counterintelligence, and other military and national security activities authorized by law.

h. **When Requested as Part of a Regulatory or Legal Proceeding.** If you or your estate are involved in a lawsuit or a dispute, the Plan may disclose PHI about you in response to a court or administrative order. The Plan may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. The Plan may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

i. **For Plan Sponsors.** The Plan may share PHI with the Plan Sponsor, for plan administration, subject to the Sponsor's agreement to special restrictions on its use and disclosures of the information.

j. **To Persons Involved With Your Care.** The Plan may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, the Plan will use its best judgment to decide if the disclosure is in your best interests.

k. **For Reporting Victims of Abuse, Neglect, or Domestic Violence.** The Plan may disclose your health information to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

l. **For Workers' Compensation.** The Plan may disclose your health information as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

m. **For Research Purposes.** The Plan may disclose your health information for research purposes, such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

n. **For Organ Procurement Purposes.** The Plan may use or disclose information to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

o. **To Correctional Institutions or Law Enforcement Officials.** The Plan may disclose your health information if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

p. **For Data Breach Notification Purposes.** The Plan may use your contact information to provide notices of unauthorized acquisition, access, or disclosure of your health information.

4. **Other Uses of Protected Health Information.** Other uses and disclosures of PHI not covered by this Notice and permitted by the laws that apply to the Plan will be made only with your **written authorization** or that of your legal representative. Examples of such uses and disclosures include:

   a. Most uses and disclosures of psychotherapy notes;

   b. Uses and disclosures of PHI for marketing purposes, including subsidized treatment communications;

   c. Disclosures that constitute a sale of PHI; and

   d. Any other uses or disclosures not described in this Notice.

   If the Plan is authorized to use or disclose PHI about you, you, or your legally authorized representative may **revoke** that authorization **in writing**, at any time, except to the extent that the Plan has taken action relying on the authorization or if the authorization was obtained as a condition of obtaining any coverages. You should understand that the Plan will not be able to take back any disclosures the Plan has already made with authorization.

The Plan is prohibited from using or disclosing your genetic information for underwriting purposes (except with regard to long-term care insurance).

5. **Your Rights Regarding Protected Health Information the Plan Maintains About You.** The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about a specific right, please write to the individual(s) at the locations listed in this document for an explanation of your rights.

   a. **Right to Inspect and Copy Your Protected Health Information.** In most cases, you have the right to inspect and obtain a copy of the PHI that the Plan maintains about you. If the Plan maintains an electronic health record containing your health information, you also have the right to request PHI in an electronic format and to direct it to be sent to another designated person or entity. To inspect and copy PHI or request PHI in electronic format, you must submit your request **in writing** to: Pilot Benefits Administration, Federal Express Corporation, 3620 Hacks Cross Road, Building B, 2nd Floor, Memphis, TN 38125.

   All requests will be forwarded to the applicable third-party administrator or insurance company, as applicable. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, or other supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes PHI collected by the Plan in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances, the Plan may deny your request to inspect and obtain a copy of your PHI. If the Plan denies your request, you may request that the denial be reviewed. The review will be conducted by an individual chosen by the Plan who was not involved in the original decision to deny your request. The Plan will comply with the outcome of that review.

   b. **Right to Amend Your Protected Health Information.** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask the Plan to amend your PHI while it is kept by or for the Plan. You must provide your request and your reason for the request **in writing**, and submit it to Manager Labor Relations, Federal Express Corporation, 3620 Hacks Cross Road, Building B, 2nd Floor, Memphis, TN 38125.

   All requests will be forwarded to the applicable third-party administrator or insurance company, as applicable. The Plan may deny your request if it is not in writing or does not include a reason that supports the request. In addition, the Plan may deny your request if you ask the Plan to amend PHI that:

      i Is accurate and complete;

      ii Was not created by the Plan, unless the person or entity that created the PHI is no longer available to make the amendment;

      iii Is not part of the PHI kept by, or for, the Plan; or

      iv Is not part of the PHI which you would be permitted to inspect and copy.

   c. **Right to a List of Disclosures.** You have the right to request a list of the disclosures of your PHI that the Plan has made. This list will not include disclosures made for

treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel, or made pursuant to your authorization or made directly to you. To request this list, you must submit your request **in writing** to Manager Labor Relations, Federal Express Corporation, 3620 Hacks Cross Road, Building B, 2nd Floor, Memphis, TN 38125.

All requests will be forwarded to the applicable third-party administrator or insurance company, as applicable. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than **6 years** before the date of the request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a **12-month** period will be free. The Plan may charge you for responding to any additional requests. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

d. **Right to Request Restrictions.** You have the right to request a restriction or limitation on PHI the Plan may use or disclose about you for treatment, payment, or health care operations, or that the Plan disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While the Plan will consider your request, the Plan is not required to agree to it unless you have paid for the services out-of-pocket, in full, and you request that the Plan does not disclose your Personal Health Information related only to those services. If the Plan agrees to your request for restriction, the Plan will comply with your request. To request a restriction, you must make your request **in writing** to Manager Labor Relations, Federal Express Corporation, 3620 Hacks Cross Road, Building B, 2nd Floor, Memphis, TN 38125.

All requests will be forwarded to the applicable third-party administrator or insurance company, as applicable. In your request, you must tell the Plan: (1) what information you want to limit; (2) whether you want to limit the Plans' use, disclosure, or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). The Plan will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer the Plan.

e. **Right to Receive Confidential Communications.** You have the right to receive communications about your PHI from the Plan in a certain way or at a certain location if you tell us about that communication in another manner may endanger you. For example, you can ask that the Plan only contact you at work or by mail. To request confidential communications, you must make your request **in writing** to Manager Labor Relations, Federal Express Corporation, 3620 Hacks Cross Road, Building B, 2nd Floor, Memphis, TN 38125.

All requests will be forwarded to the applicable third-party administrator or insurance company, as applicable.

Please specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to provide PHI to you under Subsection 5a in a particular form or format if it can readily produce the information in that form. The Plan will also accommodate your request to provide information under Subsection 5a to another person whom you designate in writing if you make that designation clearly and in accordance with any rules that the Plan reasonably prescribes.

f. **Right to Notice of a Breach.** The HITECH ACT requires that notice be provided to you in situations where the HITECH ACT regards your information to be unsecured and the privacy of that information to be breached.

g. **Right to File A Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the United States Department of Health and Human Services Office for Civil Rights. To file a complaint with the Plan, please contact Kelly Romito, HIPAA Privacy Officer, Federal Express Corporation, 3620 Hacks Cross Road, Building B, 2nd Fl., Memphis, TN 38125. **All complaints must be submitted in writing.** You will not be penalized for filing a complaint. If you have questions as how to file a complaint, please contact the Plan at 1.866.795.6353.

6. **Additional Information.**

a. **Changes to This Notice.** The Plan is required to abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice at any time. The Plan reserves the right to make the revised or changed Notice effective for PHI the Plan already has about you as well as any PHI the Plan receives in the future. The effective date of this Notice and any revised or changed Notice may be found on both page 1 of the Notice and on the last page, on the bottom right-hand corner of the Notice. If this Notice is revised, you will receive a copy of the revised Notice from the Plan by mail or by email, but only if email delivery is offered by the Plan and you agree to such delivery. Even if you receive this Notice via email, you have the right to request a paper copy of this Notice.

b. **Further Information.** You may have additional rights under other applicable laws. For additional information regarding the Plan, HIPAA Privacy Policy or our general privacy policies, please contact us at 1.866.795.6353 or write to us at Pilot Benefits Administration, Federal Express Corporation, 3620 Hacks Cross Road, Building B, 2nd Fl., Memphis, TN 38125.

c. Other Notices. You may receive separate Notices of Privacy Policies from the insurance companies or HMO who provide the Plan addressed in this Notice. To the extent such notices differ from this Notice, the provisions of such other notices may be controlling.

Plan Amendment and/or Termination

Subject to the terms and provisions of the Collective Bargaining Agreement, FedEx reserves the right to terminate, modify, or suspend any or all benefit plans as listed on the chart under "The Benefit Program" in this section. If such steps are taken, you will be informed of the effect of the changes on your rights to benefits.

Status of Benefits

If a plan is terminated, the following applies to the status of its benefits:

- If the plan provided benefits insured by an insurance company (e.g., insured plan or group life insurance), the status of benefits is governed by the terms of the insurance policy.
- If the plan provided benefits through a trust that is a Voluntary Employees' Beneficiary Association, the funds of the trust are used to pay plan benefits until those funds are exhausted.
- If the Pilots' Retirement Savings Plan terminates, each participant is entitled to a distribution of his/her account balance according to the value of the account on the distribution date.
- If the Pension Plan terminates, all participants' accrued benefits become 100 percent vested to the extent they are funded. Subject to approval by the Pension Benefit Guaranty Corporation (PBGC), the assets of the plan are allocated and distributed in the following order:
  (1) To persons receiving or eligible to receive annuity payments from the plan 36 months before the date the plan is terminated. (The five-year period dating back from the termination date is examined to determine whether or not retirement benefits were calculated under different formulas. If so, the method providing the smallest benefit is used.)
  (2) To all benefits insured by the PBGC.
  (3) To all other vested benefits.
  (4) To all other benefits payable under the plan.

  If plan assets cannot satisfy in full the benefits of everyone in (1) and (2), they are prorated among them on the basis of the present value of their respective benefits as of the termination date. If there are not enough assets to satisfy in full the benefits of the individuals in (3), their benefits are calculated according to the provisions of the plan in effect five years before the termination date. If the benefits calculated under that method still exceed the available plan assets, they are calculated under the terms of the most recent amendment to the plan that satisfies these benefits.

Any residual assets of the Pension Plan may revert to the Company if not prohibited by any state or federal law and if all liabilities to participants, retirees, and beneficiaries have been satisfied in full.

HEALTH CARE BENEFITS

(Active Health Coverage, Health Coverage for Survivors of an Active Pilot, Retiree Health Coverage and Retiree Health Coverage for Survivors of a Retiree Health Pilot)

FedEx Express offers a variety of medical plan options and other health coverage for you and your eligible dependents. These plans are designed to provide important financial protection and comprehensive health coverage.

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Important

If there is ever a conflict between this book and the official Plan documents, the Plan documents govern. You are not entitled to benefits because of a misstatement in or omission from this book.

HEALTH CARE—GENERAL INFORMATION

Eligibility

Eligible employees are any pilots employed by Federal Express Corporation who are covered by the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International.

Health Care coverage for you and your eligible dependents depends on your employment status. See this chart to see what coverage you are eligible for and when that coverage becomes effective.

If You Are…	Your Coverage is Effective…
Active pilot	On your first day of employment. You are automatically enrolled in Pilot Only health care coverage. Dependent coverage is effective on your first day of employment if you enroll in Pilot & Child(ren), Pilot & Spouse or Pilot & Family health coverage within **31 days** following your hire date or by the deadline indicated in your new hire letter.
Retired or terminated pilot and meet the age and service requirements for retiree health care coverage	On your retirement or termination date

Your Eligible Dependents

As a pilot, you may enroll your eligible dependents in your health coverage.

You are able to cover your eligible children under your medical plan until midnight on the last day of the month in which the child attains age 26 with no restrictions.

Dependents eligible to be covered under your medical coverage include your:

- Legally married spouse;
- In California only, a domestic partner registered with the state of California
- Eligible child, who is your:
  - Natural child
  - Stepchild
  - Legally adopted child, including a child placed in your home for the purpose of adoption
  - Child for whom you have legal guardianship
  - Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO), as long as the child meets the definition of an eligible dependent
  - Child who meets the guidelines for mental or physical incapacitation before age 26 (for medical only; an incapacitated dependent must meet the federal tax exemption guidelines, which indicates the dependent must live in the parent's home a minimum of six months of the year and receive at least 50% of their financial support from the parent
  - In California only, your domestic partner's child

NOTE: Your dependent(s) cannot be covered both as an employee and as a dependent.

If you are enrolling an eligible dependent for coverage, you must provide acceptable documents within 45 days of enrollment to verify the dependent is eligible for benefits. See "Dependent Eligibility Verification" for more information.

Medical coverage ends automatically at midnight on the last day of the month in which your child attains age 26, and dental and/or vision coverage ends automatically at midnight on the last day of the month in which your child attains age 23, unless incapacitated as described above. Following the date of coverage termination, medical coverage may be continued for up to 36 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA) by paying the full cost of coverage. See "COBRA—Continuation of Coverage" for more information.

Continuation of Coverage for an Incapacitated Dependent

If your child is incapacitated and you wish to continue his/her coverage beyond age 26 for medical coverage, and age 23 for dental and/or vision coverage, your child must be mentally or physically incapacitated before the limiting age mentioned. The parent and/or guardian must submit a physician statement that documents the following:

- Impairment Date
- Prognosis (months or years)
- Indication if dependent's impairment existed continuously up to the present time
- Indication if dependent is now incapable of self-support because of the impairment

- Documented diagnosis codes (ICD10) relevant to the impairment or condition in question

Incapacitated dependents must meet the federal tax exemption guidelines, which indicates dependents must live in the parent's home a minimum of six months of the year and receive at least 50% of their financial support from the parent.

Anthem conducts all incapacitation reviews related to continuing medical, dental, and vision coverage for an incapacitated child and makes the determination based on their guidelines. You must provide documentation three months in advance of your child's 26th birthday for a medical review; and three months in advance of your child's 23rd birthday for dental and vision reviews according to the following:

- **ALL PILOTS**: For children approaching age 23 (aging out of dental and/or vision), you must contact Pilot Benefits Administration to obtain the application to continue coverage. Return the application to Pilot Benefits Administration via email at PBA@fedex.com. For coverage continuation applications that are returned to Pilot Benefits Administration, Pilot Benefits Administration will serve as the liaison between you and Anthem.

- **DOMESTIC-BASED PILOTS**: For children approaching age 26 (aging out of medical), you must contact Anthem Member Services at the number listed on the back of your Medical ID card to request the application to continue coverage. Return the application to Anthem using the address/fax number on the application.

- **RESIDENTS OF HAWAII and FDA-BASED PILOTS**: For children approaching age 26 (aging out of medical), you must contact Pilot Benefits Administration to request the application to continue coverage. Return the application to Pilot Benefits Administration via email at PBA@fedex.com.

You should complete and return the application (and additional medical documentation, if necessary) three months in advance of your child's birthday to prevent any lapse in coverage.

Note: Re-certification of an incapacitated child is required every three years in order to continue coverage and the review will be handled by Anthem. The re-certification process is basically the same as described above. You must contact Anthem or Pilot Benefits Administration at least three months before the continued coverage end date to request another application for continued coverage.

Domestic Partner Coverage in California

To qualify for benefits under the Plan, the domestic partner relationship must be registered with the state of California and both the pilot and the domestic partner must reside in the state of California. Should the pilot or the domestic partner relocate from the state of California, neither the domestic partner nor the domestic partner's children would be eligible dependents under the Plan. Under the Internal Revenue Code, a pilot is not taxed on the value of benefits provided by an employer to a pilot's spouse or dependent. However, the value of benefits provided to a pilot's domestic partner (and the domestic partner's eligible children, if any) is considered part of the pilot's taxable income unless the pilot's domestic partner and/or his or her children qualify as a legal tax dependent under Section 152 of the Internal Revenue Code.

If you enroll a domestic partner and/or their eligible children for health care coverage and they do not qualify as your legal tax dependent(s), the IRS treats pilot contributions and the contributions made by the Company as taxable. Pilot contributions will be made with after-tax dollars. In addition, the value of the benefit may be considered additional taxable (or imputed) income. Imputed income is recognized for the amount contributed by the Company toward the cost of coverage for the domestic partner or for any child(ren). The amount of your imputed income depends on the health plan option and coverage tier you select. Imputed income is subject to FICA (Social Security and Medicare), federal income taxes, and any other required payroll tax. This means you will pay applicable payroll taxes on an additional amount (which will be shown on your paychecks) throughout the year and it will be included on your W-2 Form at the end of each year. You should seek the advice of your tax accountant, attorney, or other professional to assess the effect of such additions on your personal situation.

NOTE: If your domestic partnership is registered with the state of California, you will not have imputed income for California income tax purposes. Your monthly contribution for health coverage for your domestic partner (and/or your domestic partner's children) will be excluded from your income for California income tax purposes.

Any misrepresentation of dependent information will be considered a deliberate falsification of Company records and constitutes grounds for rejection of the dependent. You may be required to repay to the Plan any amount paid for all benefit expenses for the ineligible dependent.

Enrollment

Enrollment in your benefits is done via Pilot Benefits Online at https://fedexpilots.bswift.com.

You may enroll your eligible dependents in medical, dental, and/or vision coverage for the same benefit options that you enroll in. You can choose a different coverage tier for medical, dental, and vision. When you enroll in benefits, you choose one of four coverage tiers.

- Pilot Only
- Pilot & Child(ren)
- Pilot & Spouse
- Pilot & Family

If you enroll dependents, you must list their names and Social Security numbers on Pilot Benefits Online. You also must provide documents that prove that your dependents are eligible within 45 days following their enrollment. See "Dependent Eligibility Verification" for more information.

FedEx Express offers several medical plan options administered by Anthem Blue Cross (Anthem) in all areas of the United States except for Hawaii. The medical plan options administered by Anthem are the Consumer Driven Health Plan (CDHP) Purple, CDHP Orange, and the Buy Up Plan. Eligibility is based on your home address in the HR system.

Due to Hawaii regulations, the Hawaii Medical Service Association (HMSA PPO) and the Health Plan Hawaii (HMO) are offered to pilots who reside in Hawaii.

For pilots who are internationally based or considered expatriates, there is separate coverage under the International Plan, administered by GeoBlue, Anthem's worldwide partner for international coverage. The International Plan provides full coverage for the pilot and any covered dependents while international and/or in the United States.

Dependent Eligibility Verification

After enrolling a dependent in any benefit, you are required to provide documentation verifying that the dependent meets eligibility definitions. The deadline and instructions to upload the document(s) will be communicated to you via email or USPS depending on whether you agree to receive benefit information electronically (if you agree to receive communications via email, add noreply@bswift.com to your contacts/safe senders to ensure receipt).

If you fail to provide acceptable documentation by the required due date, your dependent's medical, dental, and/or vision coverage will be terminated. Before your dependent's medical, dental, and/or vision coverage is terminated, you will receive a termination letter with the termination date, dependent's name, and your appeal rights. If you submit acceptable documentation during the appeal period, coverage will be reinstated to the termination date. Otherwise, you will not be able to add your dependent back to your medical, dental, and/or vision coverage until the next Annual Benefits Enrollment or unless you have a Change in Family Status and make an election within your 31-day election period. You will still be required to provide acceptable documentation within 45 days of adding your eligible dependents during either of these situations.

Once your dependents are approved for coverage, you will be required to confirm each dependent's eligibility annually when making your online benefit elections. If you are covering an individual who does not meet the definition of an eligible dependent, you should indicate that the dependent is not eligible through Pilot Benefits Online. Any misrepresentation of dependent information will be considered a deliberate falsification of company records and constitutes grounds for rejection of the dependent. You may be required to repay the Plan any amount paid for all benefit expenses paid by the Plan for the ineligible dependent.

If you have any questions about the dependent verification process, call Pilot Benefits Administration at 1.866.795.6353.

Annual Benefits Enrollment

In the fall, you are given the opportunity to add, drop, or change medical, dental, and/or vision coverage for yourself and any eligible dependents, for the next calendar year. This is referred to as Annual Benefits Enrollment. The dates for Annual Benefits Enrollment will be communicated to you via FCIFs and email.

During Annual Benefits Enrollment, you can access Pilot Benefits Online at https://fedexpilots.bswift.com to review the benefit material and make your elections. Your medical, dental, and/or vision elections made during this period become effective January 1 of the following calendar year. If no new elections are made by the enrollment deadline, you will be enrolled in the same medical, dental, and/or vision plan option and coverage tier you had at the end of the calendar year if those medical, dental, and/or vision plan options are still available and you have had no change in dependent eligibility.

After the enrollment period ends, you cannot:

- Change your medical, dental, and/or vision plan option or coverage tier until the next Annual Benefits Enrollment period. You may be able to change your medical plan option if you move out of the service area and are not eligible for your current medical plan option in your new location. This does not apply if you have opted out of FedEx health coverage;
  or
- Opt out of medical, dental, and/or vision coverage unless you have a Change in Family Status event and you make your request to change your coverage tier within

31 days following your event or until the next Annual Benefits Enrollment period.

Opting Out of FedEx Coverage

You can elect to opt out of the Federal Express Corporation Group Health Plan for Pilots (the "Plan") for medical, dental, and/or vision coverage; however, to opt out of medical coverage, you must have other group medical coverage through a family member or other employment. If you choose to opt out of FedEx medical coverage, you will not have medical coverage (including mental health/substance abuse and prescription drug) through FedEx for yourself or any eligible dependents. Typically, the advantage of opting out is the elimination of duplicate coverage and the requirement to coordinate coverage between two health plans. By opting out of FedEx medical coverage, your other group medical plan will be your primary coverage.

You can elect to opt out of FedEx Express medical, dental, and/or vision coverage on Pilot Benefits Online at https://fedexpilots.bswift.com. You can elect to opt out during Annual Benefits Enrollment or within 31 days following the gain of other coverage when related to a Change in Family Status event.

If you lose your other group medical, dental, and/or vision coverage, you must access Pilot Benefits Online to elect medical, dental, and/or vision coverage within 31 days following the date of loss of the other coverage. Otherwise, you must wait until the next Annual Benefits Enrollment to elect medical, dental, and/or vision coverage, which will be effective as of January 1 of the following calendar year.

Important: If you elect to opt out of medical, dental, and/or vision coverage for a calendar year and make no election for the next calendar year, you will automatically waive medical, dental, and/or vision coverage for the next calendar year.

If You Are a New Hire

You are automatically enrolled as follows on your first day of employment:

- Domestic Based—Pilot Only in the Buy Up Option
- Hawaii—Pilot Only in HMSA (PPO)
- If you are assigned to an FDA as a New Hire, you will initially be enrolled as if you were a Domestic-Based Pilot. You will automatically be moved to the International medical option upon your activation to the FDA (if you are enrolled in medical at the time of your activation).

The medical plan option you are enrolled in is based on your home address in the HR system, unless internationally based. You will receive a letter that explains options available to you, associated costs for each option, and the deadline to make your elections. Access Pilot Benefits Online at https://fedexpilots.bswift.com to make your elections. This secure website provides you access to your benefits information from your computer, iPad, or smartphone. If you make no elections by the deadline, you will remain enrolled in the options and coverage tier in which you were automatically enrolled. You will have 31 days from your date of hire to make any changes.

If You Are an Expatriate or an Internationally Based Pilot

You are automatically covered by the International Plan upon activation into a foreign base. The International Plan is a fully insured plan administered by GeoBlue, Anthem's worldwide partner for international coverage. The International Plan provides coverage for you and your covered dependents wherever you are, both internationally and in the United States. You will receive a certificate from GeoBlue outlining the coverage details. If you want to opt out of medical coverage, contact Pilot Benefits Administration at 1.866.795.6353 or email PBA@fedex.com in

the Memphis area. Your dental and vision benefits are similar to the benefits provided to all other pilots.

Enrolling Your Eligible Dependents

You can elect to enroll your eligible dependents for medical coverage during your new hire enrollment, Annual Benefits Enrollment, or when you experience Change in Family Status events that allow a coverage tier change (for example, marriage, newborn, etc.). If you want to enroll for Pilot & Child(ren), Pilot & Spouse or Pilot & Family coverage, you must list your dependents and validate their eligibility for FedEx benefits on Pilot Benefits Online at https://fedexpilots.bswift.com. If you have no dependents listed, you will be automatically enrolled in Pilot Only coverage, and your dependents will not be enrolled in coverage.

New Hire	Your request for Pilot & Child(ren), Pilot & Spouse, or Pilot & Family coverage must be made by the date indicated in your new hire letter provided by Pilot Benefits Administration. You will have at least 31 days from your date of hire to add any dependents. The medical, dental, and/or vision coverage tier you choose when you are first eligible — Pilot Only, Pilot & Child(ren), Pilot & Spouse, or Pilot & Family — coverage will be effective as of your date of hire and will be in effect for the remainder of the calendar year (date you are actively at work through December 31), except as described in "Changing Your Coverage Tier — Adding or Dropping Dependent Coverage."
Annual Benefits Enrollment	Your request for Pilot & Child(ren), Pilot & Spouse, or Pilot & Family coverage must be made by the Annual Benefits Enrollment deadline. Coverage will be effective January 1 of the following calendar year and will be in effect for the remainder of the calendar year (January 1 through December 31), except as described in "Changing Your Coverage Tier — Adding or Dropping Dependent Coverage."
Change in Family Status Event	Access Pilot Benefits Online at https://fedexpilots.bswift.com within 31 days following the event to update your benefits information, make any changes in your dependents' eligibility, and make your benefit elections. If you wait more than 31 days, the allowed benefit changes will be limited. For example, if you wait more than 31 days after your marriage, you will still be able to enter your spouse's information in the system, validate your dependents' eligibility, and update your life insurance beneficiary designations — but you won't be able to enroll your spouse for medical, dental, and/or vision coverage until the next Annual Benefits Enrollment period or until you have another Change in Family Status event.

If Your Spouse or Child Is Also a Pilot/Non-Pilot Employee Eligible for FedEx Express Benefits

If both you and your spouse (or domestic partner in California only), or you and your child, are employees at a FedEx company participating in FedEx benefits, you have the choice to cover your spouse and/or child as your dependent in the medical, dental, and/or vision plan option you choose, or they may elect their own employee coverage. However, your spouse or child cannot be covered as both an employee and your dependent.

If you cover your spouse or child as a dependent for benefit coverage, they must elect to opt out of the applicable benefit as an employee.

If you cover your dependent child, within 31 days following his/her 26th birthday for medical, or 23rd birthday for dental or vision, your child should elect his/her own benefit coverage as an employee to remain covered under the Federal Express Corporation Group Health Plan.

NOTE: Your dependent children may not be covered as qualified dependents of more than one pilot/non-pilot employee for medical, dental, and/or vision coverage. If both you and your spouse or you and another pilot/non-pilot employee are actively employed by FedEx Express or a

participating employer in the Federal Express Corporation Group Health Plan and have the same dependents eligible for medical, dental, and/or vision coverage, only one pilot/non-pilot employee can cover those dependents for medical, dental, and/or vision coverage.

Covering Your Eligible Dependents Who Are Away From Home

Your covered dependents who have a different home address are covered under the same medical plan option you select for yourself and other eligible family members. Your dependent(s) can receive in-network benefits for covered medical services if they see an Anthem in-network provider in the area where they live. For a list of in-network providers in your local area or in another area of the country, you can access the Provider Directory at www.anthem.com/ca and click on "Find Care," follow the instructions: when prompted, enter FXF in the Identification Prefix Number box. You can also call Anthem Member Services at 1.866.406.0982.

If you enroll in Health Plan Hawaii, your dependents living outside the plan's service area will not be covered except in emergencies. If you want more than emergency coverage for them, you should not choose the Health Plan Hawaii medical plan option.

If you are in the International Plan, your dependents are also covered under the International Plan and receive coverage, as you do, based on where they receive care, domestically or internationally. These benefits are paid through GeoBlue.

Changing Your Coverage Tier—Adding or Dropping Dependent Coverage

There are three situations in which you may change your medical, dental, and/or vision coverage tier — that is, add or drop coverage for your dependent(s). To make your coverage tier change, access Pilot Benefits Online at https://fedexpilots.bswift.com.

- **As a New Hire.** If you wish to cover your dependent(s) for medical, dental, and/or vision, you must elect the appropriate dependent coverage tier by the deadline indicated in your new hire letter provided by Pilot Benefits Administration. Otherwise, you will be enrolled in Pilot Only medical, dental, and vision coverage as indicated in your letter.
- **When you have a Change in Family Status event.** If you experience a Change in Family Status event (for example, marriage, divorce, birth of a child, spouse gains or loses other coverage, etc.), you can make a coverage tier change if you make your election within 31 days following the event. The change is effective the date of the event. See "If You Have a Change in Family Status Event" below. Any changes you make to your benefits must be consistent with the Change in Family Status event.
- **During Annual Benefits Enrollment.** A Change in Family Status is not required during the Annual Benefits Enrollment period. The elected change in coverage tier is effective January 1 of the next year.

If You Move to a New Location

If you are moving to a new location, i.e., to and/or from Hawaii, you will be eligible for different medical plan options. It is important to change your home address in the HR system and notify Pilot Benefits Administration as soon as possible after you move.

NOTE: If being assigned to an international base or for help changing your address, visit https://pilot.fedex.com, under the Flight Operations tab go to Insite and search for address. Review—*How do I update my home address, phone number, and paycheck address on the Company issued iPad?*

You will be sent a personalized letter with information about your new medical plan options. You may access Pilot Benefits Online at https://fedexpilots.bswift.com within 31 days of the date of your address change in the HR system to review the benefits material, your new options, and make your elections. If you elect to change your assigned medical plan option, your new medical coverage will be effective on the date of your election.

If You Have a Change in Family Status Event

If you have a Change in Family Status event (for example, marriage, divorce, birth of a child, spouse gains or loses other coverage, begin or return from a leave of absence, etc.), you can make a coverage tier change if you make your election within **31 days following the event**. The change is effective the date of the event. Not every event allows you to make the same kind of changes to your benefits. You are only permitted to make benefit coverage changes consistent with your event. For example, if you get married and select the Marriage event within 31 days following your marriage, you may add your spouse, eligible children, and/or stepchildren to your benefits. In addition to adding your dependent(s), please be sure to select the coverage desired—medical, dental, and/or vision—for your new dependent(s). If your event occurred more than 31 days ago, you will not be allowed to change your coverage tier until the next Annual Benefits Enrollment period or until you have another Change in Family Status event. Your current payroll deductions will not change. For example, if you enter your spouse more than 31 days following your marriage, you will be able to enter your spouse's information and update your life insurance beneficiary designations. However, you cannot enroll your spouse for medical, dental, and/or vision coverage. Likewise, if you select the Divorce event more than 31 days following your divorce date and have Pilot & Family coverage, your spouse's coverage will end. However, your coverage tier and monthly cost will not change (until the next Annual Benefits Enrollment).

Change in Family Status events include all changes permitted by law, such as:

- Marriage or divorce
- Birth, adoption, or legal guardianship of a child
- Death of a spouse or dependent child
- Commencement or termination of domestic partnership (California residents only)
- Spouse or dependent child gains or loses employment or medical, dental, and/or vision coverage through their employer
- You or your spouse begins or returns from a leave of absence
- Spouse or dependent child has a significant change (i.e., cost or benefits) in medical, dental and/or vision care under their employer's plan
- Dependent child loses eligibility for medical, dental, and/or vision coverage (for example, child becomes age 23 for dental and/or vision or 26 for medical)

With each of the following events you will receive a letter that describes the elections you can make and your deadline:

- New Hire or newly eligible employee
- Child turns age 23/26, as applicable
- Start Leave of Absence
- Return from Leave of Absence

If you experience one of the following Change in Family Status events, it is your responsibility to access Pilot Benefits Online within 31 days following the event to update your dependents' information and make benefit changes associated with the event:

- Marriage or divorce
- Change in dependent's employment status
- Begin or return from leave of absence
- Significant change in dependent's coverage
- Commencement or termination of domestic partnership (California residents only)
- Birth, adoption, or legal guardianship of a child
- Gain or loss of other coverage for yourself or dependent
- Child loses eligibility for coverage

If you have questions or need assistance processing a Change in Family Status event, please contact Pilot Benefits Administration at 1.866.795.6353 or send an email to PBA@fedex.com**.**

Your Cost for Coverage

FedEx Express pays the majority of the cost for medical coverage. Since the medical coverage cost the Company different amounts, your coverage cost depends on the coverage you select, where you live, and whether you elect to cover your eligible dependents. The costs for medical, dental, and/or vision coverage are listed in your new hire letter, if you are a New Hire. The monthly premium rates are updated annually in the Pilot Enrollment Guide. See the most current Pilot Enrollment Guide, located on https://fedexpilots.bswift.com under the Educate tab, for medical plan option information.

According to the Collective Bargaining Agreement, the total projected cost for 2017 and each calendar year thereafter, will be determined by an actuary selected by the Company and will be developed from the experience of all pilots and eligible dependents participating in coverage, excluding fully insured.

Beginning in 2017, the cost share for each tier of each plan are as follows:

Pilot Options	Pilot Cost Share
Buy Up Plan	18% (as of January 1, 2017) 19% (as of January 1, 2018) 20% (as of January 1, 2019, and thereafter)
CDHP Purple HSA/HRA	16%
CDHP Orange HSA/HRA	15%
International*	17%
Dental, Vision, and HMO	17%

*For pilots in an FDA, the monthly premium/contribution shall not exceed the amount of the monthly premium/contribution for the same coverage tier in the plan option with the highest monthly contribution offered to domestic-based pilots.

The monthly premium/contribution may increase, but not by more than 10% over the monthly premiums payable for the immediately preceding year.

Please refer to the most recent Pilot Enrollment Guide for the monthly premium/contribution for active pilots for Pilot Only, Pilot & Child(ren), Pilot & Spouse, and Pilot & Family medical, dental, and vision coverage.

Payroll Deductions for FedEx Express Medical Plan Options

If you choose FedEx Express medical coverage, the cost is automatically deducted from your paycheck on a pre-tax basis (except for domestic partner benefits). You must notify Pilot Benefits Administration by calling 1.866.795.6353, if the correct payroll deductions are not made. Dependents are not covered if a payroll deduction is not made for that coverage. If a deduction for coverage is made in error, contact Pilot Benefits Administration. You may be entitled to a refund up to a maximum of three months prior to the date the error was discovered.

Health Care Contribution Plan

The pre-tax deduction for medical coverage is made under the Federal Express Corporation Health Care Contribution Plan. **Enrollment is automatic.** The Health Care Contribution Plan was established under Section 125 of the Internal Revenue Code (IRC). Provisions in this section of the IRC allow the pilot portion of medical contributions to be made with pre-tax dollars. What this means is that these amounts are not subject to Social Security, Medicare, or federal income taxes and, where applicable, state and local income taxes. Paying for your health coverage with pre-tax dollars increases your take-home pay and lowers your income tax liability.

Important Note: Future Social Security retirement benefits could be reduced slightly because pre-tax medical coverage contributions reduce the amount on which you and the Company pay Social Security taxes.

Domestic Partner Contribution Note: For Domestic Partner benefits, the IRS treats pilot contributions and FedEx Express contributions as taxable. The Domestic Partner portion of your monthly contributions will be deducted from your paycheck on an after-tax basis.

Your Coverage During a Leave of Absence—Medical or Nonmedical

If you are on an approved leave of absence, the cost of medical, dental, and/or vision coverage for you and your covered eligible dependents (if applicable) accumulates for the first 90 days and is deducted from your paycheck on a prorated basis when you return to work. (**NOTE:** If, while on leave of absence, you receive a payroll generated check, prorated deductions will be taken.)

If you are enrolled in the CDHP Purple HSA or CDHP Orange HSA medical option, Company bi-monthly contributions will continue during your leave of absence. However, if you are contributing to your HSA through payroll deductions, your contributions will stop immediately. When you return to work, you can choose to resume or make a new election for your HSA contribution. If you are enrolled in CDHP Purple HRA or CDHP Orange HRA medical option, monthly Company credits will continue during your leave of absence. You will continue to have access to your HSA or HRA at HealthEquity while on leave of absence.

If you remain on leave for more than 90 days, Pilot Benefits Administration will notify you of the cost to continue your coverage beyond the 90-day period.

Failure to make required medical, dental, and/or vision payments, making partial payments, or having checks returned due to insufficient funds, will result in loss of medical, dental, and/or vision coverage for you and any covered dependents. Company contributions or credits to your HSA or HRA also will cease. You will continue to have access to your HSA or HRA at HealthEquity, based on Plan rules.

During your leave of absence, you will be eligible to add dependent coverage only during the Annual Benefits Enrollment period or if you have a Change in Family Status.

- When you return from leave of absence, you will be placed in the same medical, dental, and/or vision plan option and coverage tier you were enrolled in, if available, prior to your leave.
- You will have 31 days from the date you return from leave to change your coverage tier.

Leave of absence is considered a Change in Family Status event, which allows you to drop dependent medical, dental, and/or vision coverage within 31 days of the start of the leave. For example, if you have Pilot & Spouse, Pilot & Child(ren), or Pilot & Family coverage, you may change your coverage tier to Pilot Only coverage. You can access Pilot Benefits Online within

31 days following your leave of absence effective date to make your coverage tier election. The cost of the new coverage will begin to accumulate for a maximum of 90 days from the start of your leave. If you want to add dependent medical, dental, and/or vision coverage when you return from leave, you must make your coverage tier election within 31 days following your return date.

If you experience a Change in Family Status event while you are on leave of absence (for example, birth of a child, marriage, divorce, etc.), you have 31 days following the date of the event to add or drop dependent medical, dental, and/or vision coverage consistent with the Change in Family Status event.

If you become Medicare eligible due to disability, you will remain in your current elected health plan option, with the exception of those who are enrolled in the CDHP Purple HSA or CDHP Orange HSA medical option. If you are enrolled in one of these options and become Medicare disabled, you are not eligible for the HSA medical option and will be moved to the comparable HRA medical option. For example, a pilot enrolled in the CDHP Purple HSA medical option will be moved to the CDHP Purple HRA medical option.

Your Coverage During a Leave of Absence—Military

If you are on a military leave of absence (MLOA), the cost of medical, dental, and/or vision coverage for you and your covered eligible dependents (if applicable) accumulates for the first 90 days and is deducted from your paycheck on a prorated basis when you return to work. (**NOTE:** If, while on MLOA, you receive a payroll generated check, prorated deductions will be taken.)

If you are enrolled in the CDHP Purple HSA or CDHP Orange HSA medical option, Company contributions will stop immediately. If you are contributing to your HSA through payroll deductions, your contributions will also stop immediately. You are not eligible for the HSA option while on MLOA and will be moved automatically to the comparable HRA medical option. You also have the option to elect to opt out of medical coverage while on MLOA, if you make your election within 31 days following your leave effective date.

If you are enrolled in the CDHP Purple HRA or CDHP Orange HRA medical option, Company HRA credits will continue while on MLOA. While on MLOA you will continue to have access to your HSA or HRA at HealthEquity.

If you remain on leave for more than 90 days, Pilot Benefits Administration will notify you of the cost to continue your coverage beyond the 90-day period. Failure to make required medical, dental, and/or vision payments, making partial payments or having checks returned due to insufficient funds, will result in loss of medical, dental, and/or vision coverage for you and any covered dependents. Company credits to your HRA also will cease. You will continue to have access to your HSA or HRA at HealthEquity, based on Plan rules.

Continuing Coverage During a Military Leave of Absence
• If you take leave to perform service in the uniformed services, FedEx will continue to maintain your medical, dental, and/or vision coverage provided you continue to pay the pilot portion of the premium during your military leave. • Charges incurred in connection with an illness or injury resulting from service in the armed forces are covered under TRICARE and excluded under FedEx coverage. FedEx coverage applies to nonmilitary-related illnesses or injuries not covered by the military.

Your Coverage During an Unpaid Suspension

If you are on an unpaid suspension, the full cost of medical, dental, and/or vision coverage for you and your covered eligible dependents (if applicable) must be paid to continue coverage. Full cost includes your current payroll deduction plus the amount paid by FedEx.

An unpaid suspension is considered a Change in Family Status event, which allows you to drop dependent medical, dental, and/or vision coverage within 31 days following the start of the suspension. To change your coverage tier, you must call Pilot Benefits Administration, 1.866.795.6353 or send an email to PBA@fedex.com, within 31 days after the start of your suspension. If you drop dependent medical, dental, and/or vision coverage within the 31-day timeframe, you will be billed for the cost of the coverage you elect to continue.

If you experience a Change in Family Status event while on suspension, you have 31 days following the date of the event to add or drop dependent medical, dental, and/or vision coverage (consistent with the Change in Family Status) by calling Pilot Benefits Administration. Changes in Family Status include such events as marriage, divorce, and the birth or adoption of a child.

Failure to make required medical, dental, and/or vision payments, making partial payments, or having checks returned due to insufficient funds, will result in loss of medical, dental, and/or vision coverage for you and your covered dependents. When you return from suspension, you will be placed in the same medical, dental, and/or vision plan option and coverage tier you were enrolled in prior to your suspension. You will have 31 days from the date you return from suspension to change your coverage tier.

When Medical Coverage Ends

Coverage for you and/or your covered dependents ends on the earliest of the following dates:

- FedEx Express discontinues the medical plan option, which could only be done pursuant to the Agreement or a successor Collective Bargaining Agreement.
- You stop making the required contributions to participate in the medical plan option during a suspension or any leave of absence.
- Your employment is terminated for gross misconduct.
- Your employment is terminated and you do not elect to continue coverage through COBRA.
- You or your covered dependents are no longer eligible for coverage.
- You or a covered dependent die.
- When, if ever, the Agreement or a successor Collective Bargaining Agreement no longer provides for this coverage.
- COBRA coverage ends (if elected).
- You transfer to a non-pilot position within FedEx Express or a participating employer in the Federal Express Corporation Group Health Plan and your participation in FedEx Express' benefit plans is no longer provided under the terms of the Agreement.
- You retire. Refer to the section "Retiree Health Coverage" for information about benefits available after retirement.
- You are on furlough and no longer receiving furlough pay.
- You opt out of FedEx Express group medical coverage during Annual Benefits Enrollment or due to a Change in Family Status.

If you or a covered dependent is confined in the hospital and incurs covered room and board expenses on your termination date, your medical coverage continues until you or the covered dependent is released, or for **30 days**, whichever occurs first.

If your coverage ends and your spouse is employed by FedEx Express or another FedEx Company and your spouse has coverage under the Federal Express Corporation Group Health Plan for Pilots or the Federal Express Corporation Group Health Plan, you will be eligible to enroll as a dependent under your spouse's coverage. If your spouse is also a pilot, you both must contact Pilot Benefits Administration at 1.866.795.6353 within **31 days** after your coverage ends to enroll you as a dependent of your spouse. If your spouse is not a pilot, your spouse must contact Choose Well Care Connect at 833.FDX.WELL.

COBRA—Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), group medical, dental, and/or vision coverage may be continued for up to 18 months, or in some cases 29 or 36 months, if you or your eligible dependents would otherwise lose medical, dental, and/or vision coverage because of a specific "qualifying event."

Continuation of medical, dental, and/or vision coverage is available to any qualified beneficiary (pilot, spouse, or dependent child) who is covered by any of the FedEx Express medical, dental, and/or vision plan options on the day before any of these qualifying events occur:

- Termination of employment for any reason other than gross misconduct.
- Reduction in the hours of employment.
- Loss of health coverage for someone who is on furlough and who is no longer receiving furlough pay.
- Death of a pilot.
- Divorce from a covered spouse. The pilot must enter the divorce date on Pilot Benefits Online at https://fedexpilots.bswift.com, or you or your ex-spouse must call Pilot Benefits Administration at 1.866.795.6353 or send an email to PBA@fedex.com. If notification is made after 60 days following the date of the event, the rights to continuation of coverage for such qualified beneficiary will be lost.
- A change in eligibility so that a covered dependent child ceases to qualify as an eligible dependent under the medical, dental, and/or vision plan option. You must enter the change in eligibility date on Pilot Benefits Online at https://fedexpilots.bswift.com, or you can call Pilot Benefits Administration at 1.866.795.6353 or send an email to PBA@fedex.com. If notification is made after 60 days following the date of the event, the rights to continuation of medical, dental, and/or vision coverage for such qualified beneficiary will be lost. A covered dependent child who turns age 26 for medical or age 23 for dental and vision ceases to be eligible under the plan and will be automatically offered coverage through COBRA.
- Retirement.

This continuation of medical, dental, and/or vision coverage for either 18 or 36 months is subject to certain notice requirements and time limitations as outlined in the chart under "COBRA Qualifying Events".

The COBRA Continuation period to which you or your dependents may be entitled under this section does not run concurrently with any other period provided under the Agreement during

which the cost of coverage does not increase from the amount paid prior to the qualifying event. Once your COBRA continuation coverage period begins, you are responsible for any increase in cost.

If You Have COBRA Questions

For questions about continuing medical, dental, and/or vision coverage under COBRA, contact HealthEquity WageWorks, our COBRA administrator, at 1.855.556.5737. You can also write to HealthEquity WageWorks at:

HealthEquity WageWorks
P.O. Box 223684
Dallas, TX 75222-3684

Individual Election Rights to Continue Medical, Dental, and/or Vision Coverage

Each individual who was covered by the Federal Express Corporation Group Health Plan for Pilots is a qualified beneficiary and has independent election rights to COBRA continuation coverage, if the individual meets one of the qualifying events listed under the Health Care—Medical, Dental, and Vision Benefits section— under COBRA—Continuation of Coverage, shown earlier in this section. This means that a covered spouse or covered dependent(s) can elect to continue medical, dental, and/or vision coverage even if the former pilot chooses not to continue medical, dental, and/or vision coverage. Covered pilots may elect COBRA continuation medical, dental, and/or vision coverage on behalf of their spouse or children. Parents may elect COBRA continuation medical, dental, and/or vision coverage on behalf of their children.

Social Security Disability

If any qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act, on the date medical, dental, and/or vision coverage is lost, or if a qualified beneficiary becomes disabled during the initial 60 days of COBRA coverage, the qualified beneficiary may be entitled to an additional 11 months of COBRA coverage, for a total of 29 months. The qualified beneficiary must meet the Social Security definition of disability to qualify for the extended medical, dental, and/or vision coverage and the extension also applies to covered dependents. HealthEquity WageWorks, our COBRA administrator, must be notified at 1.855.556.5737 of the disability status before the end of the initial 18-month medical, dental, and/or vision coverage period and within 60 days of your Social Security disability determination, or within the initial 60 days of COBRA if you have a Social Security Disability on the date medical, dental, and/or vision coverage is lost.

If the Social Security Administration determines that the qualified beneficiary is no longer disabled, the qualified beneficiary is required to notify HealthEquity WageWorks by calling 1.855.556.5737 within 30 days after the final determination.

Secondary Qualifying Events

If, during the 18 months of COBRA continuation, a second qualifying event occurs (e.g., divorce, the former pilot's death, or a covered dependent child ceasing to be an eligible dependent), then the 18 months of COBRA can be extended to 36 months from the date of the original qualifying event but only for the individual whose medical, dental, and/or vision coverage would have ended as a result of the second qualifying event had the first qualifying event not occurred. For example, if you terminate employment, elect COBRA coverage, and divorce within the 18-month period following your termination, your spouse or stepchild can independently elect to extend their coverage up to 36 months from the date you terminated your employment. It is the responsibility of the qualified beneficiary to notify HealthEquity WageWorks at 1.855.556.5737

within 31 days of that qualifying event. In no event, however, will COBRA continuation last beyond 36 months from the date of the original qualifying event.

Cost to Continue Medical, Dental, and/or Vision Coverage

A qualified beneficiary who elects continuation of medical, dental, and/or vision coverage is required to pay the entire cost, including any part previously paid by FedEx Express, plus a 2% administrative charge.

If you or your enrolled dependent is disabled, as defined by Social Security, COBRA for months 19 through 29 may be increased to reflect 150% of the cost per person.

You have 45 days from the date of your election to pay your first COBRA premium. Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. After that time, your premium payments are due the first of the month, with a 30-day grace period.

Claims for reimbursement of eligible medical, dental, and/or vision care expenses will not be processed and paid until you have elected COBRA continuation coverage and made the first payment. You should retain any receipts for eligible services you paid directly in order to receive appropriate reimbursement.

When COBRA Continuation Coverage Ends

COBRA continuation coverage ends at the end of the maximum 18-, 29-, or 36-month period. All COBRA continuation coverage will be terminated before the end of the maximum period if any of the following events occur:

- The qualified beneficiary fails to make required premium payments within the stated time period.
- Any qualified beneficiary becomes entitled, after the date of the COBRA election, to Medicare coverage (except for cases of end-stage renal disease).
- Any qualified beneficiary becomes covered under any group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such qualified beneficiary.
- FedEx Express ceases to provide any group health plan that can only be done in compliance with the terms of the Agreement or a successor collective bargaining agreement.
- The qualified beneficiary’s COBRA continuation coverage period ends.
- It is determined that the individual no longer meets the Social Security definition of disability during the 11-month COBRA extension period. (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate.)

When COBRA continuation health coverage ends, there is no right to convert group medical, dental, and/or vision coverage to an individual policy.

COBRA Qualifying Events

Qualifying Event	Qualifying Beneficiary	Notification	COBRA Period	COBRA Notification	Timeline
Death of pilot	Covered spouse and/or dependent children	Pilot Benefits Administration must be notified within 30 days	36 months after the first 24 consecutive months of survivor coverage continuation	The qualified beneficiary will be notified of continuation rights, cost, and requirements within 14 days of notification of the qualifying event; then, qualified beneficiary has **60 days** from the date coverage ends or the date of receipt of the COBRA notice, whichever is later, to elect medical, dental, and/or vision coverage	Qualified beneficiary has **45 days** from date of election to make payment; payment must be the full amount due from the date of the qualifying event to the current date up through the end of the month before the month in which you make your first payment; after that time, payments are due as of the first day of the month
Termination of employment	Covered pilot, spouse, and dependent children	Pilot's status is changed in the HR system within 30 days of termination	18 months (may be extended to 29 if disabled within 60 days of COBRA medical, dental, and/or vision coverage as determined by Social Security Administra-tion)	Same as above	Same as above

Qualifying Event	Qualifying Beneficiary	Notification	COBRA Period	COBRA Notification	Timeline
Divorce	Covered spouse and/or stepchildren	Pilot must enter the divorce date on Pilot Benefits Online or pilot or qualified beneficiary can call Pilot Benefits Administration, 1.866.795.6353, or send an email to PBA@fedex.com within 30 days of the event	36 months	Same as above	Same as above
Dependent child becomes ineligible for coverage (for example, age 23 for dental and/or vision or age 26 for medical)	Covered dependent child	Dependent ceases to be eligible under the plan and will be automatically offered coverage through COBRA within 30 days of the event	36 months	Same as above	Same as above
Pilot becomes entitled to Medicare (under Part A, Part B, or both) less than 18 months before the pilot terminates employment or the pilot's hours of employment are reduced	Covered spouse and dependent child(ren)	Pilot must notify Pilot Benefits Administration within 30 days	36 months measured from the date of Medicare entitlement	Same as above	Same as above

Keep Your Plan Informed of Address Change—In order to protect your family's rights, you should keep HealthEquity WageWorks and Pilot Benefits Administration informed of any changes in the address of family members. You should keep a copy of any notices you send to Health Equity WageWorks and Pilot Benefits Administration for your records.

Continuing Health Coverage for Your Survivors—If You Die While an Active Pilot

If at the time of your death, you met the age and service eligibility requirements for retiree health coverage, your eligible dependents, who were covered at the time of your death and who continue to meet the eligibility requirements, may choose to receive retiree health coverage under the Federal Express Corporation Retiree Group Health Plan for Pilots or coverage under the Federal Express Corporation Group Health Plan for Pilots through COBRA. Eligibility requirements for retiree health coverage are explained in the section—"Retiree Health – General Information." Continuation under COBRA must be elected within 60 days of your death. If your covered dependents elect retiree health coverage, they must elect that coverage within 31 days after your death. If retiree health coverage or coverage under COBRA is not elected or is canceled or terminated, coverage cannot be added at a later date.

Your covered dependents may elect health coverage after your death based on the chart below. Within 14 days of the date Pilot Benefits Administration is notified of your death, your eligible dependents will be sent information about their health coverage options.

Health Coverage for Your Surviving Spouse/Children

	Spouse/Children under Medicare Age	If Spouse Is Medicare Age at the Time of Death	When Spouse Reaches Medicare Age Following the Pilot's Death
Active Pilot Is Not Retiree Health Eligible	• For 24 months from date of death, surviving dependents are charged the applicable active pilot rate in the Active Pilot Plan (i.e., Pilot Only if surviving spouse **or** surviving children, Pilot & Child(ren) if surviving spouse **and** children). This 24-month period does not apply to the COBRA continuation period. • After 24 months at active pilot rate, up to 36 months at active pilot COBRA rate (102%) in the Active Pilot Plan (i.e., Spouse Only, Child Only, Spouse & Children, or 2 or more Children)	• For 24 months from date of death, surviving dependents are charged the applicable active pilot rate in the Active Pilot Plan (i.e., Pilot Only if surviving spouse **or** surviving children, Pilot & Child(ren) if surviving spouse **and** children). This 24-month period does not apply to the COBRA continuation period. • After 24 months at active pilot rate, up to 36 months at active pilot COBRA rate (102%) in the Active Pilot Plan (i.e., Spouse Only, Child Only, Spouse & Children, or 2 or more Children)	• For 24 months from date of death, surviving dependents are charged the applicable active pilot rate in the Active Pilot Plan (i.e., Pilot Only if surviving spouse **or** surviving children, Pilot & Child(ren) if surviving spouse **and** children). The first 24 months are not affected by attaining age 65. This 24-month period does not apply to the COBRA continuation period. • If age 65 is attained during the 1st 24 months at the Active rate, the spouse can have up to 36 months at active pilot COBRA rate (102%) in the Active Pilot Plan (i.e., Spouse Only, Child Only, Spouse & Children, or 2 or more Children)

	Spouse/Children under Medicare Age	If Spouse Is Medicare Age at the Time of Death	When Spouse Reaches Medicare Age Following the Pilot's Death
			NOTE: If the spouse attains age 65 during the 36-month COBRA period, coverage ends the first of the month in which the spouse becomes eligible for Medicare due to attaining Medicare Age.
Active Pilot Is Retiree Health Eligible	Surviving dependent must elect retiree health coverage or deferred retiree health coverage, within 31 days following the date of death, then has the choice of: • For 24 months from date of death, surviving dependents are charged the applicable active pilot rate in the Active Pilot Plan (i.e., Pilot Only if surviving spouse **or** surviving children, Pilot & Child(ren) if surviving spouse **and** children). This 24-month period does not apply to the 36-month COBRA continuation period. • After 24 months at active pilot rate, up to 36 months at active pilot COBRA rate (102%) in the active Pilot Plan (i.e., Spouse Only, Child Only, Spouse & Children or 2 or more Children). Surviving dependents who elect to defer retiree health can elect to begin participation in retiree health at any time during the 36-month COBRA period, at 100% of the applicable retiree health rate (i.e., Spouse, Child, or Spouse and Child). or	Surviving spouse is not eligible for Retiree Health due to Medicare Age. • For 24 months from date of death, surviving spouse is charged the applicable active pilot rate in the Active Pilot Plan (i.e., Pilot Only if surviving spouse **or** surviving children, Pilot & Child(ren) if surviving spouse **and** children). This 24-month period does not apply to the COBRA continuation period. • After 24 months at active pilot rate, spouse can elect up to 36 months at active pilot COBRA rate (102%) in the Active Pilot Plan (i.e., Spouse Only, Child Only, Spouse & Children, or 2 or more Children) or Spouse can immediately elect to participate in ALPA's Post Medicare Premium Reimbursement Plan (PRP) or at any time during the COBRA coverage period.	While under age 65, Surviving Spouse must initially elect Retiree Health coverage or defer Retiree Health coverage within 31 days following the date of death, then has the choice of: • For 24 months from the date of death, surviving spouse is charged the applicable active pilot rate in the Active Pilot Plan (i.e., Pilot Only if surviving spouse, Pilot & Children if surviving spouse & children). The first 24 months are not affected by attaining age 65 and this 24-month period does not apply to the 36-month COBRA continuation period. After 24 months at active pilot rate, spouse can elect up to 36 months at active pilot COBRA rate (102%) in the Active Pilot Plan (i.e., Spouse Only, Spouse & Children). • At any time until the end of the COBRA continuation period, the surviving spouse can elect to commence retiree health coverage if under age 65. **NOTE:** If the spouse attains age 65 during the 36-month

	Spouse/Children under Medicare Age	If Spouse Is Medicare Age at the Time of Death	When Spouse Reaches Medicare Age Following the Pilot's Death
	• For 24 months, surviving dependents are charged the applicable retiree health rate (i.e., Spouse, Child, or Spouse and Child). After 24 months, spouse and/or child(ren) pay 100% of the cost in the Retiree Group Health Plan. • When child(ren) reach the age limitations, coverage ends. Upon reaching the age limitations, dependent children can elect COBRA for 36 months at the pilot retiree COBRA rate (i.e., Child Only or 2 or more Children).		COBRA period, coverage ends the first of the month in which the spouse becomes eligible for Medicare due to attaining Medicare Age. Spouse can immediately elect to participate in ALPA's Post Medicare Premium Reimbursement Plan (PRP) or at any time during the COBRA coverage period. or • For 24 months, surviving spouse is charged the applicable retiree health rate (i.e., Spouse or Spouse and Child). After 24 months, spouse and/or child(ren) pay 100% of the cost in the Retiree Group Health Plan. • If spouse reaches Medicare Age during retiree health, coverage ends the first of the month in which eligible for Medicare due to attaining Medicare Age. Spouse can then elect retiree COBRA for 36 months at the pilot retiree COBRA rate (102%) (i.e., Spouse Only), or can elect coverage in ALPA's PRP.

Dependents referenced above are the same as described earlier in this section under "Your Eligible Dependents."

If, at the time of your death, you had not met the requirements for retiree health coverage, medical, dental, and/or vision coverage for your eligible dependents who were covered at the time of your death can continue for up to 60 months if they elect COBRA. See "COBRA—Continuation of Coverage," shown earlier in this section for specific details. Your survivors will receive a letter within 14 days explaining how to continue coverage and the associated costs. Your survivors will have 60 days from the date of the letter to elect to continue coverage. See the "Health Coverage for Your Surviving Spouse/Children" chart above.

MEDICAL INFORMATION FOR PILOTS AND COVERED DEPENDENTS RESIDING IN HAWAII

Medical Coverage

In Hawaii, you can elect the Health Plan Hawaii (HMO) or HMSA (PPO). Enrollment in one of these plans automatically include medical, prescription drug, mental health/substance abuse, and behavioral health coverage through the Hawaii Medical Service Association (HMSA).

These plans are fully insured benefit plans, which means the Health Plan Hawaii or HMSA, not the Company, is responsible for the risk associated with claims covered under the plan. The terms and conditions of the Certificate of Coverage or Subscriber Contract or Member Handbook issued by the Health Plan Hawaii or HMSA govern the plan provisions. The Health Plan Hawaii or HMSA, as applicable, is responsible for payment of the benefit.

What You Pay

Your monthly cost or premium is based on the medical plan option and coverage tier you elect. In addition to paying your monthly cost through payroll deductions, you will also pay any required copayments and deductibles up to the out-of-pocket maximums. For more details on the current plan design and the monthly cost for the HMSA medical options, refer to the most current Pilot Enrollment Guide located under the Educate tab on https://fedexpilots.bswift.com.

How the Health Plan Hawaii Works

The Health Plan Hawaii requires you to choose a primary care physician (PCP) from their network of providers. Your PCP will coordinate all your care within the network. When you receive care from your PCP or are referred to a specialist by your PCP, you usually pay no deductible, only a small copayment for most services.

You can get comprehensive benefits from the Health Plan Hawaii when you receive care within the network. If you go outside the Health Plan Hawaii network for care, the services are not covered, and you are responsible for all medical charges. Keep in mind that the Health Plan Hawaii operates independently of FedEx—it has its own guidelines and features, and it is fully insured rather than being self-funded like the FedEx Express medical plan options.

Health Plan Hawaii and HMSA Plan Descriptions

Benefits and services available from the Health Plan Hawaii or HMSA are not described in this book. A general description of the Health Plan Hawaii and HMSA is provided in the most current Pilot Enrollment Guide, which is available on Pilot Benefits Online at https://fedexpilots.bswift.com under the Educate tab. If you need more specific information, you can call the Health Plan Hawaii or HMSA at the number listed in the Pilot Enrollment Guide, and detailed schedules of benefits and services will be provided, without charge, upon request. Also, the Health Plan Hawaii or HMSA will mail a complete packet to prospective enrollees, including a list of their in-network providers and enrollment material, without charge, upon request. Detailed provider lists will be furnished, without charge, to all plan participants.

If you enroll in the Health Plan Hawaii or HMSA, you will receive the appropriate ID card. You should contact the Health Plan Hawaii or HMSA directly for answers to your benefit questions. Eligibility and enrollment information described in this section applies to the Health Plan Hawaii and HMSA; however, the HMO Group Service Agreement or state law may establish different eligibility provisions. Please see the complete packet from the Health Plan Hawaii or HMSA for more information. FedEx will not be responsible for claim or appeal determinations when you

choose the Health Plan Hawaii or HMSA. You should see your Health Plan Hawaii or HMSA schedule of benefits and services for a description of the appeals process.

If you would like dental and vision coverage, a separate election must be made to enroll in these benefits. For information on the dental and vision benefits, see the section titled—**Dental Benefits for Active and Pre-Medicare Retired Pilots** and **Vision Benefits for Active and Pre-Medicare Retired Pilots** in this book; or view the most current Pilot Enrollment Guide located on https://fedexpilots.bswift.com.

MEDICAL INFORMATION FOR INTERNATIONALLY BASED PILOTS AND COVERED DEPENDENTS

Medical Coverage

GeoBlue, Anthem's worldwide partner for international coverage, is the administrator for the International Plan for pilots on Foreign Duty Assignment (FDA). Covered family members of FDA pilots who remain in the United States or live abroad will have medical, prescription drug, mental health/substance abuse, and behavioral health coverage through GeoBlue. The prescription drug benefit is supported by Universal Rx. This plan, sponsored by the Company, is a fully insured benefit plan, which means GeoBlue, not the Company, is responsible for the risk associated with claims covered under the plan. The terms and conditions of the Certificate of Coverage issued by GeoBlue govern the plan provisions. The Certificate governs in the case of any discrepancy with this summary. The Company is responsible only for the payment of premiums either from corporate funds or as collected from payroll deductions. GeoBlue is responsible for payment of the benefit.

What You Pay

Your monthly cost is based on the coverage tier you elect. In addition to paying your monthly cost through payroll deductions, you will also pay any required copayments and deductibles up to the out-of-pocket maximums. For more details on the current plan design and the monthly cost for this medical option, refer to the most current Pilot Enrollment Guide located under the Educate tab on https://fedexpilots.bswift.com.

The GeoBlue program will provide access to the BlueCard network in the United States. You can access Pilot Benefits Online at https://fedexpilots.bswift.com to review plan information or download the most current Pilot Enrollment Guide and the GeoBlue Brochure. GeoBlue plan information can also be viewed on pilot.fedex.com.

Before you receive your ID card, you can also access provider network information online at the GeoBlue website: https://group.geo-blue.com/openenrollment/co/geoblue/.

Note: this is a generic log on only and does not provide access to claims or other member specific information. Once enrolled, International pilots will receive their own personalized certificate number and will utilize that to register on the site.

Once you receive your ID card, brochure, and individualized certificate, remember to register on the www.geo-blue.com website so you can access your personal information (i.e., claims information, etc.). If you do not register, you will only have access to the generic information.

Contact Member Services to ask questions about the plan's benefits and services.

Contact information:

Member Services

Collect Outside the U.S.	+1.610.230.2406
Toll-Free Within the U.S.	1.888.304.8898

customerservice@geo-blue.com

24/7 Assistance — Provided by GeoBlue

Collect Calls Accepted	+1.610.254.8771

globalhealth@geo-blue.com

Prior to making an appointment with a physician, contact GeoBlue's Global Health Team for 24/7 assistance with payment arrangements prior to your visit. Please identify yourself as a member of "FedEx group plan" and provide your certificate number from your ID card. In many countries providers require a "guarantee of payment" from insurance carriers at the time of visit. If this is not arranged prior to the visit, the physician may require payment up front.

Prescription Coverage (supported by Universal Rx)

Prescription coverage is automatically included when you enroll in the International Plan and it includes benefits for retail pharmacies and mail order. See the section titled—**Prescription Drug Benefit for International Pilots Only** in this book, or the most current Pilot Enrollment Guide located on https://fedexpilots.bswift.com for more information.

If you would like dental and vision coverage, a separate election must be made to enroll in these benefits. For information on the dental and vision benefits, see the Dental and Vision sections in this book, or view the most current Pilot Enrollment Guide located on https://fedexpilots.bswift.com.

MEDICAL INFORMATION FOR DOMESTIC-BASED PILOTS & COVERED DEPENDENTS

The Federal Express Corporation Group Health Plan for Pilots ("the Plan"), administered by Anthem Blue Cross Life and Health Insurance Company, Inc. (Anthem), provides access to the national Blue Cross Blue Shield PPO network called BlueCard. The Plan consists of the Buy Up Plan option, which is a PPO plan and Consumer Driven Health Plan (CDHP) Purple and Consumer Driven Health Plan (CDHP) Orange medical options, which are qualified high deductible health plans. These medical plan options automatically include medical, prescription drug, mental health/substance abuse, and behavioral health coverage, and they are designed to deliver premier services and comprehensive benefits that cover more than the most basic health care needs. The website—www.anthem.com/ca—and the Sydney Health mobile app provide you with quick access to health information 24 hours a day, seven days a week.

Here are just a few of the advantages of the medical options:

- Comprehensive benefits and easy access to a large network of providers and hospitals.
- Freedom to choose to receive your health care from any licensed physician, specialist, or health care facility.
- No claim filing when using an in-network provider, since the in-network providers bill Anthem directly.
- Emergency care is covered anywhere in the world, 24 hours a day, seven days a week.
- Toll-free customer service number for quick answers to all your benefits questions.
- Fast and convenient access to health care information 24 hours a day, seven days a week on Anthem's website, www.anthem.com/ca or via the Sydney Health mobile app.
- Health and wellness services and healthy lifestyle programs in addition to your health care benefits.
- Easy access to an international PPO network when you travel.

What You Pay

Your monthly cost is based on the medical plan option and coverage tier you elect. In addition to paying your monthly cost through payroll deductions, you will also pay any required copayments and deductibles up to the out-of-pocket maximums. For more details on the current plan design and the monthly cost for each medical option, refer to the most current Pilot Enrollment Guide located under the Educate tab on https://fedexpilots.bswift.com.

Annual Medical Deductible

With the exception of the Buy Up Plan in-network, each year, you will have to meet your individual annual medical deductible before the Plan pays its share of the benefit. If your dependents are covered, the family annual medical deductible must be met. Once the family deductible is satisfied, no further medical deductible expense will be required for eligible expenses of any enrolled dependent of the family for the remainder of that year. The annual medical deductible resets each January 1. Refer to the chart shown below for deductible amounts.

Copayment vs. Coinsurance

A copayment is a dollar amount that you may be required to pay at the time of service. Normally the annual medical deductible will not apply to such services and all you will have to pay is your copayment.

A coinsurance is a percentage you pay after the Plan pays, once your annual medical deductible is met. Coinsurance does not apply until you or your dependents have met the individual or family annual medical deductible. Refer to the chart shown below for coinsurance amounts. See the most current Pilot Enrollment Guide for an overview of the services that require a copayment. The enrollment guide is located under the Educate tab on https://fedexpilots.bswift.com.

Annual Medical Out-of-Pocket Maximum

Once you have met your annual medical deductible, you will pay your coinsurance and any required copayments up to the annual medical out-of-pocket maximum. Once you have met your annual medical out-of-pocket maximum, you will no longer be required to pay any coinsurances or copays for any covered expense you incur during the remainder of that year. The annual medical out-of-pocket maximum resets each January 1. Refer to the chart shown below for out-of-pocket amounts.

MEDICAL PLAN OPTIONS FOR ACTIVE PILOTS & COVERED DEPENDENTS

Buy Up Plan

Under the Buy Up Plan, there is no deductible in-network. After you pay any required copayments, the plan covers 100% of covered eligible medical expenses. However, you must meet an annual deductible before benefits are payable if you use out-of-network providers. After the out-of-network deductible is met, you pay a percentage of the covered expense—your coinsurance—up to the annual out-of-pocket maximum. When you reach the out-of-pocket maximum, in-network or out-of-network, the plan begins to pay 100% of covered eligible medical expenses (including copayments in-network) for the rest of the calendar year, for the individual who reaches the out-of-pocket limit.

	BUY UP PLAN	
	In-Network	**Out-of-Network**
Coinsurance	You pay 0% Services performed are subject to copayment	You pay 30% after deductible

	BUY UP PLAN	
	In-Network	**Out-of-Network**
Annual Deductible* (includes copays, and medical and prescription drug coinsurance)	$0	Pilot Only: $250 Family: $750
Out-of-Pocket Maximum* (includes deductible, copays, and medical and prescription drug coinsurance)	Pilot Only: $3,250 Family: $9,750	Pilot Only: $3,250 Family: $9,750

CDHP Purple or CDHP Orange

Under the CDHP options, regardless of whether you use in-network or out-of-network providers, you must meet an annual deductible before benefits are payable under the Plan. After the annual deductible is met, you pay a percentage of the covered expense—your coinsurance—up to the annual out-of-pocket maximum. When you reach the annual out-of-pocket maximum, the Plan begins to pay 100% of covered eligible medical expenses for the rest of the calendar year for the individual who reached the out-of-pocket maximum limit. For example, under the CDHP Purple in-network Pilot Only tier, you must pay the first $2,500 out of pocket before the Plan will begin to pay its share (90% coinsurance) of the cost of any eligible medical expenses. Once the amount you have paid (the $ 2,500 deductible and 10% coinsurance) reaches the annual out-of-pocket maximum of $4,250, the plan begins to pay 100% of covered eligible medical expenses for the rest of the calendar year for the individual who reaches the out-of-pocket limit.

The in-network and out-of-network deductibles are separate and do not cross accumulate. The same applies to in-network and out-of-network out-of-pocket maximums. For Pilot Plus coverage, the individual deductible and out-of-pocket maximum applies to each individual covered until the family deductible and out-of-pocket maximum are reached.

Please note some benefits may be paid by the Plan before the deductible is met, such as preventive services.

When you enroll in the CDHP Purple or CDHP Orange option, you will select either the Health Savings Account (HSA) or Health Reimbursement Account (HRA) with your medical option. You, and your covered spouse, if applicable, also have an opportunity to earn $300 through the Smart Rewards program. Both accounts and the wellness rewards program are explained below.

	CDHP PURPLE		CDHP ORANGE	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
HSA Company Contribution/ HRA Company Credit	Pilot Only: $2,000 Pilot Plus: $4,000		Pilot Only: $1,200 Pilot Plus: $2,400	
Wellness Reward in HSA or HRA	$300 contribution/credit for each covered pilot and covered spouse		$300 contribution/credit for each covered pilot and covered spouse	
Coinsurance	You pay 10% after deductible Preventive Care:	You pay 30% after deductible	You pay 20% after deductible	You pay 40% after deductible

	CDHP PURPLE		CDHP ORANGE	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
	You pay 0%	Preventive Care: You pay 30% after deductible	Preventive Care: You pay 0%	Preventive Care: You pay 40% after deductible
Annual Deductible* (includes copays, and medical and prescription drug coinsurance)	Pilot Only: $2,500 Pilot Plus: $3,000 per individual or $5,000 family	Pilot Only: $5,000 Pilot Plus: $5,000 per individual or $10,000 family	Pilot Only: $2,500 Pilot Plus: $3,000 per individual or $5,000 family	Pilot Only: $5,000 Pilot Plus: $5,000 per individual or $10,000 family
Out-of-Pocket Maximum* (includes deductible, copays, and medical and prescription drug coinsurance)	Pilot Only: $4,250 Pilot Plus: $4,250 per individual or $8,500 family	Pilot Only: $9,000 Pilot Plus: $9,000 per individual or $18,000 family	Pilot Only: $4,500 Pilot Plus: $4,500 per individual or $9,000 family	Pilot Only: $9,000 Pilot Plus: $9,000 per individual or $18,000 family

*In-network and out-of-network deductibles are separate and do not cross accumulate. The same applies to in-network and out-of-network maximums. For Pilot Plus coverage, the individual deductible and out-of-pocket maximum applies to each individual covered until the family deductible and out-of-pocket maximum are reached.

If you would like dental and vision coverage, a separate election must be made to enroll in these benefits. For information on the dental and vision benefits, see the Dental and Vision sections in this book, or view the most current Pilot Enrollment Guide located on https://fedexpilots.bswift.com.

Health Savings Account (HSA)

The Health Saving Account (HSA) is a tax-advantaged savings account when it comes to federal and most state income taxes. The Health Savings Account (HSA) is only available with the CDHP Purple and CDHP Orange medical options. You and the Company contribute money to your HSA to help cover the costs of your deductible, coinsurance, and eligible health care expenses. You may elect to contribute money to an HSA if you meet IRS rules of eligibility.

Federal tax law and IRS rules restrict the type of health benefit coverage you may have if you or your employer is making contributions to an HSA on your behalf. You must not elect the CDHP Purple HSA or CDHP Orange HSA option if you will have health benefit coverage that is not permitted under the HSA contribution rules while enrolled in the plan. The company can verify only that your company-provided health coverage is permitted coverage. The Company is not responsible for adverse tax consequences that may result if you have health benefit coverage from other sources that are not permitted under the HSA contribution rules. Consult your tax advisor if you have questions about whether health benefits provided by sources other the Company are permitted under the HSA contribution rules.

If you enroll in the CDHP Purple HSA or CDHP Orange HSA medical option, an account is required in order to receive the bi-monthly contributions from the Company, your contributions, and the wellness incentive, if applicable. Pilots who are ineligible for an HSA can elect the CDHP Purple HRA, CDHP Orange HRA, or the Buy Up Plan medical option.

HealthEquity will administer the HSA, and upon enrollment, you will receive a welcome letter at your home with more information, including how to use the account and how to use your debit card to pay for eligible health care expenses. Visit https://learn.healthequity.com/fedex to learn more about the HSA or call HealthEquity at 1.844.281.0925 for more information.

Contributions

With the CDHP Purple HSA or CDHP Orange HSA medical option the Company will make bi-monthly contributions (based on the payroll cycle) to your HSA. The bi-monthly amount contributed to your HSA is prorated based on the month of hire. You can also contribute to your HSA up to IRS limits. If you are age 55 or older in the plan year, you can make an additional catch-up contribution. Contributions are made from your paycheck on a before-tax basis, and the money will not be taxed when used for eligible health care expenses. The annual contribution amount and limits are shown in the chart below.

	PILOT ONLY COVERAGE		PILOT PLUS COVERAGE	
	CDHP Purple HSA	**CDHP Orange HSA**	**CDHP Purple HSA**	**CDHP Orange HSA**
Company contribution	$2,000	$1,200	$4,000	$2,400
Wellness reward	$300	$300	$600 (pilot + spouse)	$600 (pilot + spouse)
Your contribution	The max contribution amount is based on the annual IRS limit Refer to the most recent Pilot	Same	Same	Same

	PILOT ONLY COVERAGE		PILOT PLUS COVERAGE	
	CDHP Purple HSA	CDHP Orange HSA	CDHP Purple HSA	CDHP Orange HSA
	Enrollment Guide for contribution limit			
IRS limit	Refer to the most recent Pilot Enrollment Guide for current limit		Same	
Catch-up contribution amount if age 55 or older this year	$1,000		$1,000	

Note: The amounts shown assume you and your spouse earned the full wellness reward.

You can decide to make or change pre-tax contributions to your HSA at any time by accessing Pilot Benefits Online at https://fedexpilots.bswift.com and selecting Change HSA Contribution (for current year) on the home page.

How the HSA Works

You can use money in your account to pay for eligible health care expenses for you, your spouse, and dependents you claim on your federal tax return. You can use your HSA debit card at the time of service, at the pharmacy, or to pay a bill from a provider. You can also reimburse yourself for payments you have made (up to the available balance in the account). HSA distributions made to a domestic partner are taxable and subject to penalties.

Money in your HSA **rolls over at the end of each year** to cover future health care expenses. It will not be forfeited.

Your HSA also can be **invested in selected funds** once your balance reaches the minimum threshold of $1,000, providing you with another savings vehicle for future qualified medical expenses. For example, if your account balance is $1,500, you can invest $500, if desired. If your HSA cash balance falls below the minimum investment threshold of $1,000, there are no consequences to the investments. It simply means you will not be allowed to invest any more money until your balance exceeds the investment threshold again. The investment balance is separate from the HSA cash balance.

The account is yours. If you change medical plan options, or retire from or leave the company, the account goes with you. Upon retirement or when you leave the Company, you will be responsible for monthly administrative fees associated with your HSA.

For a complete list of eligible expenses, see the IRS Publication 502 and all pertinent updates.

See the Accounts section of this book for additional details on the HSA.

How to Enroll in an HSA

When you make your new hire elections or enroll during Annual Benefits Enrollment, if you elect the CDHP Purple HSA or CDHP Orange HSA, an account is automatically opened for you at HealthEquity. You must be enrolled in one of the CDHP medical options. The HSA is not a stand-alone account.

Health Reimbursement Account (HRA)

The Health Reimbursement Account (HRA) is a tax-advantaged account when it comes to federal and most state income taxes. The Health Reimbursement Account (HRA) is only available with the CDHP Purple and CDHP Orange medical options. The CDHP Purple HRA and CDHP Orange HRA are available to all pilots, regardless of other health benefit coverage or if you are ineligible for an HSA. If you enroll in the CDHP Purple HRA or CDHP Orange HRA medical option, an account will automatically be opened for you at HealthEquity. An account is required in order to receive the monthly credits from the Company and the wellness incentive, if applicable. You cannot contribute to the HRA.

The HRA can be used to help cover the costs of your deductible, coinsurance, and eligible health care expenses. HealthEquity will administer the HRA, and upon enrollment, you will receive a welcome letter at your home with more information, including how to use the account. There is no debit card associated with the HRA and substantiation is required. Visit https://learn.healthequity.com/fedex/hra or call 1.844.281.0925 to learn more about the HRA from HealthEquity.

Credits

With the CDHP Purple HRA and CDHP Orange HRA medical options, the Company will make monthly credits to your HRA. The amount credited by the Company to your HRA is prorated for the month of hire. The annual credit amount is shown in the chart below.

	PILOT ONLY COVERAGE		PILOT PLUS COVERAGE	
	CDHP Purple HRA	**CDHP Orange HRA**	**CDHP Purple HRA**	**CDHP Orange HRA**
Company credit	$2,000	$1,200	$4,000	$2,400
Wellness reward	$300	$300	$600 (pilot + spouse)	$600 (pilot + spouse)

How the HRA Works

You can use the money in your account to pay for eligible health care expenses for you, your spouse, and dependents enrolled in the CDHP HRA option. Substantiation is required for all eligible expenses. To substantiate the expense, you will be required to submit an itemized invoice, Explanation of Benefits, or other approved documentation to HealthEquity via the mobile app, online, or by fax.

For a complete list of eligible expenses, see IRS Publication 502. For more information on HRAs, visit Publication 969.

Money in your HRA **rolls over at the end of each year** to cover future health care expenses. Health care expenses incurred during the current plan year must be filed with HealthEquity by March 31 of the next plan year.

Your HRA balance is credited with 4% interest annually. There is no other investment feature available.

HRA Rollover Credits

If you change medical plan options, or leave or retire from the Company, the account goes with you. HealthEquity will open a separate HRA for you to allow you to receive your monthly credit

from the Company and your wellness reward, if applicable. If you incur eligible health care expenses in the upcoming new year, those expenses must be filed against next year's HRA balance.

Post-Deductible HRA

If you are currently enrolled in one of the CDHP HRA medical options and you do not plan to re-enroll in an HRA medical-option next year, any credit balance remaining in your HRA on December 31 of the current year will be automatically converted to a post-deductible HRA after a 90-day claims run-out period.

This account can be used to reimburse any eligible medical, dental, and/or vision expenses. However, you must meet the IRS annual deductible for a high deductible health plan (HDHP) before the account credits can be used to reimburse any eligible medical expenses. Refer to the most recent Pilot Enrollment Guide for current IRS HDHP minimum deductibles. Once you meet this deductible, you can file for reimbursement of eligible medical expenses from your Post-Deductible HRA. The IRS annual deductible will be monitored by HealthEquity to determine when you can use your account to pay for eligible medical expenses. Your Post-Deductible HRA can be used for eligible dental and vision expenses at any time.

Your Post-Deductible HRA also can be used in conjunction with other health care coverage or even if you decline health care coverage altogether. If your medical, prescription, dental, and/or vision expenses are processed by another vendor other than Anthem Blue Cross, you must submit your eligible expenses to HealthEquity for reimbursement.

HRA Spend Down Account

When you retire or leave the Company, you may be reimbursed from your HRA or Post-Deductible HRA for claims incurred after your termination of employment. You will no longer receive monthly credits from the Company; however, your HRA or Post-Deductible HRA credit balance following your last day of employment is converted to a spend down account after a 90-day run-out period. You can use your HRA spend down account to pay for eligible health care expenses for you, your spouse, and eligible dependents. The HRA spend down account will remain open with HealthEquity until the credit balance has been exhausted. If you die and have no surviving spouse, the remaining credits will be forfeited and the Spend Down HRA will be closed.

See the Accounts section of this book for additional details on the HRA.

How to Enroll in an HRA

When you make your new hire election or enroll during Annual Benefits Enrollment, if you elect the CDHP Purple HRA or CDHP Orange HRA, an account is automatically opened for you at HealthEquity. You must be enrolled in one of the CDHP medical options. The HRA is not a stand-alone account.

Wellness Rewards

If you enroll in one of the CDHP medical options, additional dollars can be earned and deposited into your HSA or HRA, by completing certain wellness requirements. The wellness reward is offered through Smart Rewards, and you and your covered spouse can each earn $300 annually by completing a Health Assessment and participating in two wellness programs or activities. You can complete the requirements anytime throughout the year, but no later than September 30 each year. You and your covered spouse will access the Health Assessment and all eligible wellness activities through Smart Rewards, by logging on to www.anthem.com/ca or connecting through the Sydney Health mobile app. The Smart Rewards program is located under the My Health Dashboard tab, then click on "My Rewards." Following completion of the assessment, ***you should print or save a copy of the results page for your records***. You are also required to participate in **two** of the following wellness programs or activities:

- Annual flu shot (must be administered by an Anthem in-network provider)
- Annual physical
- Colorectal exam
- Diabetes condition care (must be eligible)
- Building Healthy Families, formerly known as the Future Moms program
- Log in to Sydney (annually, only first login counts as one completed activity)
- Mammogram
- Preventive screenings (includes prostate care, skin care, and lung cancer screenings)
- Select a Primary Care Physician (if no physician currently selected)
- Tobacco free program
- Total cholesterol
- Virtual doctor visit
- Well woman exam

Anthem will track and update the programs or services you complete, based on claims processed in its system. You can track what programs you have completed and whether you have earned the wellness incentive through the Sydney App. Wellness contributions/credits are deposited into your HSA or HRA approximately 60 days after you have completed the Health Assessment and two wellness programs or activities.

How to File Claims

If you go to an in-network provider, you will not have to file a claim. The in-network provider will file the claim for you. Once the claim is filed, you will receive the Explanation of Benefits that will show you the total charge your provider billed, the covered expense the Plan allows, if any charges applied to the deductible, what the Plan paid, and your coinsurance amount. You will need the Explanation of Benefits if you have other insurance coverage that is secondary to your FedEx coverage.

If you go to an out-of-network provider, you will have to pay for the total charge of the service and file a claim. You must submit properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to the 9-month filing limit will be allowed (a total of 12 months from date incurred). Services received and charges for the services must be itemized, and clearly and accurately described. You can get an itemized statement from your provider of service. Claim forms must be used; canceled checks or receipts

are not acceptable. You can get a claim form by calling the customer service toll-free at 1.866.406.0982 or via www.anthem.com/ca. Once Anthem receives the claim, they will determine the covered expense and you will be reimbursed directly for the covered expense minus any applicable deductible, copayments, and/or coinsurance, or if you assign benefits in writing to a third party, that third party will be reimbursed minus any applicable deductible, copayments, and/or coinsurance You will also receive an EOB explaining the covered expense and payments. Submit out-of-network provider claims to the address below:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

FedEx will not be liable for benefits if your claim is not filed with Anthem within the 12-month filing deadline.

How a Covered Expense Is Determined

The Plan will pay for covered expenses you incur. A charge is incurred when the service or supply charge is rendered or received. A covered expense for medical benefits is based on a maximum charge for each covered service or supply that will be accepted for each different type of provider. It is not necessarily the amount a provider bills for the service.

In-Network Provider Charges

The maximum covered expense for services provided by an in-network provider will be the lesser of the billed charge or the negotiated rate. The negotiated rate is the amount in-network providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by provider agreements that Anthem has with providers. When you choose an in-network provider, you will not be responsible for any amount in excess of the negotiated rate.

If you go to a hospital that is an in-network provider, you should not assume all providers in that hospital are also in-network providers. To receive the greater benefits afforded when covered services are provided by an in-network provider, you should request that all your provider services (such as services by an anesthesiologist) be performed by in-network providers whenever you enter a hospital.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an ambulatory surgical center. An ambulatory surgical center is licensed as a separate facility even though it may be located on the same grounds as a hospital (although this is not always the case). If the center is licensed separately, you should find out if the facility is an in-network ambulatory surgical center provider before undergoing the surgery.

How to Find an In-Network Provider

For a list of in-network providers, call Anthem Member Services at 1.866.406.0982, or to access the online provider directory, go to www.anthem.com/ca, click “Find Care” and follow the instructions. When prompted, enter the Prefix Identification Number FXF. The network of providers is subject to change. You can also find in-network providers through the Sydney Health mobile app.

Out-of-Network Charges

Out-of-Network Professional Charges

To determine out-of-network claims for professional services Anthem will use either (1) the “Allowed Amount,” which is the amount from the 90th percentile of the FAIR Health FH RV

Benchmarks Modules; or (2) the "Negotiated Amount," which is an amount negotiated by the National Care Network (NCN), as follows:

1. **If the out-of-network professional claim is under $1,000:** The amount the Plan will pay will be based on the Allowed Amount. You will be liable for your share of the Allowed Amount and will be subject to balance billing by the provider for the amount of the provider's bill that exceeds the Allowed Amount.
2. **If the out-of-network professional claim is $1,000 or higher:** NCN will engage in a negotiation with the provider with the objective of lowering the amount billed by the provider, and the amount allowed by the Plan will be determined as follows:
   a. If NCN's negotiation is successful, then the amount the Plan will allow will be based on the Negotiated Amount. You will be liable for your share of the Negotiated Amount and will **not** be subject to balance billing by the provider for any amount above the Negotiated Amount.
   b. If NCN's negotiation is unsuccessful, then the amount the Plan will pay will be based on an amount equal to the Allowed Amount. You will be liable for your share of such Allowed Amount and will also be subject to balance billing by the provider for the amount of the provider's bill above the Allowed Amount.

Out-of-Network Facility Charges

Out-of-network claims for facility services will be determined as follows:

If the out-of-network facility is a "Traditional facility": The amount allowed by the Plan will be determined based on the specific, discounted charges agreed upon by the Traditional facility. You will be liable for your share of the discounted charges and will **not** be subject to balance billing by the facility for any amount above the discounted charges. (**NOTE:** A Traditional facility has a base contract that is separate from the PPO network.)

If the out-of-network facility is not a Traditional facility: NCN will engage in a negotiation with the facility with the objective of lowering the amount billed by the facility, and the amount allowed by the Plan will be determined as follows:

If NCN's negotiation is successful, then the amount the Plan will allow will be based on the Negotiated Amount. You will be liable for your share of the Negotiated Amount and will **not** be subject to balance billing by the facility for any amount above the Negotiated Amount.

If NCN's negotiation is unsuccessful, then the amount the Plan will allow will be based on the Data iSights (NCN's pricing tool) amount, or if there is no applicable Data iSights amount, then the amount the Plan will allow will be based on the local Blue Cross Blue Shield plan's out-of-network pricing, and if there is no applicable local Blue Cross Blue Shield pricing, then the amount the Plan will allow will be based on billed charges. You will be liable for your share of the Data iSights amount or the local Blue Cross Blue Shield pricing or billed charges, as applicable, and will also be subject to balance billing by the facility for the amount of the facility's bill above the Data iSights amount or the local Blue Cross Blue Shield pricing.

If none of the above applies: The amount the Plan will allow will be based on billed charges. You will be liable for your share of the billed charges.

Coordination of Benefits (COB) When There Is Another Plan

If you are covered by more than one group medical plan, your benefits under this Plan will be coordinated with the benefits of those other plans, as shown below. These coordination

provisions apply separately to each pilot and dependent, per calendar year. Any coverage you have for medical benefits will be coordinated as shown below.

COB When You and Your Spouse Both Have Group Medical Coverage

When You Have Medical Expenses For…	Your FedEx Express Medical Coverage Is…	Your Spouse's Medical Plan Is…
You	Primary*	Secondary
Spouse	Secondary	Primary
Child	Primary if your birthday occurs first in the year; Secondary if your spouse's birthday occurs first in the year**	Primary if your spouse's birthday occurs first in the year; Secondary if your birthday occurs first in the year**

*The Primary Plan is the plan that pays benefits first.

**Commonly referred to as the "birthday rule." The birthday rule does not apply to children of divorced parents. The birthday rule may apply if there is joint custody. Refer to the next chart for more details.

COB In Other Situations

Situation	Primary Coverage
You also have coverage through your spouse's employer	• If the other plan has a COB provision, use the guideline in the COB chart above. • If the other plan does not have a COB provision, that plan is always considered the Primary Plan. • If the other plan does not use the birthday rule, benefit coordination for dependent children is determined by the "gender rule," with the father's coverage primary and the mother's coverage secondary.
You also have coverage through a second job	The Primary Plan is the one that has covered you the longest.
You are an active covered pilot and also have retiree coverage through a former employer	The Primary Plan is always your coverage as an active employee.
You have FedEx retiree coverage and also have active coverage through another employer	The Primary Plan is your active coverage through your other employer.
You and your spouse are separated, or divorced	The medical plan options pay in this order for dependent children: 1. The plan offered by the employer of the parent appointed to provide coverage. 2. The plan of the parent who has custody, when no court order indicates the parent appointed to provide coverage. 3. The plan of the spouse of the parent with custody (stepparent). 4. The plan of the parent without custody.

Other Plan is any of the following:

- Group, blanket, or franchise insurance coverage.
- Group service plan contract, group practice, group individual practice, and other group prepayment coverage
- Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans, or self-insured employee benefit plans.
- Medicare. This does not include Medicare when by law its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured program.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement, which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

How Coordination of Benefits Works

The following describes how coverage is determined should you be covered by more than one plan:

1. If this Plan is the Primary Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If this Plan is NOT the Primary Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed the Allowable Expense. An Allowable Expense is any necessary, eligible item of expense that is at least partially covered by at least one Other Plan. For the purposes of determining the Plan's payment, the total value of Allowable Expense as provided under this Plan and all Other Plans will not exceed the greater of: (1) the amount, which the Plan would determine to be eligible expense, if you were covered under this Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.
3. The benefits of this Plan will never be greater than the sum of the benefits that would have been paid if you were covered under this Plan only.

The Claims Paying Administrator coordinates payment of benefits with administrators of Other Plans under the following procedures:

1. A plan that has no Coordination of Benefits provision pays before a plan that has a Coordination of Benefits provision. This would include Medicare in all cases except when the law requires that this Plan pays before Medicare.
2. A plan that covers you as an employee pays before a plan that covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan that covers you as a dependent of an active employee; but (b) before the plan that covers you as a retired employee.
3. For a dependent child covered under two different employers' plans, except as provided in the following paragraph, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have the birthday rule provision, benefit coordination for dependent children is determined by the "gender rule," with the father's coverage primary and the mother's coverage secondary.

4. If the parents are separated or divorced and the child is covered as a dependent under more than one plan, the plans generally pay in the following order:
   a. The plan of the parent that the court establishes as having financial responsibility for the child's health care.
   b. The plan that covers that child as a dependent of the parent with custody.
   c. The plan that covers that child as a dependent of the stepparent (married to the parent with custody).
   d. The plan that covers that child as a dependent of the parent without custody.
5. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, rule 6 applies.
6. The plans covering you under a continuation of coverage provision in accordance with state or federal laws pay after a plan covering you as an employee, a dependent, or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the Order of Benefit Determination provisions of this Plan, this rule will not apply.

When the above rules do not establish the order of payment, the plan in which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

FedEx Rights Under This Coordination of Benefits Provision

- FedEx is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.
- If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and the Plan's liability reduced accordingly.
- If payments that should have been made under this Plan have been made under any Other Plan, FedEx has the right to pay that Other Plan any amount determined to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under this Plan, and such payment will fully satisfy liability under this provision.
- If payments made under this Plan exceed the maximum payment necessary to satisfy the intent of this provision, FedEx has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

Health Care Benefits from Other Sources—You may be entitled to receive health benefits from other sources. If your illness or injury is job-related, medical or dental expenses may be covered by workers' compensation. For more information, see your manager or the Pilot Administration Center.

Coordination of Benefits With TRICARE

If you and your covered dependents have coverage through one of the TRICARE programs, Anthem is primary. Charges incurred in connection with an illness or injury resulting from service in the armed forces are covered under TRICARE and excluded under FedEx coverage. FedEx coverage applies to nonmilitary-related illnesses or injuries not covered by the military.

Coordination of Benefits With Medicare

If you are an active pilot or a dependent of an active pilot, and entitled to Medicare, the Plan is usually the Primary Plan and Medicare is the secondary payer.

If you are entitled to Medicare benefits due to age or due to disability, Medicare will be the Primary Plan unless you have a current employment status as determined by Medicare rules. Medicare coverage is primary for disabled pilots who are:

- Entitled to Medicare due to disability while under Medicare age; and
- Not actively working as defined by the law.

If you are receiving a disability benefit from Social Security, you automatically are eligible for Medicare Part A and Part B beginning your 25th month of disability. For a disabled pilot who receives Medicare after 24 months of Social Security Disability, Medicare becomes the primary payer.

NOTE: If you or a covered dependent receive Medicare coverage because of end-stage renal disease, Anthem is the primary payor for the individual with end-stage renal disease for the first 30 months the individual is enrolled in (or eligible to enroll in) Medicare. At the end of 30 months, Medicare becomes the primary payer for that individual.

In cases where Medicare is the Primary Plan, the Plan's payment will be determined according to the provisions in the section entitled "Coordinating Benefits with Medicare When Medicare is Primary," below.

Coordinating Benefits With Medicare When Medicare Is Primary

The Plan will not provide benefits under this Plan that duplicate any benefits to which you would be entitled under Medicare. If you do not enroll in Medicare Part A and Part B, benefits that otherwise may be payable by the Plan will be reduced by the amount Medicare would have paid. You will be responsible for any copay, deductible, and coinsurance amount due. The benefit reduction will occur in all cases where Medicare is considered the primary plan, even if you have not enrolled in Medicare Parts A and B.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this Plan except as follows:

1. Medicare must provide benefits first to any services covered both by Medicare and under this Plan.
2. For services you receive that are covered both by Medicare and under this Plan, coverage under this Plan will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this Plan will not exceed covered expense for the covered services.

The Plan will apply any charges paid by Medicare for services covered under this Plan toward your plan deductible, if any.

Reimbursement, Subrogation, and Third-Party Liability for Medical and Dental Claims Administered by Vengroff Williams, Inc. (VWA)

If your illness or injury is caused by the actions of a third party, payment of your medical and dental expenses and lost wages may be the responsibility of that third party. This liability could result from events such as an automobile accident or injury at another place of business. However, the plans will initially pay your eligible medical or dental expenses as long as you sign

an agreement, as described below, requiring you to reimburse the plans for benefits paid provided you meet all other provisions of the Plan. Therefore, if you receive payment from a third party, from any source of recovery, including but not limited to, liability or other insurance covering the third party, uninsured or underinsured motorist insurance, medical payment, or personal injury protection insurance and no-fault insurance, FedEx expects you to hold the payments in constructive trust for the benefit of the plans and to fully reimburse the plans from these funds in the amount of the related benefits paid from the plans on your behalf. The Plan shall not have right of reimbursement from a policy, contract, or other arrangement for which the participant pays 100% of the cost of such coverage (except for a policy, contract, or other arrangement in a no-fault jurisdiction).

If the payment you receive from a third party, less your attorney's fees and other legal expenses (net recovery), is not enough to reimburse benefit payments at 100%, you must still reimburse the plan 100% of what is left after paying your attorney's fees and other legal expenses.

FedEx shall have the first priority right of recovery from any amounts that you receive from any third party, regardless of whether these amounts were received by settlement or judgment, and regardless of whether you have been "made whole" by the amounts that you have received. The plans' rights apply to any funds recovered from another party by or on behalf of you, your covered dependents, or your estate. FedEx shall also have right to subrogation against the third party for recovery of benefits paid by the Plan.

You are required to sign an agreement acceptable to FedEx in which you agree to repay any money paid to you or to others on your behalf as plan benefits. If you do not sign this agreement, all benefit payments from the plans may be stopped. And if you do not honor this agreement, future benefit payments may be withheld until the entire amount due is reimbursed. In addition to withholding future benefits, FedEx may take any other legal action it deems appropriate, such as suing you for the full reimbursement amount. You are solely responsible for paying all legal expenses. The amount of the reimbursement is not reduced because of legal expenses you incur because you do not honor the agreement. Please read the agreement carefully and note that it applies to payments you have received or will receive, and to future benefit payments that will be made from the plans related to the same illness or injury.

To obtain a Reimbursement/Subrogation Form, contact Vengroff Williams, Inc. at 1.800.813.4054.

Coordination of Benefits and Personal Injury

The Plan also coordinates with personal injury protection coverage in those states with no-fault auto insurance laws. Benefits under this Plan are secondary to no-fault auto insurance coverage.

Covered Health Care Providers

Eligible services must be provided by health care providers (other than your spouse, child, sibling, parent, in-laws, or spouse's child or sibling) who are licensed practitioners of the healing arts acting within the scope of their license. This means that any health care provider who treats you and charges for services must be licensed, certified, or registered as a health care provider according to the requirements of the state in which the services are provided.

Medically Necessary Care

Eligible expenses for treatment of an illness or injury must be medically necessary. Medical necessity will be determined by Anthem, the claims paying administrator for medical, mental health/substance abuse, and utilization management; Express Scripts, Inc. for pharmacy; Cigna, the claims paying administrator for dental; and/or Davis Vision, the claims paying administrator for vision, as applicable, determines medical necessity, based on their respective guidelines, which are, in general, more detailed than the definition below. Medically Necessary Care is defined in the Plan document as care that is:

- Commonly and customarily recognized within the most relevant medical specialty (such as cardiology, orthopedic, etc.) with respect to the standards of good practice as appropriate and effective in the identification or treatment of a patient's diagnosed illness.
- Consistent with the symptom upon which the diagnosis and treatment of the illness is based.
- The appropriate supply or level of service that can be safely provided to a patient and with regard to a person who is an inpatient, it must mean that the patient's illness requires that the service or supply cannot be safely provided to that person on an outpatient basis.
- Provided by a practitioner, hospital, or covered provider.
- Not experimental or investigational in nature.
- Not scholastic, educational, or developmental in nature, or intended for vocational training.
- Not primarily for the convenience of the patient, practitioner, hospital, or covered provider.
- Not provided primarily for the purpose of medical or other research.
- Approved by the U.S. Food and Drug Administration (FDA), if the drug or supply is appropriate for review by the FDA.

Anthem, or the applicable claims paying administrator, determines which services and supplies are eligible expenses based on their appropriateness in diagnosing or treating an illness or injury consistent with the terms of the Plan. Charges for services and supplies shall be considered medically necessary only to the extent they are determined by the appropriate claims paying administrator's guidelines to be related to and appropriate for the treatment of the condition involved. Since the guidelines are subject to change, it is not practical to include them in this book. However, a copy of the guideline applicable to your condition, including information to verify that the Plan applies the medical/surgical benefits criteria in a comparable way to the medical necessity criteria for mental health and substance use disorder benefits, is available upon request. The documents will be made available to you within 30 days of your request, subject to normal costs and restrictions as described in "Your Rights Under ERISA," under the "Introduction" Section of this book. Anthem provides medical policies on many procedures that are available online at www.anthem.com/ca or you can request a copy by calling Anthem Member Services at the number shown on the back of your medical ID card. Please note not all services requiring medical necessity review will have a medical policy.

If a health care provider orders a particular service or supply that does not meet medical necessity guidelines, it may not be covered by the Plan. Call Anthem Member Services at 1.866.406.0982 (or other claims paying administrator) if you have questions about benefits provided for a recommended treatment. In some cases, Anthem may ask that your physician submit a written request for a preauthorization of benefits.

If you are not sure the treatment recommended by your physician will be covered by the Plan's definition of medical necessity, contact Anthem (or the applicable claims paying administrator).

Utilization Review Program (Preauthorization)

Benefits are provided only for medically necessary and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out-of-pocket expense.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this Plan.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this Plan is secondary to another plan providing benefits for you or your dependents.

The Utilization Review Program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are medically necessary and appropriate are authorized by Anthem and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

It is your responsibility to see that your physician starts the utilization review process and obtains a preauthorization before scheduling you for any service requiring preauthorization. If you receive any such service, and do not follow the procedures set forth in this section, your benefits may be reduced as shown in the "Effect on Benefits" section.

Utilization Review Preauthorization Requirements

Preauthorization is required for inpatient mental health and substance abuse covered services (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center, and intensive outpatient program). Call 1.866.406.0982 for preauthorization of a service. Preauthorization is not necessary for outpatient office visits for mental health and substance abuse services.

Preauthorization is also required for the following:

- All Inpatient hospitalization including acute rehabilitation and long-term acute care, Cardiac/Pulmonary/Vestibular Rehab.
- Skilled Nursing Facility.
- Home Health Care.
- Hospice Care.
- Transplants.
- Potentially cosmetic/investigative services, including but not limited to: Lipectomy, Liposuction, Back Surgery with disc implants, Treatment of Varicose Veins, Specific Eye, Ear and Nose procedures, and Erectile Dysfunction.
- Certain outpatient surgeries and/or diagnostic procedures. Check Anthem-CA Medical Policies online at www.anthem.com/ca/medicalpolicy or call Anthem Member Services at the number shown on the back of your medical ID card, for details before you schedule the surgery/procedure to see if preauthorization is required.

The above list of services is not all inclusive. To determine if your recommended outpatient or inpatient procedure or service requires preauthorization, call 1.866.406.0982. Failure to meet

preauthorization requirements for certain services or procedures will result in denial of benefits for services or procedures determined not to be medically necessary.

Exceptions: Utilization review is not required for inpatient hospital stays for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

The stages of Utilization Review (Preauthorization) are:

1. Pre-service review determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable.
2. Concurrent review determines whether services are medically necessary and appropriate when Anthem is notified while service is ongoing, for example, an emergency admission to the hospital.
3. Retrospective review is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

Effect on Benefits

In order for the full benefits of this Plan to be payable, the following criteria must be met:

1. When pre-service review is performed and the admission, procedure, or service is determined to be medically necessary and appropriate, benefits covered by the Plan will be provided for the treatment requested.
2. If you proceed with any services that have been determined to be not medically necessary and appropriate at any stage of the Utilization Review process, benefits will not be provided for those services.
3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not medically necessary and appropriate, benefits will not be paid for those services.

How to Obtain Utilization Review for Preauthorization

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed, your benefits will be reduced as shown above under Effect on Benefits.

Pre-Service Reviews

1. For all scheduled services that are subject to Utilization Review, you or your physician must initiate the preauthorization at least three business days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service reviews is printed on your identification card.
2. If you do not receive the preauthorized service within 60 days of the authorization, or if the nature of the service changes, a new pre-service review for preauthorization must be obtained.
3. Anthem will authorize services that are medically necessary and appropriate. For

inpatient hospital stays, Anthem will, if appropriate, authorize a specific length of stay for approved services. You, your physician, and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you or the provider of the service must contact Anthem for concurrent review. For an emergency admission or procedure, Anthem must be notified within two business days of the admission or procedure. The toll-free number is printed on your identification card.
2. When Anthem determines that the service is medically necessary and appropriate, they will, depending upon the type of treatment or procedure, authorize the service for a period of time that is medically appropriate. Anthem will also determine the medically appropriate setting.
3. If it is determined that the service is not medically necessary and appropriate, your physician will be notified by telephone no later than 24 hours following Anthem's decision. Anthem will send written notice to you and your physician within two business days following the decision. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.

Retrospective Reviews

A retrospective review is performed when Anthem is not notified of the service you received and is therefore unable to perform the appropriate review prior to your discharge from the hospital or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

Such services that have been retroactively determined to not be medically necessary and appropriate will be retrospectively denied authorization.

The Medical Necessity Review Process

Anthem will work with you and your health care providers to cover medically necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, Anthem is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the review process:

1. A decision on the medical necessity of a pre-service request will be made no later than five business days from receipt of the information reasonably necessary to make the decision and based on the nature of your medical condition.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision and based on the nature of your medical condition.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your physician.
4. If Anthem does not have the information they need, they will make every attempt to obtain that information from you or your physician. If unsuccessful and a delay is anticipated, Anthem will notify you and your physician of the delay and what is needed to make a decision. Anthem will also inform you of when a decision can be expected following receipt of the needed information.

5. All pre-service, concurrent, and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called “Review Coordinators”) using pre-established criteria and Anthem’s medical policy. These criteria and policies are developed and approved by practicing providers not employed by Anthem and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as medically necessary. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be medically necessary will be sent to you and your provider no later than two business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure, and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting physician is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not medically necessary and appropriate. Your physician will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
    - an explanation of the reason for the decision;
    - reference of the criteria used in the decision to modify or not authorize the request;
    - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request; and
    - how to request an appeal if you or your provider disagrees with the decision.
9. The reviewers may be doctors at Anthem that support the FedEx Express pilot benefits or an independent third party chosen at the sole and absolute discretion of Anthem.
10. You or your physician may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone.
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

Predetermination of Benefits

Predetermination is a review that can be requested when a service or supply does not require

preauthorization. A predetermination is **recommended** prior to services being rendered but is not required. However, because a particular service or procedure has a medical or clinical guideline associated with it, it may be subject to review for medical necessity at the point the claim is processed. In these instances, Anthem's intake representative will let the provider know that even though a preauthorization is not required, they do have the option to request a predetermination. A predetermination is encouraged when applicable before services begin and expenses are incurred so there are no surprises to the provider or member after services have already been rendered.

Personal Case Management

The Personal Case Management program enables you to obtain medically appropriate care in a more economical, cost-effective, and coordinated manner during prolonged periods of intensive medical care. Anthem, through a case manager, may recommend an alternative plan of treatment, which may include services not covered under this Plan. FedEx does not have an obligation to provide Personal Case Management.

How Personal Case Management Works

You may be identified for possible personal case management through the Plan's Utilization Review procedures, by the attending physician, hospital staff, or Anthem's claims reports. You or your family may also call Anthem.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;
2. Anthem anticipates that such treatment utilizing services or supplies covered under this Plan will result in considerable cost;
3. A cost-benefit analysis determines that the benefits payable under this Plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this Plan while maintaining the same standards of care; and
4. You (or your legal guardian) and your physician agree, in a letter of agreement, with Anthem's recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan

If Anthem determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this Plan. A case manager will review the medical records and discuss your treatment with the attending physician, you, and your family.

Anthem makes treatment recommendations only; any decision regarding treatment belongs to you and your physician. The Plan will, in no way, compromise your freedom to make such decisions.

Effects on Benefits

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. Anthem has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any member, which alternatives may be offered and the terms of the offer.
2. Any authorization of services in lieu of benefits in a particular case in no way commits Anthem to do so in another case or for another member.
3. The Personal Case Management program does not prevent Anthem from strictly

applying the expressed benefits, exclusions, and limitations of this Plan at any other time or for any other member.

NOTE: If alternative benefits are offered, a letter of agreement outlining the alternative benefits and any benefits provided in lieu of others will be provided by Anthem to you. Anthem reserves the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

Disagreement With Medical Management Decisions

1. If you or your physician disagrees with a decision, you or your physician may request a Level 1 appeal as described in the "Claims and Appeals" section. Requests for a Level 1 appeal (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests should include medical information that supports the medical necessity of the services.
2. If you, your representative, or your physician acting on your behalf finds the decision on your level 1 appeal request still unsatisfactory, a request for an appeal of a Level 1 decision may be submitted in writing to Anthem. This would be a level 2 appeal request. The level 1 decision letter from Anthem will explain what medical information is needed to support the medical necessity of the denied services. You should include the information to support the medical necessity of the services with your level 2 appeal request.
3. If the decision on your level 2 appeal request is still unsatisfactory, you may have the option to request an Independent Medical Review as described in the "Claims and Appeals" section of this book.
4. If you exhaust all levels of appeals as outlined in the "Claims and Appeals" section, you may or may not have the right to bring a civil action in federal court under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) depending on where the civil action is filed.

When You Need Care Right Away

Emergency Care

Follow these guidelines when you believe you need emergency care. **An emergency** is a sudden, serious, and unexpected illness, injury or health problem (including sudden and unexpected severe pain). This includes any illness, injury, or health problem you reasonably believe could endanger your health if you don't receive medical care right away. **You and your family members are covered 24 hours a day, seven days a week for emergency services anywhere in the world.**

Your Benefits	How to Receive Them
Medical emergency facility	Because medical emergencies require immediate attention, call 911 (if you are in an area where the system is established and operating) or go for immediate treatment at the closest emergency facility. If you are not admitted, you will need to pay the emergency room copayment. Subject to the availability of in-network health care providers on staff at the hospital, you may request that all services be performed by in-network providers to incur less cost.

Your Benefits	How to Receive Them
Emergency admission to an in-network hospital	Under CDHP Purple and CDHP Orange medical options, you pay a coinsurance after deductible (10% or 20%, respectively). Under the Buy Up Plan medical option, you pay a $75 copayment. If you are admitted to the hospital, your $75 emergency room copayment will be waived. You will pay a $500 copayment for the third and each subsequent emergency room visit for an individual. If you are admitted to the hospital, your emergency room copayment will be waived. This applies to the CDHP Purple, CDHP Orange, and Buy Up Plan medical plan options. The hospital will notify Anthem of your admission. Anthem will then coordinate your care with your in-network physician.
Emergency admission to an out-of-network hospital	Under CDHP Purple and CDHP Orange medical options, you pay the applicable in-network coinsurance amount (10% or 20%) after deductible, if a true emergency. If not a true emergency, you pay the applicable out-of-network coinsurance amount (30% or 40%) after deductible. Under Buy Up Plan medical option, you pay a $75 copayment. The copayment will be waived if admitted, then 100% coverage, if a true emergency. If not a true emergency, you pay a $75 copayment, then 30% after deductible. If you are admitted to an out-of-network hospital, you, your family, or the hospital should contact Anthem within 24 hours of your admission. The member service toll-free number, 1.866.406.0982, is also printed on your member ID card.

Urgent Care

Urgent care is the service you seek for a sudden, serious, or unexpected illness, injury or condition to keep your health from getting worse. It is not an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat the health problem.

Your Benefits	How to Receive Them
Urgent Care Centers	Urgent Care Centers are physician offices that provide walk-in care and extended hours. Office hours and days of operation vary and it is recommended that you call your physician in advance to determine if urgent care is available, the location where extended care is available and the hours of operation. Under CDHP Purple and CDHP Orange medical options, you pay the coinsurance after deductible. Under Buy Up Plan medical option, you pay a $35 copayment.

When Traveling or Temporarily Residing Outside Your Home State

If you are traveling in the United States, you and your enrolled dependents can access care from in-network health care providers.

Your Benefits	How to Receive Them
The BlueCard PPO network enables you and your enrolled dependents (including out-of-state students) traveling outside your home state to access a broader network of doctors and hospitals at discounted rates. The network provides continued benefits for you and your enrolled dependents (even out-of-state students) when traveling or temporarily residing away from home.	To locate BlueCard PPO providers, call 1.866.406.0982 or access Find Care tool at www.anthem.com/ca and follow the instructions. When prompted, enter the Prefix Identification Number FXF. • When you receive services from an in-network provider, they will file the claim for you. • When you receive services from an out-of-network provider, you may need to pay at the time of service then file a claim to the local Blue Cross/Blue Shield plan in the state where you received services. It's important that you save relevant statements and attach them to the claim form for reimbursement.

Access to GeoBlue Provider Network—When Traveling Outside the United States

Your Benefits	How to Receive Them
GeoBlue in-network hospitals can provide inpatient and outpatient services when you're traveling outside the U.S. Inpatient out-of-network care and all other medically necessary care that is not urgent or emergent will be covered subject to Anthem's out-of-network benefits.	Be prepared for the unexpected; call the International Provider Access at 1.888.243.2358 (phone number is also on your ID card) before leaving the U.S. An International Coordinator will provide you with a list of GeoBlue in-network hospitals in several international cities, or you can reach them online at www.geo-blue.com. For inpatient care at an in-network hospital, you pay only the applicable deductibles and copayments. The provider files the claim for you. For inpatient care at an out-of-network hospital, you will need to pay the hospital at the time you receive services and then submit a claim for reimbursement. To print a claim form, go to www.anthem.com/ca. If you need emergency care, go to the nearest hospital, and call the International Provider Access number on your ID card if you are admitted. If you are not admitted, you may be asked to pay for emergency services at the time of care. Before leaving the facility, request an itemized bill, which you will need to include when filing the claim to Anthem. • You will receive inpatient services at the in-network benefit level, and the in-network provider will file the claim for you. You will receive inpatient and outpatient out-of-network services that are medically necessary and deemed emergent or urgent at the in-network benefit

	level. If care is deemed not emergent or urgent, services will be covered subject to Anthem's PPO out-of-network benefits. For all outpatient and professional medical care, you pay the provider and submit the claim. You will need to pay the hospital at the time of service then file a claim for reimbursement. Visit www.anthem.com/ca to print a claim form.

Medical Charges That Are Covered

Subject to all other provisions of the Plan, medical charges covered by the Plan include but are not limited to the following:

Ambulance

The following services and supplies will be covered:

1. Base charge, mileage, and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a hospital.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system request for assistance if you believe you have an emergency medical condition requiring such assistance.
3. Base charge, mileage, and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest hospital where appropriate treatment is provided if, and only if, such services are medically necessary and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen, and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

If you have an emergency medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Ambulatory Surgical Center

Services and supplies provided by an ambulatory surgical center in connection with outpatient surgery.

Blood

Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing, and storage of self-donated blood are covered but only when specifically collected for a planned and covered surgical procedure.

Breast Cancer

Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including the following, will be covered:

1. Diagnostic mammogram examinations for the treatment of a diagnosed illness or injury. Routine mammograms will be covered.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a medically necessary mastectomy.

4. Breast prostheses following a mastectomy.

This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions.

Cancer Clinical Trials

Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III, and phase IV cancer clinical trials if all of the following conditions are met:

1. The treatment provided in a clinical trial must either:
   a. Involve a drug that is exempt under federal regulations from a new drug application; or
   b. Be approved by (i) one of the National Institutes of Health, (ii) the U.S. Food and Drug Administration in the form of an investigational new drug application, (iii) the U.S. Department of Defense, or (iv) the U.S. Veterans Health Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your physician after determining participation has a meaningful potential to benefit the beneficiary.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs mean the costs associated with the provision of services, including drugs, items, devices, and services that would otherwise be covered under this Plan, including health care services that are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device, or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

1. Drugs or devices not approved by the U.S. Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from this plan.
5. Health care services customarily provided by the research sponsors free of charge to members enrolled in the trial.

NOTE: You will be financially responsible for the costs associated with non-covered services.

For more information, contact Anthem at 1.866.406.0982 or access Anthem's Clinical Trials medical policies at www.anthem.com/ca.

Chemotherapy

Chiropractic Care

Chiropractic service for manual manipulation of the spine to correct subluxation demonstrated by physician-read X-ray. Chiropractic services are limited to 25 visits annually (in-network and out-of-network combined) for you and each of your dependents. This applies to the Buy Up Plan medical option only. Under the CDHP Purple and CDHP Orange medical options you are responsible for the applicable coinsurance after deductible.

Durable Medical Equipment

Rental or purchase of dialysis equipment and dialysis supplies are covered. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications are covered. Rental or purchase of other medical equipment and supplies that satisfy the conditions below will be covered.

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

Anthem will determine whether the item satisfies the conditions above.

Hemodialysis Treatment

Hearing Aids

Hearing aids and hearing aid repairs, batteries, and appliances are covered, up to $5,000 every three years, per participant. The Plan only contracts for the standard hearing aid model. If you choose an enhanced/deluxe hearing aid model, the Plan will pay the provider the contracted amount for the standard hearing aid model and you pay the excess up to the maximum benefit under the Plan. The provider will have you sign a waiver informing you that due to the enhanced/deluxe model selection, you will be liable for any excess amount over the standard model rate. The provider may request you pay the excess amount upfront.

Home Health Care

The following services provided by a home health agency will be covered:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as a professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. Medically necessary supplies provided by the home health agency.

One home health visit by a home health aide is defined as a period of covered service of up to four hours during any one day. Private duty nursing services provided in the home are subject to the Home Health Care benefit terms, conditions, and limits.

Home health care services are not covered if received while you are receiving benefits under the Hospice Care provision.

Hospice Care

The Plan will pay for:

1. Room and board charges in an inpatient hospice unit.
2. Services of a registered nurse, licensed practical nurse, and licensed vocational nurse.
3. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, and respiratory therapy.
4. Medical social services.
5. Services of a home health aide.
6. Dietary and nutritional guidance.
7. Nutritional support such as intravenous feeding or hyperalimentation.
8. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a physician.
9. Medical supplies.
10. Oxygen and related respiratory therapy supplies.
11. Bereavement counseling for your family.
12. Palliative care (care that controls pain and relieve symptoms but does not cure) that is appropriate for the illness.

You must be suffering from a terminal illness for which the prognosis of life expectancy is six months or less, as certified by your physician and submitted to Anthem.

Your physician must consent to your care by the hospice and must be consulted in the development of your treatment plan. The hospice must submit a written treatment plan to Anthem every 30 days.

Hospital Stays, Services, and Supplies

The following will be covered:

1. Inpatient services and supplies provided by a hospital. Covered expense will not include charges in excess of the hospital's prevailing two-bed room rate unless your physician orders, and Anthem authorizes, a private room as medically necessary.
2. Services in special care units.

Infertility

Infertility coverage will be provided for the following services:

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to correct an infertility condition.
- Drugs to treat infertility are covered under the Pharmacy benefit. These drugs are not covered if used in conjunction with the non-covered procedures listed below.

The following procedures and associated direct medical procedures and pharmacy expenses are not covered:

- Artificial insemination
- In vitro fertilization

- Gamete intrafallopian transfer
- Zygote intrafallopian transfer
- All similar procedures

Organ and Tissue Transplants

Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not a member is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Orthotics (foot)

Orthotics (foot) are limited based on Anthem's guidelines.

Outpatient Diagnostic Services

Outpatient diagnostic radiology and laboratory services are covered.

Physical Therapy, Physical Medicine, Occupational Therapy, Speech Therapy

The following services ordered by a physician and provided by a licensed therapist under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultraviolet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care that are customarily provided by chiropractors, physical therapists, and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs that are designed to rehabilitate mentally, physically, or emotionally handicapped persons.
3. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills, and ability to function in daily living activities.
4. Outpatient speech therapy following injury or organic disease.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a licensed therapist in that therapist's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her physician decide on an earlier discharge.
2. Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is an employee or enrolled dependent (spouse or child).
3. Precipitous (unplanned) births at home.

Preventive Care

1. A physician's services for routine physical examinations including well-women and well-baby care in accordance with Anthem's guidelines.
2. Radiology and laboratory services and tests ordered by the examining physician in connection with a routine physical examination.
3. All preventive exams including PSAs, mammograms, immunizations, prostate exams, and pap smears.

Professional Services

1. Services of a physician.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.
3. Other medically necessary prosthetic devices, including:
   a. Surgical implants.
   b. Artificial limbs or eyes; and
   c. The first pair of contact lenses or eyeglasses when required as a result of a covered medically necessary eye surgery.

Radiation Therapy

Reconstructive Surgery

Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Skeletal Disorders of the Jaw (Including TMJ)

Treatment of all skeletal disorders of the jaw, including but not limited to myofacial conditions and temporomandibular joint syndrome (TMJ), often involves benefits provided under both medical and dental coverages. There are specific limits and guidelines under both that could result in costly fees not covered by either. **Therefore, it is important that you submit a predetermination of benefits from your health care provider(s) to Cigna (the dental plan's claims paying administrator) before services begin and expenses are incurred. This will determine if any of these charges are covered under your dental or medical benefits.** For more information see the "Dental" section in this book.

Any outpatient TMJ surgery predetermination of benefits should be sent to **Cigna**. Inpatient TMJ claims should be preauthorized by Anthem.

Skilled Nursing Facility

Inpatient services and supplies provided by a skilled nursing facility will be covered. The amount by which your room charge exceeds the prevailing two-bed room rate of the skilled nursing facility is not considered a covered expense.

Surgery, Anesthetics, and Surgeon's Fees

Outpatient services and supplies provided by a hospital or ambulatory surgical center for outpatient surgery are covered.

Telephone and Electronic Consultation

Charges incurred for consultations done outside of the office or facility setting.

EMPLOYEE ASSISTANCE PROGRAM/MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Confidential Assistance and Resources for Everyone (CARE)

The Confidential Assistance and Resources for Everyone (CARE) program is your employee (and family) assistance program. The CARE program is administered by Anthem and it offers:

- Access to comprehensive professional support and short-term counseling for you, your eligible dependents, and any member of your household
- Easy access to licensed psychologists and social workers located in your community
- Assistance for family conflict, grief, life changes, personal growth, dependence, or co-dependence
- Crisis counseling for urgent or emergency situations
- Confidential assistance 24 hours a day, every day of the year

You are eligible for the employee assistance program on your first day of active employment. Enrollment in a medical plan option is not required to utilize the CARE program. You and each eligible household family member are allowed up to eight counseling sessions, covered at 100%, when received by an in-network provider. All services must be preauthorized by Anthem. In order to receive services, you must contact Anthem at 1.866.621.0130 to obtain a referral to a network provider. There is no need to file a claim form since this care is prepaid by FedEx.

Anthem partners with Workplace Options (WPO) to provide employee and family assistance services outside the United States. Employee and family assistance services for FDA pilots, members of the household and pilots traveling outside the United States are provided through WPO's global network of providers. You can access benefits through the CARE program or locate participating providers at www.anthemEAP.com or by calling the international phone number at 44.20.8987.6230 for care outside the United States.

If you enroll in the HMSA PPO or Health Plan Hawaii HMO, your employee assistance benefits are administered by HMSA. Contact HMSA at the number shown on the back of your medical ID card for more information.

Mental Health/Substance Abuse Services

Your Mental Health/Substance Abuse benefits are for more complex or long-term care. These benefits include:

- A variety of treatment programs to meet your needs, including individual therapy, inpatient hospitalization, and day treatment
- Access to a nationwide network of licensed accredited providers, which includes psychiatrists, psychologists, social workers, and counselors
- Confidential assistance 24 hours a day, every day of the year

Anthem has trained behavioral health customer care representatives who can view all available programs so that cross referrals to other beneficial programs can be offered.

Since benefits are payable for this type of care it is available only to you and your eligible dependents and you must enroll in the Buy Up, CDHP Purple, CDHP Orange, or High Deductible Plan (retired pilots) medical option, administered by Anthem. See the most recent Pilot Enrollment Guide located on https://fedexpilots.bswift.com for details about the mental health/substance abuse benefits.

Important: You must preauthorize all employee assistance benefits and inpatient mental health/substance abuse services and treatment (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center, and intensive outpatient program) through Anthem/BH Resource Center by calling Anthem at 1.877.657.6060.

In an Emergency

In case of emergency, seek treatment immediately. Then it is recommended that you call Anthem CARE/Behavioral Health Resource Center within 48 hours of the start of inpatient treatment.

NOTE: For International Plan, HMSA, and Health Plan Hawaii participants, mental health/substance abuse treatment must be coordinated through your medical plan provider.

Reduction in Alcohol Program

Reduction in Alcohol (RIA) Health is an alcohol treatment program that empowers you to improve your relationship with alcohol from the privacy and comfort of your home. The program uses custom treatment plans, medications, and online support to help you learn to drink in moderation or give up alcohol for good.

The RIA tools and resources are available through a secure app, which gives you access at home or on the go. Their doctors and counselors work with you to develop a program based on your health, history, goals, and schedule. For more information call 866.619.8713 or visit http://riahealth.com/.

Note, the RIA Health program is offered to the pilot's covered spouse and dependent(s). This program is not offered to pilots.

How It Works

To receive care, simply call Anthem CARE at 1.866.621.0130 or the Behavioral Health Resource Center at 1.877.657.6060, anytime 24 hours a day. When you call, an Anthem/Behavioral Health Resource Center Customer Care representative will:

- Briefly review your concerns, assess whether your needs are best suited for the CARE program or for mental health/substance abuse services, and refer you to an Anthem CARE/Behavioral Health Resource Center network provider suited to your specific needs;
- Discuss your needs and treatment plan with the provider at the beginning of care and regularly throughout treatment;
- Authorize appropriate services for covered benefit;
- Send educational information or articles to you; and
- Be available to you for discussion of treatment progress or any treatment problems you encounter.

ANTHEM PROGRAMS AND RESOURCES

If you are enrolled in the Buy Up Plan**,** CDHP Purple, or CDHP Orange medical option, you also have access to Anthem's resources to help you and your eligible dependents year-round with health care information and support. These resource programs are discussed below. You can also visit www.anthem.com/ca to learn more.

24-Hour Health Information Line

The Health Information Line offers support 24 hours a day, 7 days a week. If you need urgent care, a nurse will direct you to the nearest provider. If your condition does not require immediate care, a nurse will give you self-care tips to use until you see your doctor. Call the Health Information Line at 1.866.406.0982.

Aim Program

Health issues can be unexpected and stressful. Now you can gauge your health care costs ahead of time. Not only that, but you can compare costs too, to see where you can find quality care for less near you.

Anthem will call you when you may be able to save on certain health procedures to give you alternate providers/facilities to consider. The purpose of the program is to help you save on out-of-pocket costs and help you make smart choices when you need services like high-end radiology and ultrasound procedures, MRI, CT, PET, Nuclear Cardiology and Echocardiograms, or an endoscopy, colonoscopy, or arthroscopic surgical facility.

How the Program Works

1. Your doctor will contact Anthem when one of the above services or procedures is recommended. To make sure you are getting the right level of care and to reduce unnecessary procedures and costs, Anthem will conduct a clinical review to make sure that the procedure is necessary and safe.
2. Once approved, Anthem will check to see if the provider who will perform the procedure offers a low cost for the service in your area. They may also check other facility details.
3. If not, Anthem will call you to give you other nearby high quality, lower cost provider or facility choices.
4. You choose the provider that best meets your needs, whether it is the one your doctor suggested or one provided by Anthem. It is your decision.

Coverage Advisor

The Coverage Advisor tool will help you estimate your costs under the Buy Up Plan**,** CDHP Purple, and CDHP Orange medical options, so you can choose your medical plan option with confidence. You can access the Coverage Advisor tool at www.anthem.com/ca or https://fedexpilots.bswift.com.

Building Healthy Families, formerly known as the Future Moms Program

Building Healthy Families is Anthem's next generation maternal health program offering earlier engagement, stronger connections, fewer gaps, robust whole-person care resulting in improved

outcomes from pre-conception to early childhood stages of life. This intuitive digital experience will provide members access to pre-pregnancy, maternity, and post-partum care, as well as parenting support. The expanded digital member experience is accessible using Sydney Health.

Hinge Health

Hinge Health is a digital musculoskeletal (MSK) solution that aims to reduce back, knee, hip, neck shoulder, or other pain without the drugs or surgery, through the use of advanced motion technology, and wearable sensors for live feedback through the Hinge Health app.

The Hinge Health Digital MSK Clinic combines a complete clinical care team of physical therapists, health coaches, and physicians to work with you. Best of all, it's free!

To learn more about this program or to enroll, call Hinge Health at 1.855.902.2777 or visit hingehealth.com/fedex-express. Once you are enrolled in the program, you will receive a Hinge Health kit.

LiveHealth Online

LiveHealth Online provides you access to a board-certified doctor who can answer and diagnose common problems such as sore throats, infections, and the flu, using your computer's webcam, smartphone, or tablet. You can video chat with a doctor online, anytime from your computer or mobile device with internet access, without an appointment. Download the LiveHealth Online app to your iOS or Android device and register your account. Three steps and you are face-to-face with a doctor—sign-up, choose a doctor, and begin your consultation.

LiveHealth Online also includes your eight free counseling sessions provided through CARE—your employee assistance program—and visits with a psychologist or therapist provided under the Behavioral Health program. LiveHealth Online Psychology will make it easier for you to attend short-term counseling sessions to help at no cost with work/life balance problems such as parenting, relationships, and managing stress. You can interact privately with a psychologist or therapist for more advanced behavioral health needs from a comfortable environment. Benefit payment for these services is covered based on the medical plan option you are enrolled in. The cost is per visit and may be lower than or equal to a physician or therapy/psychology office visit, and less than an urgent care or emergency room visit. Payment via MasterCard, Visa, or Discover is required at the time of service. You can pay for these services with your HSA, HRA, or FSA, if applicable. See the most current Pilot Enrollment Guide located on https://fedexpilots.bswift.com for more information.

LiveHealth Online is available in most states. To locate in-network, board certified providers participating in this program, visit livehealthonline.com.

Quick Care Options

Knowing where to go if you get sick or hurt can potentially save you time and money, and help you get the best medical care. How do you choose where to go when the unexpected happens? When you can't see your doctor or if your doctor's office is closed, there may be viable emergency room alternatives such as retail health clinics, walk-in doctor's offices, urgent care centers, and LiveHealth Online. Visit www.anthem.com/ca or call the number on your medical ID care for more information and to find out if other sites of care are available in your area. Not all types of care and facilities are available in all areas.

Sydney Health

Sydney Health makes health care easier with the use of one convenient app to manage all of your benefits. The mobile app puts all of your health plan details in one place. It also keeps you informed and up to date on important information. The Sydney Health app allows you to:

- Use your digital ID card
- Find care and check costs
- Check what your plan covers
- View your wellness activities
- View claims details and your Explanation of Benefits

To get started, download the Sydney Health app from the App Store or Google Play. If you have previously registered on Anthem's website, there's no need to register separately for the app, just log in using your http://anthem.com/ca username and password. You may need to first register on Anthem's website prior to utilizing the Sydney Health app.

Total Health, Total You

You have access to the Total Health, Total You (THTY) program, which is designed to help you engage with your health, work on lifestyle changes, and connect with specialized health professionals no matter where you are. You can also call or chat with a Health Guide who can answer your health care questions and make sure you are making the most of your benefits. Use the Sydney Health mobile app to access this benefit.

THTY provides you and your eligible family members resources to improve your health and manage your health care expenses. Nurses and health care professionals proactively reach out to individuals who are at risk for serious health issues but may not know it, or those who have complex medical needs that aren't being met in the most appropriate way. This program differs from Condition Care because it's available to everyone, not just those living with chronic conditions.

THTY professionals work with each participant to:

- Help provide education on treatment options to enable more informed decision-making.
- Help understand and manage their health concern(s).
- Help develop self-management skills to support their physician's plan of care.
- Help prepare for hospitalization and cope with recovery.
- Help use health benefits more appropriately.
- Coordinate access to services such as condition management, 24-Hour Health Information Line, and other available care management programs.

The THTY team focuses on providing participants with resources and giving information to improve health while following a doctor's treatment plan. To get started with a personal health coach today, call 1.866.406.0982.

Inclusive Care

Inclusive Care provides medical and emotional support for the LGBTQIA+ community. THTY's service and clinical teams help you access:

- Medical and behavioral health support.
- Gender affirmation surgery guidance and counseling.
- Specialty medication support.
- Community programs and educational resources.

Please contact Anthem Member Services at the number on your medical ID card to find out more about the available services.

Virtual Primary Care (ages 18-64)

Accessing the care you need, when you need it, matters. The Sydney Health mobile app can connect you to a team of doctors ready to help you on your time. You can chat with a doctor 24/7 without an appointment or schedule a virtual primary care appointment for routine care or personalized care for chronic conditions. Please contact Anthem Member Services at the number on your medical ID card to understand what services are covered.

Cleveland Clinic Complimentary Clinical Review

Your medical coverage through Anthem includes exclusive access to a virtual, complimentary clinical review with a cardiac expert at Cleveland Clinic. This valuable service is available no matter where you live and provides you and your regular doctors or specialists with an extra layer of support during your treatment. Cleveland Clinic and Anthem are working together to provide you access to Cleveland Clinic's specialists who can explain heart conditions and care options. You may be an ideal candidate if you have a diagnosed heart condition. You will hear from cardiac care experts with personalized feedback on your condition and find out if Cleveland Clinic can assist with your care. Cleveland Clinic will answer questions you may have and ask you for basic information. Next, Cleveland Clinic will ensure that the right specialist reviews your information and shares feedback based on your unique needs. The specialist may also talk about more advanced treatment options at Cleveland Clinic.

Cleveland Clinic will work with you or a covered family member to obtain the appropriate information and medical records. You will receive feedback, generally within five business days, by phone or email. The review through Cleveland Clinic is currently offered at no cost to Anthem members. Charges will apply if you choose to schedule follow-up visits. If you decide to have further care after the complimentary clinical review, your medical plan benefits will apply. Please contact Anthem Member Services at the number on your medical ID card to understand what services are covered.

Aspire Health

Aspire is a group of health care professionals in Anthem's provider network who specialize in providing support for complex care needs, if you need extra support while living with a complex health condition or serious illness.

You will still see your existing care team and Aspire Health will work closely with them to make sure you receive the treatment and support you need. With Aspire Health, you and your family have access to experts in managing conditions and providing relief from symptoms, pain, and the stress of a serious or complex condition.

If you are facing challenging decisions about your health, Aspire Health is here to help. To learn more, go to aspirehealthcare.com. You can also reach an Aspire representative at 1.833.866.0926.

Enrollment/Participation

Participation in any of the programs or services provided by Anthem is free of charge, strictly voluntary, and completely confidential. A nurse may contact you to find out if you or any of your eligible family members want to participate in one of the programs. You may also enroll yourself by calling Anthem at 1.866.406.0982. Once enrolled, you have the option of discontinuing your participation by notifying Anthem via phone.

PRESCRIPTION DRUG BENEFIT FOR INTERNATIONALLY BASED PILOTS & COVERED DEPENDENTS

Prescription Coverage (supported by Universal Rx)

Prescription coverage provided under the International Plan includes benefits for retail pharmacies and mail order. GeoBlue's Pharmacy Benefit Manager, Universal Rx, administers the pharmacy benefits. Note, you must be enrolled in the International Plan in order to have prescription drug coverage. **See the most current Pilot Enrollment Guide located on https://fedexpilots.bswift.com for the pharmacy benefits. The enrollment guide is located under the Educate tab.**

Retail Pharmacies

Members have access to over 44,000 in-network pharmacies within the United States. Members are responsible for paying the copayment or coinsurance at retail pharmacies.

Locate an in-network pharmacy online at www.geo-blue.com. Present your medical and prescription ID card to the in-network pharmacy.

Mail-Order Program If residing in the United States

Provided by Drug Source.

Online: Visit the website at www.geo-blue.com.

Phone: Call Drug Source to order: 1.800.854.8764, (in the United States). Hours: 8:30 a.m. – 7:00 p.m. CST.

Mail-Order Program Outside the United States

Online: Visit the website at www.expatps.com and complete the online order form.

Mail: Complete the order form (both sides). Attach your prescription(s) or refill label(s) to the order form. Mail completed order form to:

Universal Rx: Attn: EPS Team
710 3rd Street
Roanoke, VA 24016, USA

Fax: Visit the website at www.expatps.com and print out the order form from the website. Fax completed form (both sides) with prescription(s) to 1.540.777.7184.

Phone: Call an EPS Representative to order: 1.540.777.1450 (in the United States). Hours: 8:30 a.m. – 5:00 p.m. EST.

Universal Rx Clinical Programs

Certain medications, generally specialty drugs, will have additional requirements before they may be covered. In partnership with Universal Rx, clinical expertise is involved in this process

and patient details, and previous medications prescribed are reviewed. If you are enrolled in the International Plan administered by GeoBlue, two pharmacy review programs are required for prescription medications obtained in the United States—Prior Authorization and Step-Therapy.

Prior Authorization

The Prior Authorization program will help to ensure you are receiving coverage for the right medication, at the right cost, in the right amount, and for the right situation. This means Universal Rx will need to review some medications before the Plan will cover them. This review will be done to ensure that the medication is medically necessary and appropriate for your situation. Universal Rx will review the information provided by your doctor to make sure you meet the coverage guidelines for the medication. If approved, the Plan will cover the medication. This only impacts prescriptions filled in the United States. This review does not apply to prescriptions filled outside the United States.

Step-Therapy

In addition to the prior authorization review, some prescription medications may be subject to step-therapy, which will encourage the use of safe and cost-effective medications before you step up to high-cost brand medications.

First-line medicines are the first steps. First-line medicines are generic and lower cost brand-name medicines approved by the U.S. Food and Drug Administration (FDA). They are proven to be safe and effective, as well as affordable. You should try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs but at a lower cost.

Second-line medicines are the second and third steps. Second-line medicines typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines.

If you have any questions about either of these programs or your prescription drug benefits, you can contact GeoBlue at their 24/7 global service center, at the number listed on the back of your medical ID card.

PRESCRIPTION DRUG BENEFIT FOR DOMESTIC-BASED PILOTS & COVERED DEPENDENTS AND PRE-MEDICARE RETIRED PILOTS

Express Scripts, Inc.

FedEx Express provides important coverage for medications prescribed to treat an illness or injury.

If you are enrolled in the CDHP Purple, CDHP Orange, or the Buy Up medical plan option as an active pilot; or CDHP Purple, CDHP Orange, Buy Up, or the High Deductible Plan as a pre-65 retired pilot (or pre-65 covered dependent), your pharmacy coverage is automatically included, and Express Scripts is the administrator of your pharmacy benefit program. This includes retail and mail-order coverage. Note, you must be enrolled in a medical plan option in order to have prescription drug coverage. The medical plan options are explained in this book, under the sections titled—"Medical Plan Information," if you are an active pilot and "Retiree Health – Medical Plan Information," if you are a Pre-Medicare retired pilot.

Prescription Drug Copayment, Coinsurance, & Deductible

Express Scripts will determine the prescription drug covered expense for each prescription filled based on the drug tier (Generic, Preferred Brand, Non-Preferred Brand, or Specialty) and whether the prescription is obtained from an in-network or out-of-network pharmacy.

If the prescription drug benefit is a flat copayment, you will pay the applicable copayment out of pocket each time you fill a prescription, and the remainder of the expense will be covered by the Plan.

If your prescription drug benefit is a coinsurance percentage, you will pay the applicable coinsurance percentage (after deductible, if applicable), up to the maximum each time you fill a prescription, and the remainder of the expense will be covered by the Plan. The deductible is the total amount you must pay out of pocket before the Plan starts to pay for its part of your prescription expense.

You may avoid higher out-of-pocket expenses by choosing an in-network pharmacy, or by utilizing the mail service program whenever possible. In addition, you may also reduce your costs by asking your physician, and your pharmacist, for the more cost-effective generic form of prescription drugs. **See the most current Pilot Enrollment Guide or Pre-65 Retiree Enrollment Guide, located on https://fedexpilots.bswift.com for the pharmacy benefits. The enrollment guides are located under the Educate tab.**

Pharmacy Benefit Definitions

Medications covered under the pharmacy benefit program are listed on Express Scripts' National Preferred Formulary and Accredo's Specialty Drug List. The drugs listed on the National Preferred Formulary and the Specialty Drug List may change from time to time. Notwithstanding Express Scripts and Accredo's National Preferred Formulary and Specialty Drug List, a drug must meet the specialty drug definition below to be regarded as a specialty drug.

Generic—Generic drug is a pharmaceutical equivalent drug created to work the same and provide the same clinical benefit as a brand-name drug. It must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, effectiveness, and intended use as the brand-name drug.

Preferred-Brand—Preferred-brand is a prescription drug that has been patented, is only produced by one manufacturer, and does not have a generic equivalent. These brand-name drugs are more expensive than generics.

Non-Preferred Brand—Non-preferred brand are drugs not listed on the drug list or formulary. Non-preferred brand-name drugs have a higher cost than preferred brand-name drugs, and often have a lower cost generic, or preferred brand drug alternative.

Specialty—Specialty drugs are used to treat chronic or complex conditions, and the dispensing and use of these drugs have one or more of several key characteristics, including:

- The requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes
- The need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive specialty pharmacy distribution
- Specialized product handling and/or administration requirements

Accredo—Accredo is Express Scripts' specialty pharmacy. If your doctor writes a prescription for a specialty medication, that medication must be filled by Accredo. Your doctor will submit your prescription to Accredo via fax, phone, or electronically. If you have questions regarding your medication, please contact Accredo at 1.800.803.2523.

National Preferred Formulary— Express Scripts uses a list of preferred drugs, which is sometimes called a formulary, to help your physician make prescribing decisions. The lists include both generic and brand-name drugs. The presence of a drug on the drug list does not guarantee that you will be prescribed that drug by your physician. The drugs listed on the National Preferred Formulary and the Specialty Drug List are decided by Express Scripts and their Pharmacy and Therapeutics Committee, which is comprised of independent physicians and pharmacists. The Pharmacy and Therapeutics Committee meets periodically and decides on changes to make in the Formulary Drug List, based on recommendations from Express Scripts and a review of relevant information, including current medical literature.

If you have any questions regarding whether a drug is on Express Scripts' National Preferred Formulary, please call 1.877.846.4710.

Ways to Obtain Your Maintenance Medications

If you take long-term maintenance medications, such as those used to treat high blood pressure, high cholesterol, or diabetes, you have the option to obtain a 30-day or 90-day supply of your maintenance medications. If you choose to obtain a 30-day supply of your maintenance medication, you can use any retail participating network pharmacy. You will pay the applicable copay or coinsurance based on the drug category for a 30-day supply, per prescription.

If you choose to obtain a 90-day supply of your maintenance medication, you can use either the Smart90 or Express Scripts Home Delivery program. The Smart90 program is a CVS, Walgreens, Rite Aid, and Duane Reade three-month supply program. When you use a participating pharmacy in the Smart90 program, you will pay 3 times the standard 30-day copay or coinsurance charge, per prescription. The Home Delivery benefit has a flat copay for Generics, and coinsurance with a maximum out-of-pocket amount for brand and non-preferred brand medications. In some cases, a 90-day supply through the Smart90 or Home Delivery program may be less expensive to you than obtaining three fills of a 30-day supply at a non-Smart90 retail network pharmacy.

GenericSelect (copay waiver)

If you (or your covered dependent) are taking a brand-name prescription drug or had a brand-name prescription drug filled within the last six months and that drug is on the GenericSelect list, if your doctor agrees that you can switch to a GenericSelect prescription drug, you will receive the first generic prescription drug at no cost.

If you begin your medication therapy with a GenericSelect drug, you also will receive your first prescription at no cost. This applies to your first fill for a 30-day supply at retail or 90-day supply through mail order. You will be required to pay the generic copayment for all future refills of the GenericSelect drug.

You are not eligible for this copay waiver for prescription drugs on the GenericSelect list that you have already used. There is no penalty for continuing with your brand-name prescription drug. You will simply pay the brand-name prescription drug copayment.

If you have questions regarding this program, your pharmacy benefits, or to receive the GenericSelect drug list, call Express Scripts Customer Service at 1.877.846.4710, or visit their website at express-scripts.com.

Prescription Drug Utilization Review

Preauthorization

Some medications require a review to ensure you receive safe and effective medicine. There are plan rules that are based on the product information approved by the Food and Drug Administration, as well as published clinical trials and guidelines. To develop prior authorization recommendations, Express Scripts pharmacists regularly review the most current research on newly approved medicines and existing medicines, and they consult with independent, licensed doctors and pharmacists.

If you or your dependent takes a medication that requires prior authorization review, your doctor should contact Express Scripts in advance to request a clinical review. If prior authorization is not obtained in advance, the pharmacist will not be able to fill your prescription. Note, the pharmacist can make an outbound call to your doctor to initiate the clinical review, with your approval.

If your prescription meets the definition of urgent, Express Scripts' review will generally be conducted with 72 hours. Generally, an urgent situation is one that, in the opinion of your provider, your health may be in serious jeopardy, or you may experience pain that cannot be adequately controlled while you wait for a decision. If Express Scripts denies preauthorization of a drug, you or your prescribing physician may appeal their decision by calling 1.877.846.4710. Please review the "Claims and Appeals" section in this book, for more information on your appeal rights.

If you have any questions regarding whether a drug requires preauthorization, please call 1.877.846.4710.

Step-Therapy

Step-therapy helps to manage drug costs by ensuring that patients try clinical, effective, lower cost medication before they step-up to a higher cost medication. In step-therapy, medicines are grouped in categories based on treatment and cost.

First-line medicines are the first steps. First-line medicines are generic and lower cost brand-name medicines approved by the U.S. Food and Drug Administration (FDA). They are proven to be safe and effective, as well as affordable. You should try these medicines first, because in most cases, they provide the same health benefit as more expensive drugs but at a lower cost.

Second-line medicines are the second and third steps. Second-line medicines typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines.

If you are prescribed a non-preferred medication that requires a trial of a preferred alternative under the step-therapy program, the first time you try to fill the prescription, whether it's in person or submitted to Express Scripts' home delivery, your pharmacist should explain that step-therapy requires you to try a first-line medicine before a second-line medicine is covered. Since only your doctor can change your current prescription, either you or your pharmacist needs to speak with your doctor to request a first-line medicine. If you need your prescription right away, you may ask your pharmacist to fill a small supply until you can consult with your doctor. Note, you might be required to pay full price for this small supply. For more information about step-therapy contact Express Scripts at 1.877.846.4710.

Quantity Limits

The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment are consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Express Scripts' clinicians maintain a list of quantity limit drugs, which is based upon manufacturer recommended guidelines and medical literature.

How to Use Your Pharmacy Services Drug Plan

When You Go to an In-Network Pharmacy

You must present your Express Scripts pharmacy ID card when you have a prescription filled. Provided you have properly identified yourself as a member, an in-network pharmacy will only charge your copayment or coinsurance. For information on how to locate an in-network pharmacy in your area, call Express Scripts Customer Service at 1.877.846.4710 or visit their website at express-scripts.com.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a prescription to an in-network pharmacy, and the in-network pharmacy indicates your prescription cannot be filled because it is subject to preauthorization or step-therapy or requires an additional copayment, this is not necessarily an adverse claim decision. If you want the prescription filled, you may be required to pay either the full cost, or the additional copayment, for the prescription drug. If the medication is subject to preauthorization or step-therapy, contact Express Scripts Customer Service at 1.877.846.4710 for assistance.

When You Go to an Out-of-Network Pharmacy

If you purchase a prescription drug from an out-of-network pharmacy, you will have to pay the full cost of the drug and submit a claim to Express Scripts, at the address below:

Express Scripts, Inc. (ESI)
P.O. Box 14711
St. Louis, MO 40512-4711

Out-of-network pharmacies do not have the necessary prescription drug claim forms. You must take a claim form with you to an out-of-network pharmacy. The pharmacist must complete the pharmacy's portion of the form and sign it.

Claim forms and customer service are available by calling Express Scripts at 1.877.846.4710. Mail your claim with the appropriate portion completed by the pharmacist to Express Scripts within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be allowed.

When You Order Your Prescription Through the Mail

You can have your prescriptions delivered to your home by using Express Scripts' Home Delivery program. Note you must be registered on the member website—express-scripts.com—to use this service. You will need your member ID or SSN to register.

Once you are a registered member, contact your doctor to request a 90-day prescription, which he/she can e-prescribe directly to Express Scripts Home Delivery. You can also contact Express Scripts at 1.877.846.4710 and they will contact your doctor for you. If you have a paper prescription, log on to express-scripts.com to print the mail-order form. Complete the form and follow the mailing instructions. You should allow 10 to 14 days for your first prescription order to be shipped.

If you have an existing prescription at a retail pharmacy, you can transfer your retail prescription to home delivery. Contact Express Scripts at 1.877.846.4710 for assistance.

Note, you may view all of your retail and mail-order pharmacy claims, check an order status, renew or refill prescriptions, and much more on express-scripts.com.

What's Not Covered—Limits and Exclusions for Express Scripts Pharmacy Services

Limits

- No more than a 30-day supply of medication may be purchased at a retail pharmacy at one time.
- No more than a 90-day supply of medication may be purchased through the mail-order program at a time.
- Specialty medication must be filled by Accredo, ESI's specialty pharmacy.
- Generics, when available, are mandatory for the High Deductible Plan medical option only. If you choose the brand name rather than the generic, you will be responsible to pay the brand copayment plus the difference in cost between the generic and brand-name drug.

Exclusions

- Immunizing agents, biological sera, blood, blood products, or blood plasma.
- Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable drugs or medications.
- Drugs and medications used to induce spontaneous and non-spontaneous abortions.
- Drugs and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient hospital facilities and physicians' offices.
- Professional charges in connection with administering, injecting, or dispensing of drugs.
- Drugs and medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering.
- Drugs and medications dispensed by or while you are confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility. Other drugs that may be prescribed by your physician while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a pharmacy by the beneficiary, or a friend, relative, or caregiver on your behalf, and are covered under this prescription drug benefit.
- Durable medical equipment, devices, appliances, and supplies, even if prescribed by a physician, except prescription contraceptive diaphragms.
- Services or supplies for which you are not charged.
- Oxygen.
- Cosmetics and health or beauty aids.
- Drugs labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational drugs, or any drugs or medications prescribed for experimental indications. If you are denied a drug because Express Scripts determines that the drug is experimental or investigative, you may appeal the decision by calling Express Scripts at 1.877.846.4710.
- Drugs that have not been approved for general use by the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.
- Over-the-counter smoking cessation drugs. This does not apply to medically

necessary drugs that you can only get with a prescription under state and federal law.

- Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.
- Drugs used primarily for the purpose of treating infertility, unless medically necessary for another covered condition.
- Anorexiants and drugs used for weight loss except when used to treat morbid obesity and based on Express Scripts' guidelines (e.g., diet pills and appetite suppressants).
- Minerals, homeopathic drugs and therapies, and over-the-counter medications.
- Allergy desensitization products or allergy serum.
- Infusion drugs, except drugs that are self-administered subcutaneously.
- Herbal supplements, nutritional and dietary supplements.
- Prescription drugs with a non-prescription (over the counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.
- Growth hormones, unless preauthorized and according to Express Scripts' guidelines.

RETIREE HEALTH COVERAGE

If you meet the age and service requirements for retiree health coverage, you are eligible to elect medical, dental, and/or vision coverage after your retirement. See the Age and Service Requirements chart in this section.

If you do not meet the age and service requirements for retiree health coverage, you and your eligible dependents' coverage ends when you retire or terminate. However, you may continue the medical, dental, and/or vision coverage you had as an active pilot for yourself and your eligible dependents through COBRA for up to 18 months. See "COBRA—Continuation of Coverage" in the "Health Care—General Information" section.

Retiree Health Coverage

If you meet the age and service requirements shown in the chart under "Eligibility" on the next page, you may elect:

- To continue medical, dental, and/or vision coverage you had as an active pilot under COBRA for up to 18 months. At any time until the end of your COBRA continuation period, you can elect to commence your retiree health coverage. See "Deferring Retiree Health Coverage" under General Plan Information of the Retiree Health section; or
- Retiree health coverage, which includes the following benefits listed below, for you if you are under Medicare eligibility age and your eligible dependents are under Medicare eligibility age by paying the required monthly cost:
    - Medical benefit (includes mental health/substance abuse and prescription drug)
    - Vision benefit
    - Dental benefit

NOTE: There is a monthly cost based on the retiree medical, dental, and/or vision plan option selected, except for the Pre-Medicare Retiree Health Reimbursement Account.

Eligibility

As a retired pilot, you may enroll you and your eligible dependents in your medical, dental, and/or vision coverage. Dependents eligible to be covered under your medical, dental, and/or vision coverage are the same as described in the "Health Care—General Information" section provided they are under Medicare eligibility age.

The table below shows the age and service requirement for retiree health coverage.

Age and Service Requirements	
Were hired into a Permanent Full-Time or Permanent Part-Time position by FedEx Express before January 1, 1988	Retire or terminate at age 55 or older with at least 10 years of permanent part-time or permanent full-time continuous service after age 45
Were hired into a permanent position by FedEx Express or another FedEx Corporation Controlled Group member on or after January 1, 1988	Retire or terminate at age 55 or older with at least 20 years of permanent part-time or permanent full-time continuous service after age 35
Were a Flying Tiger pilot on August 6, 1989, and began to work for FedEx Express on August 7, 1989	Retire or terminate at age 55 or older with at least 20 years of continuous service (derived from adding Flying Tiger continuous service years to FedEx continuous service years)
Are age 60 or older	Retire or terminate with at least 5 years of permanent part-time or permanent full-time continuous service immediately prior to age 60

Continuous Service

Continuous service is service that begins on the most recent hire date at FedEx as reflected in the HR system, in a permanent full-time or permanent part-time position, and which is uninterrupted by a break in continuous service. Resignation, retirement, discharge, reduction in force of more than two years, or reversion to a nonpermanent position is considered a break in continuous service. Periods while you were on approved leave of absence are not considered breaks in continuous service.

For Flying Tiger pilots who began to work for FedEx Express on August 7, 1989, Flying Tiger continuous service years and FedEx continuous service years are added together to meet retiree health coverage eligibility requirements. Flying Tiger service years will not be considered if there are any breaks in FedEx service years before you meet the retiree health coverage eligibility requirements.

Enrollment in Retiree Health Coverage

Once your employment status is updated in the HR system to retired or terminated, your eligibility for retiree health coverage is determined.

You will automatically be sent a COBRA packet to continue coverage under the Federal Express Corporation Group Health Plan for Pilots and, if you meet the age and service requirements under the Federal Express Corporation Retiree Group Health Plan for Pilots, you will be sent a retiree health coverage enrollment packet in a separate mailing. This packet will explain your medical, dental, and vision plan options, coverage tiers, costs for retiree health coverage, provide deadlines, and instructions for enrollment.

The Pilot Administration Center (PAC) is responsible for submitting updates to the HR system. Subject to the terms and provisions of the Collective Bargaining Agreement, FedEx reserves the right to terminate, modify, or suspend any or all benefit plans as listed on the chart beginning on page “Health Care—Medical, Dental and Visions Benefits-90” and only as permitted by the terms of the Collective Bargaining Agreement.

If, at the time of retirement, you were not participating in the Federal Express Corporation Group Health Plan for Pilots because you opted out for other group health coverage, you are still eligible to enroll in the Federal Express Corporation Retiree Group Health Plan for Pilots, as long as you meet the age and service requirements. Under certain circumstances you can elect to defer the commencement of your retiree health coverage; however, you must notify Pilot Benefits Administration of your intent by the deadline. Refer to “Deferring Retiree Health Coverage,” under General Plan Information of the Retiree Health section, for more details.

If You Are Under Medicare Age

If, at the time of retirement, you are under Medicare Age, you will automatically be assigned to the same medical plan option and coverage tier you were enrolled in as an active pilot or assigned to a medical plan option based on your home ZIP code effective on your date of retirement, if your active medical plan option is not available to you as a retiree. If you were in the International Plan, you will be enrolled in the High Deductible Plan medical option. Also, you will be assigned dental and/or vision coverage with the same coverage tier you were enrolled in prior to your retirement. If you had chosen to opt out of medical, dental, and/or vision coverage, you will not be automatically enrolled in health coverage. You will be given 31 days to elect/change your medical plan option, drop coverage, or add any eligible dependents to your retiree health coverage, as long as your dependents are eligible for medical, dental, and/or vision coverage on your retirement date.

If you are Medicare Age on your retirement date, see “When You or Your Spouse Becomes Medicare Age” in this section.

Your retiree health enrollment packet will provide information regarding your other medical, dental, and/or vision plan options, if any, coverage tiers and cost for retiree health coverage. The medical plan options available to retirees under Medicare Age are:

- Buy Up Plan
- CDHP Purple
- CDHP Orange
- High Deductible Plan
- Health Plan Hawaii (HMO)
- HMSA (PPO)
- Pre-Medicare Retiree HRA

If your home address is different than the one listed in your retiree health packet, call Pilot Benefits Administration immediately at 1.866.795.6353 or 1.901.375.6353 in the Memphis area to determine the medical plan option(s) where you live. If your address changes in the future, it is important that you notify Pilot Benefits Administration. You will be advised of the medical plan option(s) available in your new location.

You will be given a specified deadline date in your packet to enroll for retiree health coverage and elect your medical, dental, and/or vision coverage and coverage tiers.

If you do not make a medical, dental, and/or vision coverage election and you do not send in your medical, dental, and/or vision payment, your medical, dental, and/or vision coverage will end effective as of your date of retirement.

Under certain circumstances you can elect to defer the commencement of your retiree health coverage; however, you must elect retiree health coverage by the deadline indicated in your

retiree health enrollment packet by calling Pilot Benefits Administration to request that commencement of your retiree health coverage be deferred. See “Deferring Retiree Health Coverage” under General Plan Information of the Retiree Health section, for more details.

NOTE: If you do not call Pilot Benefits Administration or do not submit your initial payment by the deadline stated in your enrollment packet, you will not have an opportunity to enroll in FedEx retiree health coverage. If retiree health coverage (i.e., medical, dental, and/or vision) for the pilot retiree is refused initially or canceled at a later date, that coverage cannot be obtained or reinstated.

Dependent Coverage

If your spouse is Medicare Age on your retirement date, see “When You or Your Spouse Becomes Medicare Age” in this section. If your eligible dependents were covered on the date of your retirement and are less than Medicare Age, they are automatically enrolled in the applicable dependent coverage tier (i.e., Retiree & Spouse, Retiree & Child(ren), or Retiree, Spouse & Child(ren). If your eligible spouse and/or children were not covered prior to your retirement, you may elect to add them to your retiree health coverage as long as they are eligible for medical, dental, and/or vision coverage on the date your retiree health coverage begins. See the definition of an eligible dependent under “General Information” in the Health Care section of this book.

If you elect medical, dental, and/or vision coverage for your eligible Pre-Medicare Age spouse and/or children by the deadline indicated in your retiree health enrollment packet, coverage will be effective retroactive to your date of retirement. If you do not call Pilot Benefits Administration to make your election for retiree health coverage and your check/money order is not received by the deadline, dependent medical, dental, and/or vision coverage will not be effective until the date of your request. If your eligible dependents were not listed on FedEx Benefits Online when you retired, you must call Pilot Benefits Administration and provide proof of eligibility for the dependent(s).

You can drop coverage for your spouse and/or children at any time after retirement. The effective date of the coverage change will be the date you call Pilot Benefits Administration to request this coverage tier change. However, **if you drop coverage for a dependent(s) at a future date, you will not have the opportunity to re-enroll your dependent(s) in FedEx retiree health coverage.** Coverage is allowed only for those eligible dependents who are eligible qualifying dependents on the date of retirement (or, if later, the date of your deferred participation in the Plan, as described below). You are not required to elect dependent coverage by the retiree health enrollment date. You can choose to elect dependent coverage at a later date. If you choose to add eligible dependents at a later date, your request must be received prior to you becoming Medicare Age. When you elect dependent coverage (either at retirement, the end of any applicable retirement deferral period, or at a later date), you can only add coverage for dependents who were eligible dependents on the date you commenced retiree health coverage.

If you are Medicare Age or older when you retire and wish to cover your eligible Pre-Medicare Age dependents, you must elect to add your eligible dependents by the deadline indicated in your retiree health enrollment packet.

Deferring Retiree Health Coverage

There are certain situations in which you may wish to defer commencement of your retiree health coverage. **However, in any of these situations, you must elect retiree health coverage by the deadline in your retiree health enrollment packet, even if you defer participation.** To elect to defer your retiree health coverage, you must call Pilot Benefits Administration to ensure you meet all the eligibility guidelines.

If You Are Covered as a Dependent of an Active Participant in Any FedEx Company's Group Health Plan

If your spouse is an active pilot/non-pilot participating in any FedEx company's group health plan, you may elect to be covered as a dependent in your spouse's health plan option. It is important that your spouse request dependent coverage within 31 days—following your retirement date. This action allows you to defer your participation in retiree health coverage until your spouse drops dependent coverage, retires, terminates, or becomes ineligible for active health coverage. You must contact Pilot Benefits Administration within 31 days—following the date your spouse becomes ineligible for FedEx active health coverage so you may be enrolled/re-enrolled in your retiree health coverage. You will be responsible for the applicable retiree health coverage cost once you commence retiree health coverage. If you fail to request commencement of your retiree health coverage and make the applicable medical, dental, and/or vision payment within the 31-day period, you will lose retiree health coverage and cannot re-enroll at a later date.

If You Are Employed by Any FedEx Company

If you become employed by any FedEx company and participate in that Company's active group health plan, you must call Pilot Benefits Administration immediately so that your retiree health coverage can be deferred until you are no longer participating in FedEx active group health coverage.

Your retiree health coverage will begin if you had not previously elected coverage or resume if previously elected, when you are no longer eligible for active health coverage. You must notify Pilot Benefits Administration that you wish to begin or resume retiree health coverage at 1.866.795.6353 or 1.901.375.6353 in the Memphis area.

If You Elect to Continue Medical, Dental, and/or Vision Coverage Under COBRA

You may elect to continue medical, dental, and/or vision coverage for you and your eligible dependents in the group health plan offered to active pilots for up to 18 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You will receive a COBRA packet under separate cover from WageWorks, the COBRA administrator. If you elect COBRA, you can defer participating in retiree health coverage until the end of your COBRA continuation period.

Under COBRA, you pay the full cost of COBRA coverage (your normal active pilot contribution plus the Company's contribution amount), plus a 2% administrative fee. For more information on your cost to continue coverage under COBRA, contact Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area.

Retiree Health Continuation for Dependents

COBRA also allows continuation of retiree health coverage for your spouse or dependent child if they were covered by your retiree health coverage the day before any of the following qualifying events:

- Divorce
- A dependent child ceases to qualify as a dependent (e.g., child is age 23 for dental and/or vision or age 26 for medical)
- Death of pilot

It is the responsibility of you or your dependent to notify Pilot Benefits Administration within 60 days following the qualifying event or continued coverage will not be offered. The extended coverage for dependents continues for a maximum of 36 months and requires payment of the full cost of retiree health coverage plus a 2% administration fee.

Cost

Your retiree health coverage packet will include cost information for each medical, dental, and/or vision plan option available to you. Regardless of which medical, dental, and/or vision plan option you select, there is a monthly cost for all retirees (excluding the Pre-Medicare Retiree HRA option) election. The amount FedEx Express will contribute for each retiree and his or her eligible dependents to the cost of medical benefits will be capped at 1½ times the fiscal year 1993 per capita projected cost of the employer. **The retiree is responsible for all costs exceeding the cap.**

You may elect to have your monthly retiree health coverage cost deducted from your pension check. However, your initial payment must cover the two to three-month period before pension check deductions begin. Call Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area for help in determining your required initial payment amount. If you wish to have your cost deducted from your pension check at a later date, please contact Pilot Benefits Administration. FedEx Express also offers a payment method using a Monthly Automated Payment System (FedEx MAPS). If you choose, you can use the FedEx MAPS to have your retiree health payment automatically deducted from your bank account. The most important advantage to having your retiree health coverage cost automatically deducted from your bank account or pension check is that you do not have to remember to mail in your payment each month; however, the amount will need to be modified each calendar year to reflect the increased cost.

Medicare Eligible Prior to Medicare Age

If you become eligible for Medicare prior to Medicare age (i.e., due to disability) and participate in any medical plan option other than the Health Plan Hawaii, generally Medicare will be considered primary. If you or one of your covered dependents become Medicare eligible prior to Medicare Age, you should notify Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area.

If You Are Medicare Age or Older on Your Retirement Date—You are not eligible for retiree health coverage. However, your Pre-Medicare Age eligible dependents can participate in the Retiree Health Plan, upon your date of retirement or termination as long as you elect coverage for your eligible dependents by the deadline indicated in your retiree health enrollment packet. If your spouse is Medicare Age or older on your retirement date, your spouse is not eligible for coverage. See below for information regarding the FedEx Pilots Post Medicare Retiree Premium

Reimbursement Plan (PRP) sponsored by the Air Line Pilots Association, International (ALPA).

When You or Your Spouse Becomes Medicare Age

Effective the first of the month you or your spouse becomes Medicare Age, FedEx retiree health coverage will end for that individual. Pursuant to the Collective Bargaining Agreement between Federal Express Corporation and Air Line Pilots Association, International, upon attainment of Medicare Age, you or your spouse is eligible for the ALPA-sponsored FedEx Pilots Post Medicare Retiree Premium Reimbursement Plan (PRP) provided you met the age and service requirements for coverage under the Federal Express Corporation Retiree Group Health Plan for Pilots. Pilots retiring prior to November 3, 2015, also were required to participate in the Federal Express Corporation Retiree Group Health Plan for Pilots or Federal Express Corporation Group Health Plan for Pilots immediately prior to the attainment of Medicare Age or, if later, on your retirement or termination date.

If you are eligible for the FedEx Pilots Post Medicare Retiree Premium Reimbursement Plan (PRP), you will receive a welcome kit from ALPA at the end of the month following the month in which you retire. For more information on the benefits offered under the ALPA-sponsored PRP, you may visit the ALPA-sponsored website: veba.alpa.org.(Note, there is no www preceding this site address.) When prompted, the member number and password are both “veba”.

You or your eligible covered dependent(s), under Medicare age, will continue to be covered in the Pre-Medicare medical options, administered by Anthem, the HMSA, or the Health Plan Hawaii, if available, as long as you or your dependents meet the definition of an eligible retiree or dependent and monthly payments are received by Pilot Benefits Administration. You or your spouse’s coverage will end effective the first of the month you each reach Medicare Age and will then be eligible for the ALPA-sponsored FedEx Pilots Post Medicare Retiree Premium Reimbursement Plan (PRP).

If you have questions about your dependents’ eligibility, call Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area. Pilot Benefits Administration is available Monday through Friday from 8:00 a.m. to 5:00 p.m. CST.

Change of Residence

If you have a permanent change of address, you must call Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area with the change. An address change may result in a change in medical plan options. If your medical plan options have changed, you will receive information regarding your newly assigned medical plan option and any choices available to you.

When Retiree Health Coverage Ends

Coverage for you and/or your covered dependents ends on the earliest of the following dates:

- FedEx Express discontinues the plan, which could only be done pursuant to the Agreement or a successor collective bargaining agreement.
- You stop making the required contributions to participate in the Plan, if payments are required.
- You or your covered dependents are no longer eligible for coverage.
- You or a covered dependent dies.

- When, if ever, this Agreement or a successor collective bargaining agreement no longer provides for this coverage.
- COBRA coverage ends (if selected).
- You transfer to a non-pilot position within FedEx Express or a participating employer and your participation in FedEx Express's benefit plans is no longer provided under the terms of the Agreement.
- You opt out of FedEx Express retiree health coverage.
- The first of the month you or your covered spouse attains Medicare Age.

If you or a covered dependent is confined in the hospital and incurs covered room and board expenses on your termination/retirement date, your coverage continues until you are released or for 30 days, whichever occurs first.

If your coverage ends and your spouse is employed by FedEx Express or another FedEx Company and your spouse has coverage under the Federal Express Corporation Group Health Plan for Pilots or the Federal Express Corporation Group Health Plan, you will be eligible to enroll as a dependent under your spouse's coverage, if you are otherwise eligible as a dependent. Your spouse should contact Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area within **31 days** after your coverage ends to enroll you as a dependent of your spouse.

MEDICAL PLAN OPTIONS ADMINISTERED BY ANTHEM FOR PRE-MEDICARE RETIRED PILOTS & COVERED DEPENDENTS

The Federal Express Corporation Retiree Group Health Plan for Pilots ("the Plan"), administered by Anthem Blue Cross Life and Health Insurance Company, Inc. (Anthem), provides access to the national Blue Cross Blue Shield PPO network called BlueCard. The Plan consists of the Consumer Driven Health Plan (CDHP) Purple, Consumer Driven Health Plan (CDHP) Orange medical options, which are qualified high deductible plans, and the Buy Up Plan and High Deductible Plan medical options that are PPO plans. These options deliver premier services and comprehensive benefits that cover more than the most basic health care needs. They offer an extensive respected national network of doctors and hospitals so you and your family can expect ease and convenience when you need medical services. The website (www.anthem.com/ca) provides you with quick access to empowering health information 24 hours a day, seven days a week. The plans also offer health and wellness services and healthy lifestyle programs in addition to your health care benefits.

Here are just a few of the advantages of the medical plan options:

- Comprehensive benefits and easy access to a large network of providers and hospitals.
- Freedom to choose to receive your health care from any licensed physician, specialist, or health care facility.
- No claim filing when using an in-network provider, since the in-network providers bill Anthem directly.
- Emergency care is covered anywhere in the world, 24 hours a day, seven days a week.
- Toll-free customer service number for quick answers to all your benefits questions.
- Fast and convenient access to health care information on Anthem's website, 24 hours a day, seven days a week, www.anthem.com/ca.
- Easy access to an international PPO network when you travel.

What You Pay

Your monthly cost is based on the medical plan options and coverage tier you elect. In addition to paying your monthly cost, you will also pay any required copayments and deductibles up to the out-of-pocket maximums. **For more details on the plan design and the monthly cost for each medical plan option shown below, refer to the most current Pre-65 Retiree Pilot Enrollment Guide. The enrollment guide is located on https://fedexpilots.bswift.com under the Educate tab.**

Annual Medical Deductible

With the exception of the Buy Up Plan in-network, each year, you will have to meet your individual annual medical deductible before the Plan pays its share of the benefit. If your dependents are covered, the family annual medical deductible must be met. Once the family required for any enrolled dependent of the family for the remainder of that year. The annual

medical deductible resets each January 1. Refer to the chart shown below for deductible amounts. Once the deductible is satisfied, no further medical deductible expense will be due.

Copayment vs. Coinsurance

A copayment is a dollar amount that you may be required to pay at the time of service. Normally the annual medical deductible will not apply to such services and all you will have to pay is your copayment.

A coinsurance is a percentage you pay after the Plan pays, once your annual medical deductible is met. Coinsurance does not apply until you or your dependents have met the individual or family annual medical deductible. Refer to the chart shown below for coinsurance amounts. See the most current Pre-65 Retiree Pilot Enrollment Guide for an overview of the services that require a copayment. The enrollment guide is located under the Educate tab on **https://fedexpilots.bswift.com**.

Annual Medical Out-of-Pocket Maximum

Once you have met your annual medical deductible, you will pay your coinsurance and any required copayments up to the annual medical out-of-pocket maximum. Once you have met your annual medical out-of-pocket maximum, you will no longer be required to pay any coinsurances or copays for any covered expense you incur during the remainder of that year. The annual medical out-of-pocket maximum resets each January 1. Refer to the chart shown below for out-of-pocket amounts.

MEDICAL PLAN OPTIONS FOR PRE-MEDICARE RETIRED PILOTS & COVERED DEPENDENTS

Buy Up Plan

Under the Buy Up Plan, there is no deductible in-network. After you pay any required copayments, the plan covers 100% of covered eligible medical expenses. However, you must meet an annual deductible before benefits are payable, if you use out-of-network providers. After the out-of-network deductible is met, you pay a percentage of the covered expense—your coinsurance—up to the annual out-of-pocket maximum. When you reach the out-of-pocket maximum, in-network or out-of-network, the plan begins to pay 100% of covered eligible medical expenses (including copayments in-network) for the rest of the calendar year, for the individual who reaches the out-of-pocket limit.

	BUY UP PLAN	
	In-Network	**Out-of-Network**
Coinsurance	You pay 0% Services performed are subject to copayment	You pay 30% after deductible

	BUY UP PLAN	
	In-Network	**Out-of-Network**
Annual Deductible* (includes copays, and medical and prescription drug coinsurance)	$0	Pilot Only: $250 Family: $750
Out-of-Pocket Maximum* (includes deductible, copays, and medical and prescription drug coinsurance)	Pilot Only: $3,250 Family: $9,750	Pilot Only: $3,250 Family: $9,750

*In-network and out-of-network deductibles are separate and do not cross accumulate. The same applies to in-network and out-of-network maximums. For Pilot Plus coverage, the individual deductible and out-of-pocket maximum applies to each individual covered until the family deductible and out-of-pocket maximum are reached.

CDHP Purple, CDHP Orange, or High Deductible Plan

Under the CDHP options, regardless of whether you use in-network or out-of-network providers, you must meet an annual deductible before benefits are payable under the Plan. After the annual deductible is met, you pay a percentage of the covered expense—your coinsurance—up to the annual out-of-pocket maximum. When you reach the annual out-of-pocket maximum, the Plan begins to pay 100% of covered eligible medical expenses for the rest of the calendar year for the individual who reached the out-of-pocket maximum limit. For example, under the CDHP Purple in-network Pilot Only tier, you must pay the first $2,500 out of pocket, the Plan will begin to pay its share (90% coinsurance) of the cost of any eligible medical expenses. Once the amount you have paid (the $2,500 deductible and 10% coinsurance) reaches the annual out-of-pocket maximum of $4,250, the plan begins to pay 100% of covered eligible medical expenses for the rest of the calendar year for the individual who reaches the out-of-pocket limit.

The in-network and out-of-network deductibles are separate and do not cross accumulate. The same applies to in-network and out-of-network out-of-pocket maximums. For Pilot Plus coverage, the individual deductible and out-of-pocket maximum applies to each individual covered until the family deductible and out-of-pocket maximum are reached.

Please note, some benefits may be paid by the Plan before the deductible is met such as preventive services.

See the charts below for the annual deductible and out-of-pocket maximums for both in-network and out-of-network. **NOTE:** Pilot Plus applies if you (the pilot) have one or more dependents enrolled on your medical plan.

	IN-NETWORK		OUT-OF-NETWORK	
	CDHP Purple	**CDHP Orange**	**CDHP Purple**	**CDHP Orange**
Annual Deductible Pilot Only Pilot Plus	 $2,500 $3,000/individual; or $5,000/family	 $2,500 $3,000/individual; or $5,000/family	 $5,000 $5,000/individual; or $10,000/family	 $5,000 $5,000/individual; or $10,000/family
Coinsurance (after deductible is met)	You pay 10%	You pay 20%	You pay 30%	You pay 40%
Annual Out-of-Pocket Maximum (includes				

	IN-NETWORK		OUT-OF-NETWORK	
	CDHP Purple	**CDHP Orange**	**CDHP Purple**	**CDHP Orange**
deductible, copays, and medical and prescription drug coinsurance) Pilot Only Pilot Plus	 $4,250 $4,250/individual; or $8,500/family	 $4,500 $4,500/individual; or $9,000/family	 $9,000 $9,000/individual; or $18,000/family	 $9,000 $9,000/individual; or $18,000/family

	IN-NETWORK	OUT-OF-NETWORK
	High Deductible Plan	**High Deductible Plan**
Annual Deductible Individual Family	 $500 $1,500	 $1,000 $3,000
Coinsurance (after deductible is met)	You pay 20%	You pay 40%
Annual Out-of-Pocket Maximum (includes deductible, copays, and medical and prescription drug coinsurance) Pilot Only Family	 $3,000 $9,000	 $5,000 $15,000

*In-network and out-of-network deductibles are separate and do not cross accumulate. The same applies to in-network and out-of-network maximums. For Pilot Plus coverage, the individual deductible and out-of-pocket maximum apply to each individual covered until the family deductible and out-of-pocket maximum are reached.

Lifetime Maximum Benefits

You should know that:

- The lifetime maximum benefit for the High Deductible Plan medical option is $3 million per covered individual. The Retiree Health Plan is self-funded.
- The lifetime maximum benefit applies to benefit payments combined from all prior FedEx Express self-funded medical plan options covered under the Federal Express Corporation Group Health Plan for Pilots and Federal Express Corporation Retiree Group Health Plan for Pilots, in which you currently participate or participated in the past.
- If you enroll in the Health Plan Hawaii, you start over under the Health Plan Hawaii lifetime maximum. However, if you switch back to the High Deductible Plan medical option in some future year, you will resume with the lifetime maximum amount you had accumulated under the Federal Express Corporation Retiree Group Health Plan for Pilots self-funded medical plan option before you switched to the Health Plan Hawaii.

Pre-Medicare Retiree Health Reimbursement Account (HRA) Option

In lieu of the medical options described above, you have the option to elect the Pre-Medicare Retiree HRA. HealthEquity will administer the HRA.

With this option the Company will credit annually $4,813 to your HRA and an additional $4,813 for a covered spouse in a separate account (or domestic partner in California only) each January, if eligible. The HRA credit is prorated in the year of retirement. You can use this account to purchase health insurance outside the Company and/or pay for eligible health care expenses.

Eligible health care expenses must be filed with HealthEquity by March 31 of the next calendar year. You will have until March 31 of the current year to submit claims incurred in the prior plan year. Substantiation is required for all eligible expenses. To substantiate the expense, you will be required to submit an itemized invoice, Explanation of Benefits, or other approved documentation to HealthEquity via the mobile app, online, or by fax. Credits remaining in your Pre-Medicare Retiree HRA after the run-out period—March 31 of each year—roll over to cover future qualified health care expenses.

If you elect the Pre-Medicare Retiree HRA option, you are not allowed to elect any other company medical plan option during a future Annual Benefits Enrollment period. You may elect to drop the Pre-Medicare Retiree HRA option at any time but may not re-elect the option in the future. You may also elect dental and vision coverage with the Pre-Medicare Retiree HRA option.

Pre-Medicare Retiree HRA Rollover Credits

If you (and your spouse) enroll in the Pre-Medicare Retiree HRA option and you remain enrolled the next year, you (and your spouse) will start the new year with two HRAs at HealthEquity, one with any remaining credits from the prior year and a new account for the new year's credits and expenses. This is necessary to allow you to continue to file any eligible prior year health care expenses against your prior year HRA, through March 31. Once the filing period expires on March 31, any HRA credits that remain in your HRA from the prior year will be added to your HRA for the new year and can be used for future health care expenses.

HealthEquity will open a separate Pre-Medicare Retiree HRA for you and your spouse to allow each of you to receive the $4,813 credit from the Company in January. If you incur eligible health care expenses in the new year, those expenses must be filed against the new credit made to your HRA.

See the "Accounts" section of this book for additional details on the Pre-Medicare Retiree HRA.

How a Covered Expense Is Determined

The Plan will pay for covered expenses you incur. A charge is incurred when the service or supply charge is rendered or received. A covered expense for medical benefits is based on a maximum charge for each covered service or supply that will be accepted for each different type of provider. It is not necessarily the amount a provider bills for the service.

In-Network Provider Charges

The maximum covered expense for services provided by an in-network provider will be the lesser of the billed charge or the negotiated rate. The negotiated rate is the amount in-network providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by provider agreements that Anthem has with providers. When you choose an in-network provider, you will not be responsible for any amount in excess of the negotiated rate.

If you go to a hospital that is an in-network provider, you should not assume all providers in that hospital are also in-network providers. To receive the greater benefits afforded when covered services are provided by an in-network provider, you should request that all your provider services (such as services by an anesthesiologist) be performed by in-network providers whenever you enter a hospital.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an ambulatory surgical center. An ambulatory surgical center is licensed as a separate facility even though it may be located on the same grounds as a hospital (although this is not always the case). If the center is licensed separately, you should find out if the facility is an in-network ambulatory surgical center provider before undergoing the surgery.

How to Find an In-Network Provider

For a list of in-network providers, call Anthem Member Services at 1.866.406.0982, or to access the online provider directory, go to www.anthem.com/ca and click “Find Care” and follow the instructions. When prompted, enter the Prefix Identification Number FXF. The network of providers is subject to change. You can also find in-network providers through the Sydney Health mobile app.

Out-of-Network Charges

Out-of-Network Professional Charges

To determine out-of-network claims for professional services, Anthem will use either (1) the “Allowed Amount,” which is the amount from the 90th percentile of the FAIR Health FH RV Benchmarks Modules; or (2) the “Negotiated Amount,” which is an amount negotiated by the National Care Network (NCN), as follows:

1. **If the out-of-network professional claim is under $1,000:** The amount the Plan will pay will be based on the Allowed Amount. You will be liable for your share of the Allowed Amount and will be subject to balance billing by the provider for the amount of the provider’s bill that exceeds the Allowed Amount.

2. **If the out-of-network professional claim is $1,000 or higher:** NCN will engage in a negotiation with the provider with the objective of lowering the amount billed by the provider, and the amount allowed by the Plan will be determined as follows:

a. If NCN's negotiation is successful, then the amount the Plan will allow will be based on the Negotiated Amount. You will be liable for your share of the Negotiated Amount and will not be subject to balance billing by the provider for any amount above the Negotiated Amount.
b. If NCN's negotiation is unsuccessful, then the amount the Plan will pay will be based on an amount equal to the Allowed Amount. You will be liable for your share of such Allowed Amount and will also be subject to balance billing by the provider for the amount of the provider's bill above the Allowed Amount.

Out-of-Network Facility Charges

Out-of-network claims for facility services will be determined as follows:

1. **If the out-of-network facility is a "Traditional facility":** The amount allowed by the Plan will be determined based on the specific, discounted charges agreed upon by the Traditional facility. You will be liable for your share of the discounted charges and will not be subject to balance billing by the facility for any amount above the discounted charges. (**NOTE:** A Traditional facility has a base contract that is separate from the PPO network.)

2. **If the out-of-network facility is not a Traditional facility:** NCN will engage in a negotiation with the facility with the objective of lowering the amount billed by the facility, and the amount allowed by the Plan will be determined as follows:
   a. If NCN's negotiation is successful, then the amount the Plan will allow will be based on the Negotiated Amount. You will be liable for your share of the Negotiated Amount and will not be subject to balance billing by the facility for any amount above the Negotiated Amount.
   b. If NCN's negotiation is unsuccessful, then the amount the Plan will allow will be based on the Data iSights (NCN's pricing tool) amount, or if there is no applicable Data iSights amount, then the amount the Plan will allow will be based on the local Blue Cross Blue Shield plan's out-of-network pricing, and if there is no applicable local Blue Cross Blue Shield pricing, then the amount the Plan will allow will be based on billed charges. You will be liable for your share of the Data iSights amount or the local Blue Cross Blue Shield pricing or billed charges, as applicable, and will also be subject to balance billing by the facility for the amount of the facility's bill above the Data iSights amount or the local Blue Cross Blue Shield pricing.

3. **If none of the above applies:** The amount the Plan will allow will be based on billed charges. You will be liable for your share of the billed charges.

How to File Claims

If you go to an in-network provider, you will not have to file a claim. The in-network provider will file the claim for you. Once the claim is filed, you will receive an explanation of benefits (EOB) that would show you the total charge your provider billed, the covered expense the Plan allows, if any charges applied to the deductible, what the Plan paid, and your coinsurance amount. You will need the EOB if you have other insurance coverage that is secondary to your FedEx coverage.

If you go to an out-of-network provider, you will have to pay for the total charge of the service and file a claim. You must submit properly and fully completed claim forms within 90 days of the

date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to the 9-month filing limit will be allowed (a total of 12 months from date incurred). Services received and charges for the services must be itemized, and clearly and accurately described. You can get an itemized statement from your provider of service. Claim forms must be used; canceled checks or receipts are not acceptable. You can get a claim form by calling the customer service toll-free at 1.866.406.0982. Once Anthem receives the claim, they will determine the covered expense and you will be reimbursed directly for the covered expense minus any applicable deductible, copayments, and/or coinsurance, or if you assign benefits in writing to a third party, that third party will be reimbursed minus any applicable deductible, copayments, and/or coinsurance. Refer to "Out-of-Network Charges" explained earlier in this section. You will also receive an EOB explaining the covered expense and payments. Submit out-of-network provider claims to the address below:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

FedEx will not be liable for benefits if Anthem does not receive the claim on time.

Coordination of Benefits (COB) When There Is Another Plan

If you are covered by more than one group health plan, your benefits under this Plan will be coordinated with the benefits of those other plans, as shown below. These coordination provisions apply separately to each pilot and dependent, per calendar year. Any coverage you have for medical benefits will be coordinated as shown below.

COB When You and Your Spouse Both Have Group Medical Coverage

When You Have Medical Expenses For…	Your FedEx Express Medical Coverage Is…	Your Spouse's Medical Plan Is…
You	Primary*	Secondary
Spouse	Secondary	Primary
Child	Primary if your birthday occurs first in the year; Secondary if your spouse's birthday occurs first in the year**	Primary if your spouse's birthday occurs first in the year; Secondary if your birthday occurs first in the year**
*The Primary Plan is the plan that pays benefits first. **Commonly referred to as the "birthday rule." The birthday rule does not apply to children of divorced parents. The birthday rule may apply if there is joint custody. Refer to the next chart for more details.		

COB in Other Situations

Situation	Primary Coverage
You also have coverage through your spouse's employer	• If the other plan has a COB provision, use the guideline in the COB chart above. • If the other plan does not have a COB provision, that plan is always considered the Primary Plan.

Situation	Primary Coverage
	• If the other plan does not use the birthday rule, benefit coordination for dependent children is determined by the "gender rule," with the father's coverage primary and the mother's coverage secondary.
You also have coverage through a second job	The Primary Plan is the one that has covered you the longest.
You are an active covered pilot and also have retiree coverage through a former employer	The Primary Plan is always your coverage as an active employee.
You have FedEx retiree coverage and also have active coverage through another employer	The Primary Plan is your active coverage through your other employer.
You and your spouse are separated or divorced	The medical plan options pay in this order for dependent children: 1. The plan offered by the employer of the parent appointed to provide coverage. 2. The plan of the parent who has custody, when no court order indicates the parent appointed to provide coverage. 3. The plan of the spouse of the parent with custody (stepparent). 4. The plan of the parent without custody.

Other Plan is any of the following:

- Group, blanket, or franchise insurance coverage.
- Group service plan contract, group practice, group individual practice, and other group prepayment coverage.
- Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans, or self-insured employee benefit plans.
- Medicare. This does not include Medicare when by law its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured program.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement that reserves the right to take the services or benefits of other plans into consideration in determining benefits.

How Coordination of Benefits Works

The following describes how coverage is determined should you be covered by more than one plan:

1. If this Plan is the Primary Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If this Plan is NOT the Primary Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed the Allowable Expense. An

Allowable Expense is any necessary, eligible expense that is at least partially covered by at least one Other Plan. For the purposes of determining the Plan's payment, the total value of Allowable Expense as provided under this Plan and all Other Plans will not exceed the greater of: (1) the amount that the Plan would determine to be eligible expense, if you were covered under this Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

3. The benefits of this Plan will never be greater than the sum of the benefits that would have been paid if you were covered under this Plan only.

The Claims Paying Administrator coordinates payment of benefits with administrators of Other Plans under the following procedures:

1. A plan that has no Coordination of Benefits provision pays before a plan that has a Coordination of Benefits provision. This would include Medicare in all cases except when the law required that this Plan pays before Medicare.
2. A plan that covers you as an employee pays before a plan that covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan that covers you as a dependent of an active employee, but (b) before the plan that covers you as a retired employee.
3. For a dependent child covered under two different employers' plans, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have the birthday rule provision, benefit coordination for dependent children is determined by the "gender rule," with the father's coverage primary and the mother's coverage secondary.
4. If the parents are separated, divorced, or remarried and the child is covered as a dependent under more than one plan, the plans generally pay in the following order:
   a. The plan of the parent that the court establishes as having financial responsibility for the child's health care.
   b. The plan that covers that child as a dependent of the parent with custody.
   c. The plan that covers that child as a dependent of the stepparent (married to the parent with custody).
   d. The plan that covers that child as a dependent of the parent without custody.
5. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, rule 6 applies.
6. The plans covering you under a continuation of coverage provision in accordance with state or federal laws pays after a plan covering you as an employee, a dependent, or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the Order of Benefit Determination provisions of this Plan, this rule will not apply.
7. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

FedEx Rights Under This Coordination of Benefits Provision

- FedEx is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.
- If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and the Plan's liability reduced accordingly.
- If payments that should have been made under this Plan have been made under any Other Plan, FedEx has the right to pay that Other Plan any amount determined to be warranted to satisfy the intent of this provision. Any such amount will be considered a

benefit paid under this Plan, and such payment will fully satisfy liability under this provision.

- If payments made under this Plan exceed the maximum payment necessary to satisfy the intent of this provision, FedEx has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

Coordination of Benefits With TRICARE

If you and your covered dependents have coverage through one of the TRICARE programs, the Plan is primary. Charges incurred in connection with an illness or injury resulting from service in the armed forces are covered under TRICARE and excluded under FedEx coverage. FedEx coverage applies to nonmilitary-related illnesses or injuries not covered by the military.

Coordination of Benefits With Medicare

- For retired pilots and their spouses.
- If you are a retired pilot or the spouse of a retired pilot covered under the Plan and are eligible for Medicare Part A, Medicare will become the primary payer for medical benefits.

Coordinating Benefits With Medicare

The Plan will not provide benefits under this Plan that duplicate any benefits to which you would be entitled under Medicare. If you do not enroll in Medicare Part A and Part B, benefits that otherwise may be payable by the Plan will be reduced by the amount Medicare would have paid. You will be responsible for any copay, deductible, and coinsurance amount due. The benefit reduction will occur in all cases where Medicare is considered the primary plan, even if you have not enrolled in Medicare Parts A and B.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this Plan except as follows:

1. Medicare must provide benefits first to any services covered both by Medicare and under this Plan.
2. For services you receive that are covered both by Medicare and under this Plan, coverage under this Plan will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this Plan will not exceed covered expense for the covered services.

The Plan will apply any charges paid by Medicare for services covered under this Plan toward your plan deductible, if any.

Reimbursement, Subrogation, and Third-Party Liability for Medical, Dental, and Disability Claims Administered by Vengroff Williams, Inc. (VWA)

If your illness or injury is caused by the actions of a third party, payment of your medical and dental expenses and lost wages may be the responsibility of that third party. **This liability could result from events such as an automobile accident or injury at another place of business.** However, the plans will initially pay your eligible medical or dental expenses or disability benefits as long as you sign an agreement, as described below, requiring you to reimburse the plans for benefits paid provided you meet all other provisions of the Plan.

Therefore, if you receive payment from a third party, from any source of recovery, including but not limited to, liability or other insurance covering the third party, uninsured or underinsured motorist insurance, medical payment or personal injury protection insurance, and no-fault insurance, FedEx expects you to hold the payments in constructive trust for the benefit of the plans and to fully reimburse the plans from these funds in the amount of the related benefits paid from the plans on your behalf. The Plan shall not have right of reimbursement from a policy, contract, or other arrangement for which the participant pays 100% of the cost of such coverage (except for a policy, contract, or other arrangement in a no-fault jurisdiction).

If the payment you receive from a third party, less your attorney's fees and other legal expenses (net recovery), is not enough to reimburse benefit payments at 100%, you must still reimburse the plan 100% of what is left after paying your attorney's fees and other legal expenses.

FedEx shall have the first priority right of recovery from any amounts that you receive from any third party, regardless of whether these amounts were received by settlement or judgment, and regardless of whether you have been "made whole" by the amounts that you have received. The plans' rights apply to any funds recovered from another party by or on behalf of you, your covered dependents, or your estate. FedEx shall also have the right to subrogation against the third party for recovery of benefits paid by the plan.

You are required to sign an agreement acceptable to FedEx in which you agree to repay any money paid to you or to others on your behalf as plan benefits. If you do not sign this agreement, all benefit payments from the plans may be stopped. And if you do not honor this agreement, future benefit payments may be withheld until the entire amount due is reimbursed. In addition to withholding future benefits, FedEx may take any other legal action it deems appropriate, such as suing you for the full reimbursement amount. You are solely responsible for paying all legal expenses. The amount of the reimbursement is not reduced because of legal expenses you incur because you do not honor the agreement. Please read the agreement carefully and note that it applies to payments you have received or will receive, and to future benefit payments that will be made from the plans related to the same illness or injury.

To obtain a Reimbursement/Subrogation Form, contact Vengroff Williams, Inc. at 1.800.813.4054.

Coordination of Benefits and Personal Injury

The Plan also coordinates with personal injury protection coverage in those states with no-fault auto insurance laws. Benefits under this plan are secondary to no-fault auto insurance coverage.

Covered Health Care Providers

Eligible services must be provided by health care providers (other than your spouse, child, sibling, parent or in-laws, or spouse's child or sibling) who are licensed practitioners of the healing arts acting within the scope of their license. This means that any health care provider who treats you and charges for services must be licensed, certified, or registered as a health care provider according to the requirements of the state in which the services are provided.

Medically Necessary Care

Eligible expenses for treatment of an illness or injury must be medically necessary. Medical necessity will be determined by Anthem, the claims paying administrator for medical, pharmacy, mental health/substance abuse and utilization management, Cigna, the claims paying administrator for dental, and/or Davis Vision, the claims paying administrator for vision, as applicable, determines medical necessity, based on their respective guidelines, which are, in general, more detailed than the definition below. Medically Necessary Care is defined in the Plan document as care that is:

- Commonly and customarily recognized within the most relevant medical specialty (such as cardiology, orthopedic, etc.) with respect to the standards of good practice as appropriate and effective in the identification or treatment of a patient's diagnosed illness.
- Consistent with the symptom upon which the diagnosis and treatment of the illness is based.
- The appropriate supply or level of service that can be safely provided to a patient and with regard to a person who is an inpatient, it must mean that the patient's illness requires that the service or supply cannot be safely provided to that person on an outpatient basis.
- Provided by a practitioner, hospital, or covered provider.
- Not experimental or investigational in nature.
- Not scholastic, educational, or developmental in nature, or intended for vocational training.
- Not primarily for the convenience of the patient, practitioner, hospital, or covered provider.
- Not provided primarily for the purpose of medical or other research.
- Approved by the U.S. Food and Drug Administration (FDA), if the drug or supply is appropriate for review by the FDA.

Anthem, or the applicable claims paying administrator, determines which services and supplies are eligible expenses based on their appropriateness in diagnosing or treating an illness or injury consistent with the terms of the Plan. Charges for services and supplies shall be considered medically necessary only to the extent they are determined by the appropriate claims paying administrator's guidelines to be related to and appropriate for the treatment of the condition involved. Since the guidelines are subject to change, it is not practical to include them in this book. However, a copy of the guideline applicable to your condition, including information to verify that the plan applies the medical/surgical benefits criteria in a comparable way to the medical necessity criteria for mental health and substance use disorder benefits, is available upon request. The documents will be made available to you within 30 days of your request, subject to normal costs and restrictions as described in Your Rights Under ERISA, under the "Introduction" section of this book. Anthem provides medical policies on many procedures that are listed online at www.anthem.com/ca/medicalpolicy or you can request a copy by calling Anthem Member Services at the number shown on the back of your medical ID card. Please note, not all services requiring medical necessity review will have a medical policy.

If a health care provider orders a particular service or supply that does not meet medical necessity guidelines, it may not be covered by the Plan. Call Anthem Member Services at 1.866.406.0982 (or other claims paying administrator) if you have questions about benefits provided for a recommended treatment. In some cases, Anthem may ask that your physician

submit a written request for a preauthorization of benefits.

If you are not sure the treatment recommended by your physician will be covered by the Plan's definition of medical necessity, contact Anthem (or the applicable claims paying administrator).

Utilization Review Program (Preauthorization)

Benefits are provided only for medically necessary and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out-of-pocket expense.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this Plan.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this Plan is secondary to another plan providing benefits for you or your dependents.

The Utilization Review Program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are medically necessary and appropriate are authorized by Anthem and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

It is your responsibility to see that your physician starts the utilization review process and obtains a preauthorization before scheduling you for any service requiring preauthorization. If you receive any such service, and do not follow the procedures set forth in this section, your benefits may be reduced as shown in the Effect on Benefits section.

Utilization Review Preauthorization Requirements

Preauthorization is required for inpatient mental health and substance abuse covered services (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center, and intensive outpatient program). Call 1.866.406.0982 for preauthorization. Preauthorization is not necessary for outpatient office visits for mental health and substance abuse services.

Preauthorization is also required for the following:

- All Inpatient hospitalization including acute rehabilitation and long-term acute care, Cardiac/Pulmonary/Vestibular Rehab
- Skilled Nursing Facility
- Home Health Care
- Hospice Care
- Transplants
- Potentially cosmetic/investigative services, including but not limited to: Lipectomy, Liposuction, Back Surgery with disc implants, Treatment of Varicose Veins, Specific Eye, Ear and Nose procedures, and Erectile Dysfunction
- Certain outpatient surgeries and/or diagnostic procedures.

Check Anthem-CA Medical Policies online at www.anthem.com/ca/medicalpolicy or call Anthem Member Services at the number shown on back of your medical ID card for details before you schedule the surgery/procedure to see if preauthorization is required. The above list of services is not all inclusive. To determine if your recommended outpatient or inpatient procedure or

service requires preauthorization, call 1.866.406.0982. Failure to obtain any preauthorization will result in denial of benefits determined not medically necessary.

Exceptions: Utilization review is not required for inpatient hospital stays for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

The stages of Utilization Review (Preauthorization) are:

1. Pre-service review determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable.
2. Concurrent review determines whether services are medically necessary and appropriate when Anthem is notified while service is ongoing, for example, an emergency admission to the hospital.
3. Retrospective review is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

Effect on Benefits

In order for the full benefits of this Plan to be payable, the following criteria must be met:

1. When pre-service review is performed and the admission, procedure, or service is determined to be medically necessary and appropriate, benefits covered by the Plan will be provided for the treatment requested.
2. If you proceed with any services that have been determined to be not medically necessary and appropriate at any stage of the Utilization Review process, benefits will not be provided for those services.
3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not medically necessary and appropriate, benefits will not be paid for those services.

How to Obtain Utilization Review for Preauthorization

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed your benefits will be reduced as shown above in Effect on Benefits.

Pre-Service Reviews

1. For all scheduled services that are subject to Utilization Review, you or your physician must initiate the preauthorization at least three working days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service reviews is printed on your identification card.
2. If you do not receive the preauthorized service within 60 days of the authorization, or if the nature of the service changes, a new pre-service review for preauthorization must be obtained.
3. Anthem will authorize services that are medically necessary and appropriate. For inpatient hospital stays, Anthem will, if appropriate, authorize a specific length of stay for

approved services. You, your physician, and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you or the provider of the service must contact Anthem for concurrent review. For an emergency admission or procedure, Anthem must be notified within two working days of the admission or procedure. The toll-free number is printed on your identification card.
2. When Anthem determines that the service is medically necessary and appropriate, they will, depending upon the type of treatment or procedure, authorize the service for a period of time that is medically appropriate. Anthem will also determine the medically appropriate setting.
3. If it is determined that the service is not medically necessary and appropriate, your physician will be notified by telephone no later than 24 hours following Anthem's decision. Anthem will send written notice to you and your physician within two business days following the decision. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.

Retrospective Reviews

Retrospective review is performed when Anthem is not notified of the service you received and are therefore unable to perform the appropriate review prior to your discharge from the hospital or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

Such services that have been retroactively determined to not be medically necessary and appropriate will be retrospectively denied authorization.

The Medical Necessity Review Process

Anthem will work with you and your health care providers to cover medically necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, Anthem is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the review process:

1. A decision on the medical necessity of a pre-service request will be made no later than five business days from receipt of the information reasonably necessary to make the decision and based on the nature of your medical condition.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision and based on the nature of your medical condition.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your physician.
4. If Anthem does not have the information they need, they will make every attempt to obtain that information from you or your physician. If unsuccessful and a delay is anticipated, Anthem will notify you and your physician of the delay and what is needed to make a decision. Anthem will also inform you of when a decision can be expected

following receipt of the needed information.

5. All pre-service, concurrent, and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called “Review Coordinators”) using pre-established criteria and Anthem’s medical policy. These criteria and policies are developed and approved by practicing providers not employed by Anthem and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as medically necessary. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be medically necessary will be sent to you and your provider no later than two business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure, and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting physician is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not medically necessary and appropriate. Your physician will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
    - an explanation of the reason for the decision
    - reference of the criteria used in the decision to modify or not authorize the request
    - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request
    - how to request an appeal if you or your provider disagrees with the decision
9. The reviewers may be doctors at Anthem that support the FedEx Express pilot benefits or an independent third party chosen at the sole and absolute discretion of Anthem.
10. You or your physician may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone.
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

Predetermination of Benefits

Predetermination is a review that can be requested when a service or supply does not require preauthorization. A predetermination is **recommended** prior to services being rendered but is not required. However, because a particular service or procedure has a medical or clinical guideline associated with it, it may be subject to review for medical necessity at the point the claim is processed. In these instances, Anthem's intake representative will let the provider know that even though a preauthorization is not required, they do have the option to request a predetermination. A predetermination is encouraged when applicable, before services begin and expenses are incurred so there are no surprises to the provider or member after services have already been rendered.

Personal Case Management

The Personal Case Management program enables you to obtain medically appropriate care in a more economical, cost-effective, and coordinated manner during prolonged periods of intensive medical care. Anthem, through a case manager, may recommend an alternative plan of treatment, which may include services not covered under this Plan. FedEx does not have an obligation to provide Personal Case Management.

How Personal Case Management Works

You may be identified for possible personal case management through the Plan's Utilization Review procedures, by the attending physician, hospital staff, or Anthem's claims reports. You or your family may also call Anthem.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;
2. Anthem anticipates that such treatment utilizing services or supplies covered under this Plan will result in considerable cost;
3. A cost-benefit analysis determines that the benefits payable under this Plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this Plan while maintaining the same standards of care; and
4. You (or your legal guardian) and your physician agree, in a letter of agreement, with Anthem's recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan

If Anthem determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this Plan. A case manager will review the medical records and discuss your treatment with the attending physician, you, and your family.

Anthem makes treatment recommendations only; any decision regarding treatment belongs to you and your physician. The Plan will, in no way, compromise your freedom to make such decisions.

Effects on Benefits

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only.

Anthem has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any member, which alternatives may be offered and the terms of the offer.

2. Any authorization of services in lieu of benefits in a particular case in no way commits Anthem to do so in another case or for another member.
3. The Personal Case Management program does not prevent Anthem from strictly applying the expressed benefits, exclusions, and limitations of this Plan at any other time or for any other member.

NOTE: If alternative benefits are offered, a letter of agreement outlining the alternative benefits and any benefits provided in lieu of others will be provided by Anthem to you. Anthem reserves the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

Disagreement With Medical Management Decisions

1. If you or your physician disagrees with a decision, you or your physician may request a Level 1 appeal as described in the Claim and Appeals in the “Introduction” section. Requests for a Level 1 appeal (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests should include medical information that supports the medical necessity of the services.
2. If you, your representative, or your physician acting on your behalf finds the decision on your level 1 appeal request still unsatisfactory, a request for an appeal of a Level 1 decision may be submitted in writing to Anthem. This would be a level 2 appeal request. The level 1 decision letter from Anthem will explain what medical information is needed to support the medical necessity of the denied services. You should include the information to support the medical necessity of the services with your level 2 appeal request.
3. If the decision on your level 2 appeal request is still unsatisfactory, you may have the option to request an Independent Medical Review as described in the “Claims and Appeals” section of this book.
4. If you exhaust all levels of appeals as outlined in the “Claims and Appeal” section, you may or may not have the right to bring civil action in federal court under section 502(a) of the Employee Retirement Income Security Act of 1974 depending on where the civil action is filed.

When You Need Care Right Away

Emergency Care

Follow these guidelines when you believe you need emergency care. **An emergency** is a sudden, serious, and unexpected illness, injury, or health problem (including sudden and unexpected severe pain). This includes any illness, injury, or health problem you reasonably believe could endanger your health if you don’t receive medical care right away. **You and your family members are covered 24 hours a day, seven days a week for emergency services anywhere in the world.**

Your Benefits	How to Receive Them
Medical Emergency Facility	Because medical emergencies require immediate attention, call 911 (if you are in an area where the system is established and operating) or go for immediate treatment at the closest emergency facility. If you are not admitted, you will need to pay the emergency room copayment. Subject to the availability of in-network health care providers on staff at the hospital, you may request that all services be performed by in-network providers to incur less cost.
Emergency Admission to an In-Network Hospital	Under CDHP Purple and CDHP Orange medical options, you pay coinsurance after deductible (10% or 20%, respectively). Under the Buy Up Plan medical option, you pay a $75 copayment. If you are admitted to the hospital, your $75 emergency room copayment will be waived. You will pay a $500 copayment for the third and each subsequent emergency room visit for an individual. If you are admitted to the hospital your emergency room copay will be waived. This applies to the CDHP Purple, CDHP Orange and Buy Up Plan medical plan options. The hospital will notify Anthem of your admission. Anthem will then coordinate your care with your in-network physician.
Emergency Admission to an Out-of-Network Hospital	Under CDHP Purple and CDHP Orange medical options, you pay the applicable in-network coinsurance amount (10% or 20%) after deductible, if a true emergency. If not a true emergency, you pay the applicable out-of-network coinsurance amount (30% or 40%) after deductible. Under Buy Up Plan medical option, you pay a $75 copayment, waived if admitted, then, 100% coverage, if a true emergency. If not a true emergency, you pay a $75 copayment, then 30% after deductible. If you are admitted to an out-of-network hospital, you, your family, or the hospital should contact Anthem within 24 hours of your admission. The customer service toll-free number, 1.866.406.0982, is also printed on your member ID card.

Urgent Care

Urgent care is the service you seek for a sudden, serious, or unexpected illness, injury, or condition to keep your health from getting worse. It is not an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat the health problem.

Your Benefits	How to Receive Them
Urgent Care Centers	Urgent Care Centers are physician offices that provide walk-in care and extended hours. Office hours and days of operation vary and it is recommended that you call your physician in advance to determine if urgent care is available, the location where extended care is available, and the hours of operation. Under CDHP Purple and CDHP Orange medical options, you pay the coinsurance after deductible. Under Buy Up Plan medical option, you pay a $35 copayment.

When Traveling or Temporarily Residing Outside Your Home State

If you are traveling in the United States, you and your enrolled dependents can access care from network health care providers.

Your Benefits	How to Receive Them
The BlueCard PPO network enables you and your enrolled dependents (including out-of-state students) traveling outside your home state to a broader network of doctors and hospitals at discounted rates. The network provides continued benefits for you and your enrolled dependents (even out-of-state students) when traveling or temporarily residing away from home.	To locate BlueCard PPO providers, call 1.866.406.0982. or access the Find Care tool at www.anthem.com/ca and follow the instructions. When prompted, enter the Prefix Identification Number: FXF. • When you receive services from an in-network provider, if he or she in the national BlueCard PPO network, the provider will file the claim for you. • When you receive services from an out-of-network provider, you may need to pay for the medical services at the time of service then file a claim to the local Blue Cross/Blue Shield plan in the state where you received services. It's important that you save relevant statements and attach them to the claim form for reimbursement.

Access to GeoBlue Provider Network—When Traveling Outside the United States

Your Benefits	How to Receive Them
GeoBlue in-network hospitals can provide inpatient and outpatient services when you're traveling outside the U.S. Inpatient out-of-network care and all other medically necessary care that is not urgent or emergent will be covered subject to Anthem's out-of-network benefits.	Be prepared for the unexpected, call the International Provider Access at 1.888.243.2358 (phone number is also on your ID card) before leaving the U.S. An International Coordinator will provide you with a list of GeoBlue in-network hospitals in several international cities. Or you can reach them online at www.geo-blue.com/. For inpatient care at an in-network hospital, you pay only the applicable deductibles and copayments. The provider files the claim for you. For inpatient care at an out-of-network hospital, you will need to pay the hospital at the time you receive services and then submit a claim for reimbursement. To print a claim form, go to www.anthem.com/ca. If you need emergency care, go to the nearest hospital, and call the International Provider Access number on your ID card if you are admitted. If you are not admitted, you may be asked to pay for emergency services at the time of care. Before leaving the facility, request an itemized bill, which you will need to include when filing the claim to Anthem. • You will receive inpatient services at the in-network benefit level, and the in-network provider will file the claim for you. • You will receive inpatient and outpatient out-of-network services that are medically necessary and deemed emergent or urgent at the in-network

	benefit level. If care is deemed not emergent or urgent, services will be covered subject to Anthem's PPO out-of-network benefits. For all outpatient and professional medical care, you pay the provider and submit the claim. You will need to pay the hospital at the time of service then file a claim for reimbursement. Visit www.anthem.com/ca to print a claim form.

Medical Charges That Are Covered

The following services and supplies will be covered:

Ambulance

1. Base charge, mileage, and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a hospital.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a “911” emergency response system request for assistance if you believe you have an emergency medical condition requiring such assistance.
3. Base charge, mileage, and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest hospital where appropriate treatment is provided if, and only if, such services are medically necessary and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR), and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

If you have an emergency medical condition that requires an emergency response, please call the “911” emergency response system if you are in an area where the system is established and operating.

Ambulatory Surgical Center

Services and supplies provided by an ambulatory surgical center in connection with outpatient surgery.

Blood

Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing, and storage of self-donated blood are covered but only when specifically collected for a planned and covered surgical procedure.

Breast Cancer

Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including the following, will be covered:

1. Diagnostic mammogram examinations for the treatment of a diagnosed illness or injury. Routine mammograms will be covered.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a medically necessary mastectomy.
4. Breast prostheses following a mastectomy.

This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions.

Cancer Clinical Trials

Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III, and phase IV cancer clinical trials if all of the

following conditions are met:

1. The treatment provided in a clinical trial must either:
   a. Involve a drug that is exempt under federal regulations from a new drug application; or
   b. Be approved by (i) one of the National Institutes of Health, (ii) the U.S. Food and Drug Administration in the form of an investigational new drug application, (iii) the U.S. Department of Defense, or (iv) the U.S. Veterans Health Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your physician after determining participation has a meaningful potential to benefit the beneficiary.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs mean the costs associated with the provision of services, including drugs, items, devices, and services that would otherwise be covered under this Plan, including health care services that are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device, or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

1. Drugs or devices not approved by the U.S. Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from this Plan.
5. Health care services customarily provided by the research sponsors free of charge to members enrolled in the trial.

NOTE: You will be financially responsible for the costs associated with non-covered services.

For more information, contact Anthem at 1.866.406.0982 or access Anthem's Clinical Trials medical policies at www.anthem.com/ca.

Chemotherapy

Chiropractic Care

Chiropractic service for manual manipulation of the spine to correct subluxation demonstrated by physician-read X-ray. Chiropractic services are limited to 25 visits annually (in-network and out-of-network combined) for you and each of your dependents. This applies to the Buy Up Plan and High Deductible Plan medical options only. Under the CDHP Purple and CDHP Orange medical options you are responsible for the applicable coinsurance after deductible.

Durable Medical Equipment

Rental or purchase of dialysis equipment; dialysis supplies are covered. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications are covered. Rental or purchase of other medical equipment and supplies that satisfy the conditions below will be covered:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

Anthem will determine whether the item satisfies the conditions above.

Hemodialysis Treatment

Hearing Aids

Hearing aids and hearing aid repairs, batteries, and appliances are covered up to a $500 lifetime maximum benefit in the High Deductible Plan medical option. In all other plans, hearing aids and hearing aid repairs, batteries, and appliances are covered, up to $5,000 every three years, per participant. The Plan only contracts for the standard hearing aid model. If you choose an enhanced/deluxe hearing aid model, the Plan will pay the provider the contracted amount for the standard hearing aid model and pay you the excess up to the maximum benefit under the Plan. The provider will have you sign a waiver informing you that due to the enhanced/deluxe model selection, you will be liable for any excess amount over the standard model rate. The provider may request you pay the excess amount upfront.

Home Health Care

The following services provided by a home health agency will be covered:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as a professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. Medically necessary supplies provided by the home health agency.

One home health visit by a home health aide is defined as a period of covered service of up to four hours during any one day. Private duty nursing services provided in the home are subject to the Home Health Care benefit terms, conditions, and limits.

Home health care services are not covered if received while you are receiving benefits under the Hospice Care provision.

Hospice Care

The Plan will pay for:

1. Room and board charges in an inpatient hospice unit.
2. Services of a registered nurse, licensed practical nurse, and licensed vocational nurse.

3. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, and respiratory therapy.
4. Medical social services.
5. Services of a home health aide.
6. Dietary and nutritional guidance.
7. Nutritional support such as intravenous feeding or hyperalimentation.
8. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a physician.
9. Medical supplies.
10. Oxygen and related respiratory therapy supplies.
11. Bereavement counseling for your family.
12. Palliative care (care that controls pain and relieves symptoms but does not cure) that is appropriate for the illness.

You must be suffering from a terminal illness for which the prognosis of life expectancy is six months or less, as certified by your physician and submitted to Anthem.

Your physician must consent to your care by the hospice and must be consulted in the development of your treatment plan. The hospice must submit a written treatment plan to Anthem every 30 days.

Hospital Stays, Services, and Supplies

The following will be covered:

1. Inpatient services and supplies, provided by a hospital. Covered expense will not include charges in excess of the hospital's prevailing two-bed room rate unless your physician orders, and Anthem authorizes, a private room as medically necessary.
2. Services in special care units.

Infertility

Infertility coverage will be provided for the following services:

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to correct an infertility condition.
- Drugs to treat infertility are covered under the pharmacy benefit. These drugs are not covered if used in conjunction with the non-covered procedures listed below.

The following procedures and associated direct medical procedures and pharmacy expenses are not covered:

- Artificial insemination
- In vitro fertilization
- Gamete intrafallopian transfer
- Zygote intrafallopian transfer
- All similar procedures

Organ and Tissue Transplants

Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not a member is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Orthotics (foot)

Orthotics (foot) are limited based on Anthem's guidelines.

Outpatient Diagnostic Services

Outpatient diagnostic radiology and laboratory services are covered.

Physical Therapy, Physical Medicine, Occupational Therapy, Speech Therapy

The following services ordered by a physician and provided by a licensed therapist under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultraviolet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care that are customarily provided by chiropractors, physical therapists, and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs that are designed to rehabilitate mentally, physically, or emotionally handicapped persons.
3. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills, and ability to function in daily living activities.
4. Outpatient speech therapy following injury or organic disease.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a licensed therapist in that therapist's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her physician decide on an earlier discharge.
2. Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is an employee or enrolled dependent (spouse or child).
3. Precipitous (unplanned) births at home.

Preventive Care

1. A physician's services for routine physical examinations including well-women and well-baby care in accordance with Anthem's guidelines.
2. Radiology and laboratory services and tests ordered by the examining physician in

connection with a routine physical examination.
3. All preventive exams including PSAs, mammograms, immunizations, prostate exams and pap smears.

Professional Services

1. Services of a physician.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.
3. Other medically necessary prosthetic devices, including:
   a. Surgical implants;
   b. Artificial limbs or eyes; and
   c. The first pair of contact lenses or eyeglasses when required as a result of a covered medically necessary eye surgery.

Radiation Therapy

Reconstructive Surgery

Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Skeletal Disorders of the Jaw (Including TMJ)

Treatment of all skeletal disorders of the jaw, including but not limited to myofacial conditions and temporomandibular joint syndrome (TMJ), often involves benefits provided under both medical and dental coverages. There are specific limits and guidelines under both that could result in costly fees not covered by either. **Therefore, it is important that you submit a predetermination of benefits from your health care provider(s) to Cigna (the dental plan's claims paying administrator) before services begin and expenses are incurred. This will determine if any of these charges are covered under your dental or medical benefits.** For more information see the "Dental" section in this book.

Any outpatient TMJ surgery predetermination of benefits should be sent to Cigna. Inpatient TMJ claims should be preauthorized by Anthem.

Skilled Nursing Facility

Inpatient services and supplies provided by a skilled nursing facility will be covered. The amount by which your room charge exceeds the prevailing two-bed room rate of the skilled nursing facility is not considered covered expense.

Surgery, Anesthetics, and Surgeon's Fees

Outpatient services and supplies provided by a hospital or ambulatory surgical center for outpatient surgery are covered.

EMPLOYEE ASSISTANCE PROGRAM/MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Confidential Assistance and Resources for Everyone (CARE)

The Confidential Assistance and Resources for Everyone (CARE) program is your employee (and family) assistance program. The CARE program is administered by Anthem and it offers:

- Access to comprehensive professional support and short-term counseling for you, your eligible dependents, and any member of your household
- Easy access to licensed psychologists and social workers located in your community
- Assistance for family conflict, grief, life changes, personal growth, dependence, or co-dependence
- Crisis counseling for urgent or emergency situations
- Confidential assistance 24 hours a day, every day of the year

You and each eligible household family member is allowed up to eight counseling sessions, covered at 100%, when received by an in-network provider.

All services must be preauthorized by Anthem. In order to receive services, you must contact Anthem at 1.866.621.0130 to obtain a referral to a network provider. There is no need to file a claim form since this care is prepaid by FedEx.

If you enroll in the HMSA PPO or Health Plan Hawaii HMO, your employee assistance benefits are administered by HMSA. Contact HMSA at the number shown on the back of your medical ID card for more information.

Mental Health/Substance Abuse Services

Your Mental Health/Substance Abuse benefits are for more complex or long-term care. These benefits include:

- A variety of treatment programs to meet your needs, including individual therapy, inpatient hospitalization, and day treatment
- Access to a nationwide network of licensed accredited providers, which includes psychiatrists, psychologists, social workers, and counselors
- Confidential assistance 24 hours a day, every day of the year

Anthem has trained behavioral health customer care representatives who can view all available programs so that cross referrals to other beneficial programs can be offered.

Since benefits are payable for this type of care it is available only to you and your eligible dependents and you must enroll in the Buy Up, CDHP Purple, CDHP Orange, or High Deductible Plan medical option, administered by Anthem. **See the most recent Pre-65 Retiree Enrollment Guide for details about mental health/substance abuse benefits. The guide is located on https://fedexpilots.bswift.com under the Educate tab.**

Important: You must preauthorize all employee assistance benefits and inpatient mental health/substance abuse services and treatment (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center, and intensive outpatient program) through Anthem/BH Resource Center by calling Anthem at 1.877.657.6060.

How It Works

To receive care, simply call Anthem CARE at 1.866.621.0130 or the Behavioral Health Resource Center at 1.877.657.6060 anytime 24 hours a day. When you call, an Anthem/Behavioral Health Resource Center Customer Care representative will:

- Briefly review your concerns, assess whether your needs are best suited for the CARE program or for mental health/substance abuse services, and refer you to an Anthem CARE/Behavioral Health Resource Center network provider suited to your specific needs.
- Discuss your needs and treatment plan with the provider at the beginning of care and regularly throughout treatment.
- Authorize appropriate services for covered benefit.
- Send educational information or articles to you.
- Be available to you for discussion of treatment progress or any treatment problems you encounter.

In an Emergency

In case of emergency, seek treatment immediately. Then it is recommended that you call Anthem CARE/Behavioral Health Resource Center within 48 hours of the start of inpatient treatment.

Reduction in Alcohol Program

Reduction in Alcohol (RIA) Health is an alcohol treatment program that empowers you to improve your relationship with alcohol from the privacy and comfort of your home. The program uses custom treatment plans, medications, and online support to help you learn to drink in moderation or give up alcohol for good.

The RIA tools and resources are available through a secure app, which gives you access at home or on the go. Their doctors and counselors work with you to develop a program based on your health, history, goals, and schedule. For more information call 866.619.8713 or visit http://riahealth.com/.

ANTHEM PROGRAM AND RESOURCES

If you enroll in the Buy Up Plan, CDHP Purple, CDHP Orange, or High Deductible Plan medical options, you also have access to Anthem's resources to help you and your eligible dependents year-round with health care information and support. These resource programs are discussed below. You can also visit www.anthem.com/ca to learn more.

24-Hour Health Information Line

The Health Information Line offers support 24 hours a day, 7 days a week. If you need urgent care, a nurse will direct you to the nearest provider. If your condition does not require immediate care, a nurse will give you self-care tips to use until you see your doctor. Call the Health Information Line at 1.866.406.0982.

Aim Program

Health issues can be unexpected and stressful. Now you can gauge your health care costs ahead of time. Not only that, but you can compare costs too, to see where you can find quality care for less near you.

Anthem will call you when you may be able to save on certain health procedures to give you alternate providers/facilities to consider. The purpose of the program is to help you save on out-of-pocket costs and help you make smart choices when you need services like high-end radiology and ultrasound procedures, MRI, CT, PET, Nuclear Cardiology, and Echocardiograms, or an endoscopy, colonoscopy, or arthroscopic surgical facility.

How the program works:

1. Your doctor will contact Anthem when one of the above services or procedures is recommended. To make sure you are getting the right level of care and to reduce unnecessary procedures and costs, Anthem will conduct a clinical review to make sure that the procedure is necessary and safe.
2. Once approved, Anthem will check to see if the provider who will perform the procedure offers a low cost for the service in your area. They may also check other facility details.
3. If not, Anthem will call you to give you other nearby high quality, lower cost provider or facility choices.
4. You choose the provider that best meets your needs, whether it is the one your doctor suggested or one provided by Anthem. It is your decision.

Coverage Advisor

The Coverage Advisor tool will help you estimate your costs under the Buy Up Plan, CDHP Purple, CDHP Orange, and High Deductible Plan medical options so you can choose your medical plan option with confidence. You can access the Coverage Advisor tool at www.anthem.com/ca or https://fedexpilots.bswift.com.

Building Healthy Families, formerly known as the Future Moms Program

Building Healthy Families is Anthem's next generation maternal health program offering earlier

engagement, stronger connections, fewer gaps, robust whole-person care resulting in improved outcomes from pre-conception to early childhood stages of life. This intuitive digital experience will provide members access to pre-pregnancy, maternity, and post-partum care, as well as parenting support. The expanded digital member experience is accessible using Sydney Health.

Hinge Health

Hinge Health is a digital musculoskeletal (MSK) solution that aims to reduce back, knee, hip, neck shoulder, or other pain without the drugs or surgery, through the use of advanced motion technology, and wearable sensors for live feedback through the Hinge Health app.

The Hinge Health Digital MSK Clinic combines a complete clinical care team of physical therapists, health coaches, and physicians to work with you. Best of all, it's free!

To learn more about this program or to enroll, call Hinge Health at 1.855.902.2777 or visit hingehealth.com/fedex-express. Once you are enrolled in the program, you will receive a Hinge Health kit.

LiveHealth Online (available for medical and psychological visits)

LiveHealth Online provides you assess to a board-certified doctor who can answer and diagnose common problems such as sore throats, infections, and the flu, using your computer's webcam, smartphone, or tablet. You can video chat with a doctor online, anytime from your computer or mobile device with internet access, without an appointment. Download the LiveHealth Online app to your iOS or Android device and register your account. Three steps and you are face-to-face with a doctor—sign-up, choose a doctor, and begin your consultation.

LiveHealth Online also includes your eight free counseling sessions provided through CARE—your employee assistance program—and visits with a psychologist or therapist provided under the Behavioral Health program. LiveHealth Online Psychology will make it easier for you to attend short-term counseling sessions to help with work/life balance problems such as parenting, relationships, and managing stress at no cost. You can interact privately with a psychologist or therapist for more advanced behavioral health needs from a comfortable environment. Benefit payment for these services is covered based on the medical plan option you are enrolled in. The cost is per visit and may be lower than or equal to a physician or therapy/psychology office visit, and less than an urgent care or emergency room visit. Payment via MasterCard, Visa, or Discover is required at the time of service. You can pay for these services with your HSA or HRA, if applicable. See the most current Pre-65 Retiree Enrollment Guide located on https://fedexpilots.bswift.com for more information.

LiveHealth Online is available in most states. To locate in-network, board certified providers participating in this program, visit livehealthonline.com or contact Anthem at 1.866.406.0982.

Prescription availability is defined by physicians' judgement and state regulations.

Quick Care Options

Knowing where to go if you get sick or hurt can potentially save you time and money, and help you get the best medical care. How do you choose where to go when the unexpected happens? When you can't see your doctor or if your doctor's office is closed, there may be viable emergency room alternatives such as retail health clinics, walk-in doctor's offices, urgent care centers, and LiveHealth Online. Visit www.anthem.com/ca or call the number on your medical

ID card for more information and to find out if other sites of care are available in your area. Not all types of care and facilities are available in all areas.

Sydney Health

Sydney Health makes health care easier with the use of one convenient app to manage all of your benefits. The mobile app puts all of your health plan details in one place. It also keeps you informed and up to date on important information. The Sydney Health app allows you to:

- Use your digital ID card.
- Find care and check costs.
- Check what your plan covers.
- View claims details and your Explanation of Benefits.

To get started, download the Sydney Health app from the App Store or Google Play. If you have previously registered on Anthem's website, there's no need to register separately for the app, just log in using your http://anthem.com/ca username and password. You may need to first register on Anthem's website prior to utilizing the Sydney Health app.

Total Health, Total You

You have access to the Total Health, Total You (THTY) program that is designed to help you engage with your health, work on lifestyle changes, and connect with specialized health professionals no matter where you are. You can also call or chat with a Health Guide who can answer your health care questions and make sure you are making the most of your benefits. Use the Sydney Health mobile app to access this benefit.

THTY provides you and your eligible family members resources to improve your health and manage your health care expenses. Nurses and health care professionals proactively reach out to individuals who are at risk for serious health issues but may not know it, or those who have complex medical needs that aren't being met in the most appropriate way. This program differs from Condition Care because it's available to everyone, not just those living with chronic conditions.

THTY professionals work with participants to:

- Help provide education on treatment options to enable more informed decision-making.
- Help understand and manage their health concern(s).
- Help develop self-management skills to support their physician's plan of care.
- Help prepare for hospitalization and cope with recovery.
- Help use health benefits more appropriately.
- Coordinate access to services such as condition management, 24-Hour Health Information Line, and other available care management programs.

The THTY team focuses on providing participants with resources and giving information to improve health while following a doctor's treatment plan. To get started with a personal health coach today, call 1.866.406.0982.

Inclusive Care

Inclusive Care provides medical and emotional support for the LGBTQIA+ community. THTY's service and clinical teams help you access:

- Medical and behavioral health support.
- Gender affirmation surgery guidance and counseling.
- Specialty medication support.
- Community programs and educational resources.

Please contact Anthem Member Services at the number on your medical ID card to find out more about the available services.

Cleveland Clinic Complimentary Clinical Review

Your medical coverage through Anthem includes exclusive access to a virtual, complimentary clinical review with a cardiac expert at Cleveland Clinic. This valuable service is available no matter where you live and provides you and your regular doctors or specialists with an extra layer of support during your treatment. Cleveland Clinic and Anthem are working together to provide you access to Cleveland Clinic's specialists who can explain heart conditions and care options. You may be an ideal candidate if you have a diagnosed heart condition. You will hear from cardiac care experts with personalized feedback on your condition and find out if Cleveland Clinic can assist with your care. Cleveland Clinic will answer questions you may have and ask you for basic information. Next, Cleveland Clinic will ensure that the right specialist reviews your information and shares feedback based on your unique needs. The specialist may also talk about more advanced treatment options at Cleveland Clinic.

Cleveland Clinic will work with you or a covered family member to obtain the appropriate information and medical records. You will receive feedback, generally within five business days, by phone or email. The review through Cleveland Clinic is currently offered at no cost to Anthem members. Charges will apply if you choose to schedule follow-up visits. If you decide to have further care after the complimentary clinical review, your medical plan benefits will apply. Please contact Anthem Member Services at the number on your medical ID card to understand what services are covered.

Aspire Health

Aspire is a group of health care professionals in Anthem's provider network who specialize in providing support for complex care needs, if you need extra support while living with a complex health condition, or serious illness.

You will still see your existing care team and Aspire Health will work closely with them to make sure you receive the treatment and support you need. With Aspire Health, you and your family have access to experts in managing conditions and providing relief from symptoms, pain, and the stress of a serious or complex condition.

If you are facing challenging decisions about your health, Aspire Health is here to help. To learn more, go to aspirehealthcare.com. You can also reach an Aspire representative at 1.833.866.0926.

Enrollment/Participation

Participation in any of the programs or services provided by Anthem is free of charge, strictly voluntary, and completely confidential. A nurse may contact you to find out if you or any of your eligible family members want to participate in one of the programs. You may also enroll yourself by calling Anthem at 1.866.406.0982. Once enrolled, you have the option of discontinuing your participation by notifying Anthem via phone.

LIMITS AND EXCLUSIONS

There are limits and exclusions that apply to your medical coverage. Be sure to read through the list carefully to know if benefits for a medical service or supply are limited or excluded altogether under the medical plan options.

Limits

- **Abortions**, either elective or non-elective, are limited based on Anthem's guidelines.
- **Acupuncture** is limited based on Anthem's guidelines.
- **Admission kits** are limited based on Anthem's guidelines.
- **Allergy testing** is limited based on Anthem's guidelines.
- **Ambulance service** is limited for travel to and from the nearest appropriate facility.
- **Anesthetics** and their administration are limited based on Anthem's guidelines.
- **Assistant surgeon** charges are limited out-of-network to a percentage of the maximum allowable amount or negotiated fees and are based on Anthem's guidelines.
- **Augmentative communication devices** are limited based on Anthem's guidelines.
- **Biofeedback** is limited based on Anthem's guidelines.
- **Birthing center charges** shall be considered one charge for mother and child where Anthem has contracted per diem charges with an in-network provider; birthing center charges shall be considered separate charges if out-of-network.
- **Blood products** not replaced by or for the patient are limited based on Anthem's guidelines. In addition, charges for the autologous drawing and storage of a covered individual's blood are covered if Anthem determines such drawing and storage is medically appropriate.
- **Breast pump** is limited based on Anthem's guidelines.
- **Chiropractic care.** Chiropractic services are limited to 25 visits annually (in-network and out-of-network combined) for you and each of your dependents. Applies only to the Buy Up option.
- **Clinical trials** are limited based on Anthem's guidelines.
- **Clomid treatment** is limited based on Anthem's guidelines.
- **Condition and/or nutrition counseling** are limited based on Anthem's guidelines.
- **Consumable (disposable) medical supplies** are limited to ostomy supplies and urinary catheters.
- **Co-surgeons** are limited out-of-network to a percentage of the maximum allowable amount or negotiated fees.
- **Electronic heart pacemaker** is limited based on Anthem's guidelines.
- **Enteral and/or nutritional formula** is limited based on Anthem's guidelines.
- **Extracorporeal Shock Wave Lithotripsy charges** are limited based on Anthem's guidelines.
- **Genetic testing** is limited based on Anthem's guidelines.
- **Hearing aids** and hearing aid repairs, batteries, and appliances are covered up to a $500 lifetime maximum benefit in the High Deductible Plan medical option. In all other plans, hearing aids and hearing aid repairs, batteries, and appliances are covered up to $5,000, every three years, per participant.

- **Home births or home deliveries** are only excluded in-network.
- **Home health aide services** must be rendered or supervised by a registered nurse, registered physical therapist, registered occupational therapist, or medical social worker.
- **Home health care services and supplies** are limited based on Anthem's guidelines.
- **Home uterine monitoring** is limited based on Anthem's guidelines.
- **Hospice services and supplies** are limited based on Anthem's guidelines.
- **Infertility drugs** are covered when used in conjunction with testing and treatment of the underlying medical condition.
- **Inpatient hospital room and board** is limited up to the semiprivate room rate. If the hospital only has private rooms, benefits are covered at the private room rate unless Anthem has a negotiated rate.
- **Lesion removal** is limited based on Anthem's guidelines.
- **Mammograms** are covered based on physician's orders.
- **Mastectomy due to cancer** is limited to the following services and supplies:
  (1) Reconstruction of the breast on which the mastectomy was performed;
  (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  (3) Prosthesis; and
  (4) Treatment of physical complications at all stages of mastectomy including treatment for lymphedema.
- **Medical supplies** are limited based on Anthem's guidelines.
- **Multiple surgical procedures.** When multiple surgical procedures are performed during a single operative session, payment is based on Anthem's guidelines.
- **Organ transplant program** charges are limited based on Anthem's guidelines.
- **Orthotics (foot)** are limited based on Anthem's guidelines.
- **Other nutritional formula** is limited to nutritional formula requiring a prescription based on Anthem's guidelines.
- **Outpatient physical therapy, speech therapy, and occupational therapy** are based on Anthem's guidelines.
- **Oxygen** and rental of equipment for its administration is limited based on Anthem's guidelines.
- **Participating midwife** must provide services under the direct supervision of an in-network physician at an authorized in-network facility.
- **Podiatric treatment** is limited based on Anthem's guidelines, and in addition: Covered expenses for weak, strained, unstable, flat or unbalanced feet, metatarsalgia, and bunions are limited to:
  (a) Surgical procedures or nail root removal
  (b) Lab and X-rays
  (c) Medical supplies
  (d) Corrective shoes used in lieu of or as part of a brace

  Corns, calluses, and toenail trimming are not covered expenses unless they are necessary for treating metabolic or peripheral-vascular disease.
- **Post-mastectomy bras** are limited based on Anthem's guidelines.
- **Prenatal information**, pregnancy risk assessment, and consultation are limited based on Anthem's guidelines.
- **Prescription drugs** prescribed by a practitioner and dispensed by a licensed

pharmacist in connection with a hospital confinement or issued, administered, or delivered by a practitioner or home health agency are limited based on Anthem's guidelines.

- **Prolotherapy** is limited based on Anthem's guidelines.
- **Prosthetic device or appliance** used to replace or restore a functional body part, excluding TMJ, is limited based on Anthem's guidelines.
- **RAST testing** is limited based on Anthem's guidelines.
- **Reduction mammoplasty** is limited based on Anthem's guidelines.
- **Removal of birthmarks** is limited based on Anthem's guidelines.
- **Rental of durable medical equipment** is limited to the purchase price as determined by Anthem's guidelines.
- **Routine Pap smears** are limited based on Anthem's guidelines.
- **Skilled Nursing Facility.** Services provided by a Skilled Nursing Facility are limited based on Anthem's guidelines. Room and board, including regular daily services and supplies furnished by the Skilled Nursing Facility, are limited based on Anthem's guidelines. The admission must be preauthorized as determined by the guidelines. Failure to obtain such preauthorization will result in denial of benefits determined not medically necessary. Other services and supplies rendered during an approved confinement to a Skilled Nursing Facility are reviewed for medical necessity based on Anthem's guidelines.
- **Surgical dressings** are limited based on Anthem's Guidelines.
- **Therapy needed for developmental delay** is limited based on Anthem's guidelines.
- **Transplant travel and lodging expenses** are limited based on Anthem's guidelines (only available when using an In-Network Transplant facility).
- **Treatment, including surgical, for morbid obesity** is limited based on Anthem's guidelines.
- **Tuberculin testing** is limited based on Anthem's guidelines.
- **X-ray and laboratory examinations** are limited based on Anthem's guidelines. Failure to obtain preauthorization for certain diagnostic procedures based on Anthem's guidelines shall result in denial of benefits determined not medically necessary.
- **X-ray, radium, or other radioactive substances**. Treatment by X-ray, radium, or other radioactive substances are limited based on Anthem's guidelines.

Exclusions

- **Acupuncture.** Excluded from the High Deductible Plan medical option.
- **Academic or educational testing, counseling, and remediation** performed to treat learning disabilities.
- **Acts of war.** Charges incurred as a result of service in the armed forces of any country at war, whether declared or not, or any act or hazard of war, unless the covered pilot is an expatriate or on temporary assignment in a war area on Company business.
- **Air conditioners.** Air purifiers, air conditioners, or humidifiers.
- **Applied kinesiology.**
- **Artificial insemination.**
- **Breast implant removal**, unless determined to be medically necessary by Anthem's guidelines.
- **Charges for conditions** for which others are responsible.

- **Claims** filed more than one year after date of service.
- **Company-required physical exams**, such as FAA exams.
- **Consumable (disposable) medical supplies** except for ostomy supplies and urinary catheters. Any necessary consumable medical supplies administered or used by covered health providers providing care in the home will be covered as part of the Home Health Care benefit.
- **Cosmetic surgery** or other services, supply, or cosmetic or reconstructive procedure that is performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, replacement of tissue removed due to disease, or injury for the purpose of improving bodily function or symptomatology, or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Treatment for accidental injuries must commence within 90 days after the accident. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.
- **Criminal activities.** Conditions that result from:
  (1) Participation in a serious criminal act that the administrator determines, in its sole discretion, to be a felony; and
  (2) Any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- **Custodial care or rest cures**, which is for a confinement for bed rest without medical necessity, except as specifically provided under the Hospice Care benefit.
- **Dance therapy/movement therapy.**
- **Dental exclusions** listed in the Pilot Benefit Book are also exclusions based on Anthem's guidelines.
- **Dental implants** are not covered as medical expenses unless connected with treatment or extraction that results from accidental injury.
- **Dental plates, bridges, crowns caps** or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in Anthem's guidelines. Cosmetic dental surgery or other dental services for beautification are not covered.
- **Educational services.** Testing or services that are educational or developmental, for vocational training or performed to treat learning disabilities.
- **Effective coverage.** Services received before your effective date or after your coverage ends.
- **Environmental change.** Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy.
- **Excess amounts.** Any amounts in excess of covered expense.
- **Exercise equipment.** Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness.
- **Expenses in excess of negotiated fees**, maximum allowable amount, FAIR Health Rates, or National Care Network (NCN) limits.
- **Expenses incurred after the termination date of coverage.**
- **Expenses for travel and lodging** related to medical or dental treatment, except for organ transplants in-network and only available when using a network transplant facility.

- **Experimental or investigative procedure** or medication. But, if you are denied benefits because it is determined that the requested treatment is experimental or investigative, you may request an independent medical review.
- **Eye refractions or any other examination** to determine the need for, or proper adjustment of, eyeglasses or for the purchase of eyeglasses under the medical coverage.
- **Food or dietary supplements.**
- **Growth hormones.** These are not covered as a medical expense.
- **Incidental procedures** or those that are not medically indicated at the time provided.
- **Infertility services** including artificial insemination, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or similar procedures, and associated direct medical procedures and pharmacy expenses.
- **Lifestyle programs.** Programs to alter one's lifestyle, which may include but are not limited to diet, exercise, imagery, or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by Anthem.
- **Local, state, or federal agency services.** Any services actually given to you by a local, state, or federal government agency, except when payment under this Plan is expressly required by federal or state law. The Plan will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- **Maintenance treatment** unless covered based on Anthem's guidelines.
- **Medical research.** Medical treatment primarily for research.
- **Mental health and substance abuse** services, except for outpatient visits that are not pre-authorized.
- **Mental health and substance abuse** services obtained for mental health/substance abuse care that are not medically necessary according to the Plan definition.
- **Mouth condition charges.** Charges incurred for practitioner's services or examination, including x-ray exams and the like, involving one or more teeth, the tissue, or structure around them, the alveolar process, or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of all skeletal disorders of the jaw, including, but not limited to, myofacial conditions, temporomandibular joint disorders, or malocclusions involving joints or muscles by methods, including, but not limited to, crowning, wiring, or repositioning teeth. This exclusion does not apply to:
  - Charges made for treatment or removal of malignant tumors;
  - Charges for the treatment of accidental injury to natural teeth that are for provider services or examination;
  - Provider services for setting a fractured or dislocated jaw; or
  - Hospital, radiology, pathology and anesthesia charges, and charges for in-hospital prescription drugs incurred in connection with a dental procedure performed during a hospital confinement.
- **Natural childbirth education classes.**
- **Non-prescription nutritional formulas.** Nutritional formulas that can be purchased without a prescription and/or that are not medically necessary for the treatment of an illness.
- **No proof of charges.** Medical expenses for which you furnish no proof of charges.
- **Not medically necessary.** Services or supplies that are not medically necessary.

- **Optometric services**, eye exercises including orthoptics.
- **Orthopedic shoes** (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes related foot complications except as specifically stated in Anthem's guidelines.
- **Other charges** excluded by Anthem's PPO.
- **Outpatient prescription drugs** or medications and insulin, and diabetic supplies except as covered under the prescription drug benefit and deemed medically necessary. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health, or beauty aids.
- **Prescription and non-prescription diabetic supplies**, except as specifically stated in the Prescription Drug Benefit for "Active (Domestic) and Pre-Medicare Retired Pilots" section.
- **Prescription drugs not administered in a doctor's office or facility.** See the section titled—"Prescription Drug Benefit for Active (Domestic) and Pre-Medicare Retired Pilots."
- **Radial keratotomy**, or similar procedures, unless there is proven intolerance to contacts and glasses.
- **Rest home.** Services provided by a rest home, a home for the aged, a nursing home, or any similar facility.
- **Reversals of sterilization.**
- **Skeletal disorders of the jaw.** Treatment of all skeletal disorders of the jaw, including but not limited to, myofacial conditions and temporomandibular joint syndrome (TMJ), often involves benefits provided under both medical and dental coverages. There are specific limits and guidelines under both that could result in costly fees not covered by either. Therefore, it is important that you submit a predetermination of benefits from your health care provider(s) to Cigna (the dental plan's claims paying administrator) before services begin and expenses are incurred. This will determine if any of these charges are covered under your dental or medical benefits. Any outpatient TMJ surgery predetermination of benefits should be sent to Cigna. Inpatient TMJ claims should be preauthorized by Anthem.
- **Smoking cessation programs** or treatment of nicotine or tobacco use. Smoking cessation drugs. **Travel and lodging expenses unless** related to organ transplants.
- **Vitamins** (except prenatal vitamins requiring a prescription and medically necessary for the treatment of an illness based on Anthem's guidelines), minerals, homeopathic drugs and therapies, and over the counter medications.
- **Volunteer services.** Professional services received from a volunteer or a person who lives in your home or who is related to you by blood or marriage [spouse of the covered patient, or by relatives of the pilot or relatives of the pilot's spouse (child, brother, sister or parent)].
- **Weight loss (excluding treatment for morbid obesity)** or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, and vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations, counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa.
- **Wigs.** Scalp hair prostheses, including wigs or any form of hair replacement.
- **Work-related conditions** if benefits are recovered or can be recovered, either by

adjudication, settlement, or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

GLOSSARY OF TERMS

A–C

Change in Family Status

Allows you to add or drop dependent coverage within 31 days of a qualifying event such as marriage, birth, death, or divorce.

Coinsurance

The percentage you pay for covered medical and dental services or prescription drugs. The percentage varies by medical plan option.

Consumer Driven Health Plan (CDHP)

A CDHP is a qualified high deductible plan that can be combined with a financial account such as a Health Savings Account or a Health Reimbursement Account.

Copayment

The flat fee you pay for certain services. Normally, the annual medical deductible will not apply to such services and all you will have to pay is your copayment.

Coverage Tier

Coverage tier indicates whether you are covering yourself only or covering your spouse/children in a particular benefit option. There are four medical, dental, and vision coverage tiers:

- Pilot Only
- Pilot & Child(ren)
- Pilot & Spouse
- Pilot & Family

D–G

Deductible (Annual)

The amount you pay for covered services each year before your medical and/or dental coverage begins to pay benefits. You must satisfy an annual deductible in the CDHP Purple, CDHP Orange, Buy Up Plan, and High Deductible Plan medical options. See the “Medical Plan Options for Active Pilots & Covered Dependents” and “Medical Plan Options for Pre-Medicare Retired Pilots & Covered Dependents” charts for annual deductible amounts.

Diagnostic X-Rays and Tests

Preadmission testing, inpatient or outpatient X-rays and testing.

Emergency

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition that the covered person reasonably perceives could permanently endanger health if medical treatment is not received immediately, such as a suspected heart attack, severe lacerations, or broken bones.

Formulary

A list of “preferred” medications that are determined to be clinically effective, in addition to being cost effective, when compared to similar-acting drugs.

GeoBlue

Anthem’s worldwide partner that can provide access available 24 hours per day, 7 days per week for urgent and emergent care all over the world to domestic active or retired pilots and their dependents traveling outside the United States who are enrolled in the Buy Up Plan, CDHP Purple, CDHP Orange, or High Deductible Plan (for retirees only) medical option. GeoBlue also administers the International Plan for Internationally based pilots.

H–K

Health Reimbursement Account (HRA)

The HRA is a tax-advantaged savings account when it comes to federal and most state income taxes. The account is established with a third -party trustee/custodian to which the Company credits the HRA with a certain amount to help cover your deductible, coinsurance, and health care expenses. You cannot contribute to the HRA.

Health Savings Account (HSA)

The HSA is a tax-advantaged savings account when it comes to federal and most state income taxes. The account is established with a third -party trustee/custodian to which the Company shall, and the Pilot may, contribute to help cover your deductible, coinsurance, and eligible health care expenses.

HMO (Health Maintenance Organization)

A type of health plan in which doctors, hospitals, and other providers agree to provide health care services to participants for a flat fee. Care must be coordinated by a PCP. HMOs do not provide benefits for care received outside of the HMO’s network.

In-Network Provider (Participating Provider)

A physician, hospital, lab, pharmacy, or other health professional or facility that participates in the claims paying administrator’s provider network.

L–N

Lifetime Maximum Benefit

The most you can receive in benefits from the Plan for the High Deductible Plan medical option over the course of your lifetime (applies separately to each covered family member).

Medically Necessary

Eligible expenses for treatment of an illness or injury must be medically necessary. Medical necessity will be determined by Anthem, the claims paying administrator for medical, mental health/substance abuse, and utilization management; Express Scripts, Inc., the claims paying administrator for pharmacy; Cigna, the claims paying administrator for dental; and Davis Vision, the claims paying administrator for vision, as applicable, based on their respective guidelines

that are, in general, more detailed than the definition below. Medically Necessary Care is defined in the Plan document as care that is:

- Commonly and customarily recognized by the most relevant medical specialist (such as cardiology, orthopedic, etc.) with respect to the standards of good practice as appropriate and effective in the identification and treatment of a diagnosed illness or injury.
- Consistent with the symptom upon which the diagnosis and treatment of the illness or injury is based.
- The appropriate supply or level of service that can be safely provided to a patient and with regard to a person who is an inpatient, it must mean that the patient's illness requires that the service or supply cannot be safely provided to that person on an outpatient basis.
- Provided by a practitioner, hospital, or covered provider.
- Not experimental or investigational in nature.
- Not scholastic, educational, or developmental in nature, or intended for vocational training.
- Not primarily for the convenience of the patient, practitioner, hospital, or covered provider.
- Not provided primarily for the purpose of medical or other research.
- Approved by the U.S. Food and Drug Administration (FDA), if the drug or supply is appropriate for review by the FDA.

Anthem, or the applicable claims paying administrator, determines which services and supplies are eligible expenses based on their appropriateness in diagnosing or treating an illness or injury consistent with the terms of the Plan. Charges for services and supplies shall be considered medically necessary only to the extent they are determined by the appropriate claims paying administrator's guidelines to be related to and appropriate for the treatment of the condition involved. Since the guidelines are subject to change, it is not practical to include them in this book. However, a copy of the guideline applicable to your condition, including information to verify that the plan applies the medical/surgical benefits criteria in a comparable way to the medical necessity criteria for mental health and substance use disorder benefits, is available upon request. The documents will be made available to you within 30 days of your request, subject to normal costs and restrictions as described in Your Rights Under ERISA, in the "Introduction" section. Anthem provides medical policies on many procedures that are listed online at www.anthem.com/ca/medicalpolicy or you can call Anthem Member Services at the number shown on the back of your medical ID card to request a copy.

If a health care provider orders a particular service or supply that does not meet medical necessity guidelines, it may not be covered by the Plan. Call Anthem Member Services at 1.866.406.0982 (or other claims paying administrator) if you have questions about benefits provided for a recommended treatment. In some cases, Anthem may ask that your physician submit a written request for a preauthorization of benefits.

If you are not sure the treatment recommended by your physician will be covered by the Plan's definition of medical necessity, contact Anthem (or the applicable claims paying administrator).

Medical Plan Options

Your medical plan options are based on your home ZIP code and include one or more of the following:

Active pilot medical plan options:

- Buy Up Plan
- CDHP Purple
- CDHP Orange
- International Plan*
- HMSA (PPO)**
- Health Plan Hawaii (HMO)**

*Internationally based pilots are eligible for the International Plan only.
**Pilots with a home ZIP code in Hawaii are only eligible for HMSA or Health Plan Hawaii.

Retiree medical plan options:

- Buy Up Plan
- CDHP Purple
- CDHP Orange
- High Deductible Plan
- HMSA*
- Health Plan Hawaii HMO*
- Pre-Medicare Retiree HRA

*Retired pilots with a home ZIP code in Hawaii are only eligible for HMSA or Health Plan Hawaii.

O–Q

Opt Out

To elect not to have medical (including mental health/substance abuse and prescription drug), dental, and/or vision coverage through FedEx Express for yourself or your eligible dependents.

Out-of-Network Provider (Non-Participating Provider)

A physician, hospital, lab, pharmacy, or other health professional or facility that does not participate in a medical plan option's network.

Out-of-Pocket Maximum (Annual)

The most you will have to pay toward covered expenses in a calendar year. Once you reach the out-of-pocket maximum, the Plan begins to pay 100% of covered expenses for the rest of the calendar year—unless you've already met your lifetime maximum or any other annual maximums that apply, e.g., annual chiropractic limit. Charges that exceed the Allowed Amount or Negotiated Amount as described in the sections titled—"Medical Plan Information" under "Out-of-Network Professional Charges"; and "Retiree Health – Medical Plan Information" under "Out-of-Network Professional Charges."

Outpatient Care

Tests, treatments, and surgeries performed in a physician's office or outpatient department of a hospital or other health care facility.

Post-Deductible Health Reimbursement Account (HRA)

If you disenroll from the CDHP HRA option, you continue to have access to the credits in your account. Any credits remaining in your HRA will be converted to a post-deductible HRA and can be used to pay any eligible health care expenses once you meet the IRS annual deductible.

PPO (Preferred Provider Organization)

A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. You may seek care from out-of-network providers, but generally pay a higher deductible and coinsurance, and are responsible for charges above Allowed Amount or Negotiated Amount as described in the section titled—"Medical Plan Information" under "Out-of-Network Professional Charges" and "Retiree Health – Medical Plan Information" under "Out-of-Network Professional Charges."

Preauthorization

A review for medical appropriateness before a medical service is rendered. Preauthorization is your responsibility. See **Utilization Review Program (Preauthorization)** under the sections titled—"Medical Plan Information" and "Retiree Health – Medical Plan Information" for more information regarding when preauthorization is required and who is responsible for the preauthorization.

Predetermination of Dental Benefits

A written determination from CIGNA that you and your dental provider can request before treatment begins and expenses are incurred. It explains whether a recommended course of treatment is a covered dental service and if charges are within reasonable and customary limits.

Predetermination of Medical Benefits

Predetermination is a review that can be requested when a service or supply does not require preauthorization. A predetermination is **recommended** prior to services being rendered but is not required. However, because a particular service or procedure has a medical or clinical guideline associated with it, it may be subject to review for medical necessity at the point the claim is processed. In these instances, Anthem's intake representative will let the provider know that even though a preauthorization is not required, they do have the option to request a predetermination. A predetermination is encouraged when applicable before services begin and expenses are incurred so there are no surprises to the provider or member after services have already been rendered.

Preventive Care

Health care services intended to prevent illness or injury or to detect problems early. Preventive care includes routine physical exams or checkups, well-woman exams, well-baby care, and immunizations. A physician's services for routine physical examinations including well-women and well-baby care in accordance with Anthem's guidelines. Radiology and laboratory services and tests ordered by the examining physician in connection with a routine physical examination. Preventive care includes all preventive exams including PSAs, mammograms, immunizations, prostate exams, and pap smears.

Primary Care Physician (PCP)

A doctor who coordinates the overall health care of patients. You choose a PCP from a provider network directory that usually includes doctors in family practice, internal medicine, and pediatrics.

Proprietary Drugs

Proprietary drugs include brand-name medications, single-source medications that do not currently have a generic equivalent, and medications that may come under a trademarked name.

Provider

A PCP, specialist, hospital, lab, pharmacy, or other health professional or facility that provides health care services or supplies.

R–T

Self-Funded Medical Plan Options

The CDHP Purple, CDHP Orange, Buy Up Plan, and High Deductible Plan (for retirees only) medical options are self-funded. This means that claims for medical coverage are paid by FedEx out of its general assets and contributions made by employees. The Health Plan Hawaii, HMSA, and International Plan are fully insured.

Specialty Pharmacy

A specialty pharmacy is designed to handle high cost, complex medications used to treat rare and chronic health conditions, such as cancer, multiple sclerosis, and rheumatoid arthritis.

Accredo is Express Scripts' specialty pharmacy.

Spend-Down HRA

When you retire or leave the Company, your HRA will be converted to a Spend-Down HRA, and you will continue to have access to the HRA credits.

Step-Therapy

Step-therapy helps to manage drug costs by ensuring that patients try clinical, effective, lower cost medication before they step-up to a higher cost medication. In step-therapy, drugs are grouped into categories, based on treatment and cost.

If you are prescribed a non-preferred alternative under this program, your non-preferred medication will not be covered until a preferred alternative or step one medication is tried. If your doctor does not agree that a preferred alternative is right for you, your doctor can request a coverage review. Clinical documentation must be provided to support the need for a step-one, non-preferred medication.

U–Z

Urgent Care

An acute, unforeseen illness or injury that requires prompt treatment, such as sprains and strains, vomiting, fever, cramps, small lacerations, rashes, or earaches.

Wellness Incentive

If you meet the requirements of the health rewards program, you and spouse can earn extra money or credits, which will be deposited or credited to your HSA/HRA. Wellness activities are completed through the Smart Rewards program. You must be enrolled in one of the CDHP HSA or CDHP HRA medical plan options in order to be eligible for the Wellness Incentive.

DENTAL AND VISION BENEFITS

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DENTAL AND VISION – GENERAL INFORMATION

Eligibility

Eligible employees are any pilots employed by Federal Express Corporation who are covered by the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International.

Active Dental and Vision coverage is effective for you and your eligible dependents on your first day of employment if you enroll within 31 days following your hire date or by the deadline indicated in your new hire letter.

You will have an opportunity to add or drop coverage annually during Annual Benefits Enrollment, or within 31 days following a qualified Change in Family Status event (you are only permitted to make benefit coverage changes consistent with your event).

If you are a retired or terminated pilot and meet the age and service requirements for retiree health (See Retiree Health Coverage in this book), retiree Dental and Vision coverage is effective on your retirement or termination date.

Opting In/Out of FedEx Coverage

If you lose/gain other dental and/or vision coverage, you must access Pilot Benefits Online at https://fedexpilots.bswift.com to elect/waive coverage within 31 days following the date of loss/gain of the other coverage. Otherwise, you must wait until the next Annual Benefits Enrollment to elect/waive coverage, which will be effective January 1 of the following calendar year.

Important: If you elected to waive dental and/or vision coverage for the current year and make no election during Annual Benefits Enrollment, you will automatically opt out for dental and/or vision for the next year.

Eligible Dependents

As a pilot, you may enroll your eligible dependents in the dental and/or vision plan.

You are able to cover your eligible children under your dental and/or vision plan until midnight on the last day of the month in which the child attains age 23.

Dependents eligible to be covered under your dental and/or vision coverage include your:

- Legally married spouse, including a common-law spouse (as defined by the state where common-law status is established).
- In California only, domestic partner registered with the state of California.
- Eligible child under age 23, including natural child, stepchild, legally adopted child, including a child placed in your home for the purpose of adoption, a child for whom you have legal guardianship, a child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO), as long as the child meets the definition of an eligible dependent.
- If your child is approaching age 23, you must contact Pilot Benefits

Administration (PBA) to request the application to continue coverage for an incapacitated child. You must complete and return the application (and provide medical documentation, if necessary) three months in advance of your child's 23rd birthday. Return the application to PBA via email at PBA@fedex.com. For coverage continuation applications that are returned to PBA, PBA will serve as the liaison between you and Anthem. Anthem conducts all incapacitation reviews related to continuing dental and/or vision coverage for an incapacitated child and makes the determination based on their guidelines.

– In California only, your domestic partner's child.

NOTE: Your spouse/domestic partner (in California only) cannot be covered both as an employee and as a dependent.

Following the end date of coverage, dental and/or vision coverage may be continued for up to 36 months under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) by paying the full cost of coverage.

If you are enrolling an eligible dependent for dental and/or vision coverage, you must provide acceptable documents within 45 days of enrollment to verify the covered dependent is eligible for benefits. Proof of eligibility includes documents such as a birth certificate, marriage license, i.e., for any newly added dependent. If you fail to provide acceptable documentation by the required due date, your dependent's dental and/or vision coverage will be terminated.

Domestic Partner Coverage in California

To qualify for benefits under the Plan, the domestic partner relationship must be registered with the state of California and both the pilot and the domestic partner must reside in the state of California. Should the pilot or the domestic partner relocate from the state of California, neither the domestic partner nor the domestic partner's children would be eligible dependents under the Plan. Under the Internal Revenue Code, a pilot is not taxed on the value of benefits provided by an employer to a pilot's spouse or dependent. However, the value of benefits provided to a pilot's domestic partner (and the domestic partner's eligible children, if any) is considered part of the pilot's taxable income unless the pilot's domestic partner and/or his or her children qualify as a legal tax dependent under Section 152 of the Internal Revenue Code.

If you enroll a domestic partner and/or their eligible children for dental and/or vision coverage, and they do not qualify as your legal tax dependent(s), the IRS treats pilot contributions and the contributions made by the Company as taxable. Pilot contributions will be made with after-tax dollars. In addition, the value of the benefit may be considered additional taxable (or imputed) income. Imputed income is recognized for the amount contributed by your Company toward the cost of coverage for the domestic partner or for any child(ren). The amount of your imputed income depends on the option and coverage tier you select. Imputed income is subject to FICA (Social Security and Medicare), federal income taxes, and any other required payroll tax. This means you will pay applicable payroll taxes on an additional amount (which will be shown on your

paychecks) throughout the year, and it will be included on your W-2 form at the end of each year. You should seek the advice of your tax accountant, attorney, or other professional to assess the effect of such additions on your personal situation.

NOTE: If your domestic partnership is registered with the state of California, you will not have imputed income for California income tax purposes. Your monthly contribution for health coverage for your domestic partner (and/or your domestic partner's children) will be excluded from your income for California income tax purposes.

Any misrepresentation of dependent information will be considered a deliberate falsification of Company records and constitutes grounds for rejection of the dependent. You may be required to repay to the Plan any amount paid for all benefit expenses paid by the Plan for the ineligible dependent.

Enrollment

Enrollment in your benefits is done via Pilot Benefits Online at https://fedexpilots.bswift.com or by contacting Pilot Benefits Administration at 1.866.795.6353.

If you enroll in Pilot & Child(ren), Pilot & Spouse, or Pilot & Family dental and/or vision coverage, you must list your dependents' names and Social Security numbers on Pilot Benefits Online.

If You Are a New Hire

You will receive a letter that explains the benefit options available to you, associated costs for each option, and the deadline to make your elections. Access Pilot Benefits Online at https://fedexpilots.bswift.com to make your elections. This secure website provides you access to your benefits information from your computer, iPad, or smartphone. If you make no elections by the deadline indicated in your new hire letter, you will remain enrolled in the dental and vision options and coverage tier in which you were automatically enrolled.

Annual Benefits Enrollment

In the Fall, you are given the opportunity to add, drop, or change dental and/or vision coverage for yourself and any eligible dependents for the next calendar year. This is referred to as Annual Benefits Enrollment. The dates for Annual Benefits Enrollment will be communicated to you via FCIFs and email.

During the Annual Benefits Enrollment period, you can access Pilot Benefits Online at https://fedexpilots.bswift.com to review the benefit material and make your elections. Your dental and/or vision elections made during this period become effective January 1 of the following calendar year. If no new elections are made by the enrollment deadline, you will be enrolled in the same dental and/or vision plan option and coverage tier you had at the end of the calendar year, if those dental and/or vision plan options are still available, and you have had no change in dependent eligibility.

Opting Out of FedEx Coverage

You can elect to opt out of FedEx Express dental and/or vision coverage on Pilot Benefits Online at https://fedexpilots.bswift.com. You also can elect to opt out during Annual Benefits Enrollment or within 31 days following the gain of other coverage when related to a Change in Family Status event.

If you lose your other dental and/or vision coverage, you must access Pilot Benefits Online at https://fedexpilots.bswift.com to elect coverage within 31 days following the date of loss of the other coverage. Otherwise, you must wait until the next Annual Benefits Enrollment to elect coverage, which will be effective as of January 1 of the following calendar year.

Important: If you elect to opt out of coverage for a calendar year and make no election for the next calendar year, you will automatically waive coverage for the next calendar year.

If Your Spouse or Child Is Also a Pilot/Non-Pilot Employee Eligible for FedEx Express Benefits

- If both you and your spouse (or domestic partner in California only), or you and your child, are employees at a FedEx company participating in FedEx benefits, you have the choice to cover your spouse and/or child as your dependent in the dental and/or vision plan option you choose, or they may elect their own employee coverage. However, your spouse or child cannot be covered as both an employee and your dependent.
- If you cover your spouse or child as a dependent for benefit coverage, he/she must opt out of the applicable benefit as an employee.
- If you cover your dependent child, within 31 days following his/her 23rd birthday, your child must elect his/her own benefit coverage as an employee to remain covered.
- **NOTE:** Your dependent children may not be covered as qualified dependents of more than one pilot/non-pilot employee for dental and/or vision coverage. If both you and your spouse or you and another pilot/non-pilot employee are actively employed by FedEx, only one pilot/non-pilot employee can cover those dependents for dental and/or vision coverage.

If You Have a Change in Family Status Event

If you have a Change in Family Status event as permitted by law (for example, marriage, divorce, birth of a child, spouse gains or loses other coverage, begin or return from a leave of absence, etc.), you can make a coverage tier change if you make your election within **31 days following the event**. The change is effective the date of the event. Not every event allows you to make the same kind of changes to your benefits. You are only permitted to make benefit coverage changes consistent with your event. For example, if you get married and select the Marriage event within 31 days following your marriage, you may add your spouse, eligible children, and/or stepchildren to your benefits. If your event occurred more than 31 days ago, you will not be allowed to change your coverage tier until the next Annual Benefits Enrollment period or until you have another Change in Family Status event. If you select the Divorce event more than 31 days following your

divorce date and have Pilot & Spouse or Pilot & Family coverage, your spouse's coverage will end. However, your coverage tier and monthly cost will not change (until the next Annual Benefits Enrollment). **NOTE: Your stepchildren and children of your domestic partner are no longer eligible for coverage on the date of divorce or termination of domestic partnership.**

If you experience a Change in Family Status event, it is your responsibility to access Pilot Benefits Online at https://fedexpilots.bswift.com within 31 days following the event to update your dependents' information and make benefit changes associated with the event. **NOTE: If you currently have Pilot & Child(ren) or Pilot & Family coverage, you must still add any newly eligible child for access to health benefits.**

If you have questions or need assistance processing a Change in Family Status event, please contact Pilot Benefits Administration at 1.866.795.6353 or send an email to PBA@fedex.com.

Your Cost for Coverage

FedEx Express pays the majority of the cost for dental and/or vision coverage. The monthly premium is updated annually in the Pilot Enrollment Guide. See the most current Pilot Enrollment Guide, located on https://fedexpilots.bswift.com under the Educate tab.

The total projected cost for 2017 and each calendar year thereafter, will be determined by an actuary selected by the Company and will be developed from the experience of all pilots and eligible dependents participating in coverage, excluding fully insured.

Beginning in 2017, the cost share for each tier of each plan are as follows:

Pilot Options	Pilot Cost Share
Dental and Vision	17%

*For pilots based in FDA, the monthly premium/contribution shall not exceed the amount of the monthly premium/contribution for the same coverage tier in the plan option with the highest monthly contribution offered to domestic-based pilots.

The monthly premium/contribution may increase but not by more than 10% over the monthly premiums payable for the immediately preceding year.

If you choose dental and/or vision coverage, the cost is automatically deducted from your paycheck on a pre-tax basis (except for domestic partner benefits). You must notify Pilot Benefits Administration by calling 1.866.795.6353, if the correct payroll deductions are not made. Dependents are not covered if a payroll deduction is not made for that coverage. If payment for coverage is made in error, contact Pilot Benefits Administration. You may be entitled to a refund up to a maximum of three months prior to the date the error was discovered.

Your Coverage During a Leave of Absence or Suspension

If you are on an approved leave of absence (LOA), the cost of coverage for you and your covered eligible dependents (if applicable) accumulates for the first 90 days and is deducted from your paycheck on a prorated basis when you return to work. (**NOTE:** If, while on LOA, you receive a payroll generated check, prorated deductions will be taken.) If you remain on leave for more than 90 days, you will receive a bill for your portion of the contributions.

If you are on a suspension, the full cost of dental and/or vision coverage for you and your covered eligible dependents (if applicable) must be paid to continue coverage. Full cost includes your current payroll deduction plus the amount paid by FedEx.

Termination of Coverage

Failure to make required payments, making partial payments, or having checks returned due to insufficient funds, will result in loss of coverage for you and any covered dependents. If your coverage terminates, when you return you may elect to reenroll in the same coverage tier you were enrolled in, if available, prior to your leave or suspension. You must contact PBA within 31 days following the return-to-work date in order to reenroll.

Adding or Dropping Dependent Coverage

Leave of absence and suspension are considered a Change in Family Status event, which allows you to add or drop dependent coverage within 31 days of the start of the leave or suspension. For example, if you have Pilot & Spouse, Pilot & Child(ren), or Pilot & Family coverage, you may change your coverage tier to Pilot Only coverage. You can access Pilot Benefits Online at https://fedexpilots.bswift.com, within 31 days following the effective date of your leave or suspension to make your coverage tier election. The cost of the new coverage will begin to accumulate for a maximum of 90 days from the start of your event. If you want to add dependent(s) to coverage when you return, you must make your election within 31 days following your return date or wait until the next Annual Benefits Enrollment period.

When Dental and/or Vision Coverage Ends

Coverage for you and/or your covered dependents ends on the earliest of the following dates:

- FedEx Express discontinues the Plan, which could only be done pursuant to the Agreement or a successor.
- You stop making the required contributions to participate in the Plan during a suspension or LOA.
- Your employment is terminated for gross misconduct.
- Your employment is terminated and you do not elect to continue coverage through COBRA.
- You or your covered dependents are no longer eligible for coverage.

- You or a covered dependent dies.
- When, if ever, the Agreement or a successor collective bargaining agreement no longer provides for this coverage.
- COBRA coverage ends (if elected).
- You transfer to a non-pilot position within FedEx Express or a participating employer in the FedEx Corporation Group Health Plan and your participation in FedEx Express' benefit plans is no longer provided under the terms of the Agreement.
- You retire unless you qualify for coverage after retirement as described in the section—**Retiree Health – General Information** or you elect to continue coverage through COBRA.
- You are on furlough and no longer receiving furlough pay.
- You opt out of FedEx Express group dental and/or vision coverage during Annual Benefits Enrollment or due to a Change in Family Status event.

If your coverage ends and your spouse is employed by FedEx Express or another FedEx company and your spouse has coverage under the Federal Express Corporation Group Health Plan for Pilots or the FedEx Corporation Group Health Plan, you will be eligible to enroll as a dependent under your spouse's coverage, if you are otherwise eligible as a dependent. You must enroll in your spouse's plan within 31 days following your coverage end date.

COBRA – Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), group dental and/or vision coverage may be continued for up to 18 months, or in some cases 29 or 36 months, if you or your eligible dependents would otherwise lose dental and/or vision coverage because of a specific "qualifying event." See the COBRA section of this book for more information.

DENTAL BENEFITS: ACTIVE AND PRE-MEDICARE RETIRED PILOTS

IMPORTANT: *Participation in the Dental Plan requires an enrollment election separate from your medical enrollment election.*

Your FedEx Express Dental Plan provides you and your family with valuable help in paying for preventive dental care and care to treat dental problems. There is no dental coverage for you and your covered dependents if you opt out of FedEx Express dental coverage. You must be enrolled in dental coverage in order to receive benefits.

Cigna Dental is the claims paying administrator for the domestic-based dental plan under the Federal Express Corporation Group Health Plan for Pilots and Federal Express Corporation Retiree Group Health Plan for Pilots. Active and retired pilots, along with their covered family members residing in the United States will have access to Cigna's Dental PPO network. The dental benefits are self-funded meaning all claims are paid by FedEx.

Please call Cigna at 1.800.311.4725 or visit www.mycigna.com for any questions on the domestic-based dental plan.

Cigna Global Dental is the claims paying administrator for the international dental plan. Pilots on Foreign Duty Assignment (FDA) and their covered family members who live abroad or remain in the United States will have access to dental services from a local provider in their area of residence. The dental benefits are fully insured meaning all claims are paid by the insurance company.

Please call Cigna Global Dental at 1.800.441.2668 (global toll-free) or 302.797.3100 (global direct call, can call collect outside the United States) or visit www.CignaEnvoy.com for any questions on the international dental plan.

See the most current Pilot Enrollment Guide for an overview of the dental benefits. The enrollment guide is located under the Educate tab on https://fedexpilots.bswift.com.

Your Coverage

You must meet the annual dental deductible before benefits for most dental services are paid. After you or your covered dependent has met the separate dental deductible, the Plan pays a percentage of the cost of covered dental expenses. Participating providers have agreed to provide their services at a lower negotiated rate, which lowers your out-of-pocket cost.

Preventive dental care is covered at 100% and not subject to the annual deductible. Charges for eligible services are allowed only when deemed necessary for treatment of dental disease or injury. Cigna Dental and Cigna Global Dental determine medical necessity.

It is strongly recommended you obtain a predetermination of benefits before incurring significant dental expenses.

Coordination of Benefits (COB) When There Is Another Plan

If you are covered by more than one plan, your benefits under this Plan may be coordinated with the benefits of those other plans. The coordination provisions apply separately to each pilot and dependent, per calendar year.

Claim forms for reimbursement of dental treatment must be filed within one year from the date the dental expense is incurred.

Dental charges may be considered covered medical expenses if treatment begins within 90 days after an accident that injured a sound natural tooth. The accident must have occurred while you were covered under the Plan.

Dental Deductible

The dental deductible is the amount you pay toward the cost of covered care before your dental coverage begins to pay benefits. For most dental services, you must meet the annual deductible before benefits are paid. Each individual has a separate $50 deductible in the Dental Plan, but there is an overall maximum deductible amount of $100 per family in the Plan. Each covered individual cannot have more than the individual deductible amount count toward the maximum family deductible. Four preventive dental care checkups each year are not subject to the annual deductible.

Covered Health Care Providers

Eligible services must be provided by persons (other than the spouse or relative of the covered person) who are licensed practitioners of the healing arts acting within the scope of their licenses. This means that any dental health care provider who treats you and charges for these services must be licensed, certified, or registered as a health care provider in the state in which the service was performed.

Cigna Dental (PPO Network) for Domestic-Based Pilots

If you live in the United States, you and your covered family members will have access to Cigna’s Dental PPO network which consists of over 153,000 dentists and specialists. Participating providers have agreed to provide their services at a lower negotiated rate, which lowers your out-of-pocket cost.

You also have the option to use a non-network dentist; however, your out-of-pocket cost could be higher. When you use a non-network dentist, Cigna will apply the plan benefits and reimburse using Maximum Reimbursable Charge (MRC), based on Fair Health at the 90th percentile for all provider charges in the geographic area. The dentist may balance bill up to their usual fees. You will be responsible for the deductible, if applicable, coinsurance, and any amount that exceeds the MRC.

If you have any questions related to your dental benefits, a claim, or to locate a participating dentist, contact Cigna at 1.800.311.4725. You can also visit Cigna's website at www.mycigna.com. If you are not enrolled in the dental plan, visit www.cigna.com for general information.

Cigna Global Dental for FDA pilots

If you are on Foreign Duty Assignment, you and your covered family members who live abroad or remain in the United States will have access to dental services from a local provider in their area of residence. Dental providers participating in Cigna's network have agreed to provide their services at a lower negotiated rate, which lowers your out-of-pocket cost.

You also have the option to use a non-network dentist in the United States; however, your out-of-pocket cost could be higher. When you use a non-network dentist, Cigna Global Dental will apply the dental plan benefits and reimburse using the 80th percentile of the Maximum Reimbursable Charge (MRC), based on all provider charges in the geographic area. The dentist may balance bill up to their usual fees.

If you have any questions related to your dental benefits, a claim, or to locate a participating dentist, contact Cigna Global at 1.800.441.2668 (global toll-free) or 1.302.797.3100 (global direct dial or collect outside the United States). You can also visit Cigna Global's website at www.cignaenvoy.com.

Preventive Dental Care

This Plan is designed to encourage you to take care of your teeth on a regular basis. Preventive dental care is covered at 100% and not subject to the deductible. Preventive dental care includes:

Checkups, bitewing X-rays, and cleanings (four each year),
One fluoride treatment each year for dependents until age 19, and
One treatment every 36 months for Sealants until age 14.

Additional preventive dental care in the same calendar year is covered but is subject to the deductible.

Predetermination of Benefits

Predetermination of benefits is a process that allows you, your dentist, and Cigna Dental or Cigna Global Dental to review a proposed course of treatment and estimated fees before the dental work is done.

A predetermination of benefits is strongly recommended before services begin and expenses are incurred. A predetermination of benefits is valid for one year from the date issued and treatment must begin before the one-year period expires.

This process protects you and allows you and your dentist to be fully informed before the care is provided. It provides you with an estimate of the amount of benefits that will be paid and how much of the cost must be paid by you. Any difference between the amount of benefits, determined by Cigna, and the total charges is your responsibility. Once you have a clear understanding of the benefits payable under this plan, the choice of treatment may be made in an informed manner and is entirely between you and your dentist. Charges for eligible services are allowed only when deemed medically necessary and appropriate for treatment of dental disease or injuries. If total charges for a planned course of treatment exceed $200, it is strongly recommended that you obtain a predetermination of benefits before incurring significant dental expenses.

Predetermination of benefits is recommended for:

- Crowns
- Dental surgery
- Bridges
- Dentures
- Partials
- Periodontal treatment
- Orthodontic treatment
- Temporomandibular joint syndrome (TMJ) and skeletal disorders of the jaw

Predetermination does not guarantee that benefits will be paid. Actual benefits may differ from the estimated benefits, depending on:

- The actual services provided
- The amount of the deductible
- Whether the plan-year benefit maximum has been met
- Whether the patient is covered by more than one dental plan

Steps to Take to Obtain a Predetermination of Benefits

1. **Ask your health care/dental provider** to submit a written request for a predetermination of benefits. Your health care/dental provider should send a written request to Cigna that clearly indicates that it is a request for predetermination of benefits. The request should include a complete description of the proposed course of treatment, appropriate medical/dental codes, expected charges, and tax identification number of the service provider.
2. **Cigna reviews** the predetermination request for medical/dental necessity and determines eligibility of services and allowable fees that payment is based on.
3. **Check your mail.** A written response will be sent to your health care/dental provider and to you indicating whether services are considered eligible expenses or not and/or whether fees are within reasonable and customary limits.

Medical Necessity

All eligible expenses for treatment of an illness or injury must be medically necessary. Cigna Dental or Cigna Global Dental determines medical necessity.

Orthodontic Charges

The Orthodontic benefit pays at 50% after the annual deductible has been met. Orthodontic charges that result from orthodontia treatment are paid in quarterly installments. Twenty-five percent of the total cost (total case fee) is paid at initial placement (banding). The remaining 75% will be divided across the estimated months of treatment and is paid at 50% on a quarterly basis.

This payment method is used because the total charge made by the dentist represents services you have not yet received. Payments are subject to the Plan's annual deductible, annual maximum, and patient's eligibility.

Skeletal Disorders of the Jaw (Including TMJ)

Treatment of all skeletal disorders of the jaw, including myofascial conditions or temporomandibular joint syndrome (TMJ), often involves dental services such as crowning, bridgework, orthodontics, and appliances. The Plan—both medical and dental coverage—has specific guidelines and limits that are applicable when treating skeletal disorders of the jaw. These disorders may be determined as a functional condition, or dental in nature, rather than as an organic condition or medical in nature. Treatment may include appliances, physical therapy, and various diagnostic testing, which may result in limited or excluded dental benefits.

Therefore, it is important that you submit a predetermination of benefits from your health care provider(s) to Cigna before services begin and expenses are incurred. This will determine if any of these charges are covered under your dental or medical benefits.

Any outpatient TMJ surgery predetermination of benefits should be sent to Cigna. Inpatient TMJ claims should be preauthorized by Anthem. Cigna only covers non-surgical procedures for TMJ. For more information see the section titled—**What's Covered and Not Covered–Limits and Exclusions** in this book.

NOTE: There is no coverage for TMJ services under the international dental plan through Cigna Global Dental.

Alternate Benefit Rule

When two or more eligible services are separately suitable for the dental care of a specific condition, you can receive benefits only for the less costly service, assuming it would have produced the same satisfactory results (e.g., a tooth may be satisfactorily restored with a filling instead of a crown). Composite fillings on molar teeth will receive the alternative benefit of an amalgam filling; porcelain or porcelain fused to metal crown on a molar tooth will receive the alternative benefit of a full-cast crown. While the choice of treatment is ultimately yours and the benefits paid can be used toward the treatment you and your dentist choose, the Plan will not pay more than the reasonable and

customary amount allowed for the least costly treatment. The alternate benefit rule substitutions are based on Cigna's guidelines.

What's Covered and Not Covered – Limits and Exclusions

Limits

- Benefits for X-rays include:
  - Routine Bitewings – 4 per calendar year
  - Panoramic X-rays (covered at 100%) – once every three years; and
  - Full mouth X-rays (covered at 100%) – once every three years
  - Complete series of radiographic images and panoramic radiographic images (full mouth or panoramic) limited to a combined total of one every 36 months
- Oral evaluation – 4 per calendar year
- Cleanings – 4 per calendar year including periodontal maintenance procedures following active therapy
- Fluoride Application – 1 per calendar year for children under age 19
- Sealants per tooth limited to posterior tooth – 1 treatment per tooth every 36 months for children under age 14
- General anesthesia is considered an allowable expense when associated with oral surgery.
- Crowns (including replacement crowns) are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with filling material. The teeth cannot be abutments to a covered partial denture or fixed bridge.
- Charges for freestanding crowns are covered at 80%. Charges for crowns used in abutments to a fixed bridge are covered at 80%. The bridge is covered at 50%.
- Hospital charges for dental services are not covered as dental benefits. Some dental expenses excluded as dental benefits may be covered by your medical plan option. To be considered eligible under your medical plan option, the treatment or service must be medically necessary and coordinated through your medical plan option. In addition, predetermination of benefits is strongly recommended. See your specific medical plan option for coverage details.
- Eligible charges made by the dentist or oral surgeon for oral surgery or dental treatment while the patient is hospitalized are considered dental expenses.

Exclusions

Prescription drugs are not considered covered dental expenses but may be covered under the Prescription Drug Benefit. Health Plan Hawaii participants should check their plan booklet for coverage of prescription drugs prescribed by a dentist.

Other exclusions include:

- Drugs or medicines dispensed in a physician's office.
- Charges for local anesthesia billed separately.
- Charges for nutritional counseling.
- Replacement of dentures, partials or bridges if you have been covered by the Plan for less than six months or if the existing denture, partial, or bridge is less than 60 months.
- Crowns, bridges, dentures, and partials for treatment of temporomandibular joint syndrome (TMJ).
- Fluoride treatment after 19th birthday.
- Appliances, restorations, or procedures for the purpose of splinting or occlusion.
- Charges incurred before the effective date of your or your eligible dependent's coverage by the Plan.
- Unnecessary services or supplies.
- Expenses in excess of reasonable and customary charges.
- Injuries caused by a third party.
- Dental implants for accidents. Dental implants for certain conditions may qualify as an eligible expense under the medical plan.
- Testing or services that are educational or developmental in nature.
- Services from the dental or medical department of an employer, employee association, or similar organization.
- Charges that would not have been made if you were not covered by the Plan.
- Dental charges for which you furnish no proof of charges.
- Job-related injuries entitling you to benefits under any Workers' Compensation law.
- Charges incurred as a result of participation in a serious criminal act that the administrator determines, in its sole discretion, would be a felony.
- Services or supplies furnished by or covered as a benefit under a program of the U.S. government or its agencies.
- Charges incurred as a result of service in the armed forces of any country at war, whether declared or not, or any act or hazard of war, unless the covered pilot is an expatriate or on temporary assignment in a war area on Company business.
- Expenses for travel and lodging related to medical or dental treatment.
- Expenses incurred after termination of coverage date.
- Replacement of teeth that were extracted before you were covered under the Plan.
- Replacement of congenitally missing teeth.
- Claims filed more than one year after date of service.
- Diagnostic: cone beam imaging.
- Preventive Services: instruction for plaque control, oral hygiene, and diet.

Restorative Services: Veneers of porcelain or acrylic materials on crowns or pontics on, or replacing the upper and lower first, second, and/or third molars.

Periodontic: bite registrations; splinting.

Prosthodontic: precision or semi-precision attachments.

Procedures, appliances, or restorations, except full dentures, whose main purpose is to change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth or restore occlusion.

Athletic mouth guards.

Services performed primarily for cosmetic reasons.

Personalization.

Services that are deemed to be medical in nature.

Services and supplies received from a hospital.

Drugs: prescription drugs.

Charges in excess of the Maximum Reimbursable Charge (MRC).

Contracted providers are not obligated to provide discounts on non-covered services and may charge their usual fees.

Reimbursement, Subrogation, and Third-Party Liability – Administered by Vengroff Williams, Inc. for Dental Claims

If your illness or injury is caused by the actions of a third party, payment of your expenses and lost wages may be the responsibility of that third party. **This liability could result from events such as an automobile accident or injury at another place of business.** However, the Plans will initially pay your eligible expenses as long as you sign an agreement, as described below, requiring you to reimburse the Plans for benefits paid provided you meet all other provisions of the Plan. Therefore, if you receive payment from a third party, from any source of recovery, including but not limited to, liability or other insurance covering the third party, uninsured or underinsured motorist insurance, medical payment, or personal injury protection insurance and no-fault insurance, FedEx expects you to hold the payments in constructive trust for the benefit of the Plans and to fully reimburse the Plans from these funds in the amount of the related benefits paid from the Plans on your behalf. The Plan shall not have right of reimbursement from a policy, contract, or other arrangement for which the participant pays 100% of the cost of such coverage (except for a policy, contract, or other arrangement in a no-fault jurisdiction).

If the payment you receive from a third party, less your attorney's fees and other legal expenses (net recovery), is not enough to reimburse benefit payments at 100%, you must still reimburse the Plan 100% of what is left after paying your attorney's fees and other legal expenses.

FedEx shall have the first priority right of recovery from any amounts that you receive from any third party, regardless of whether these amounts were received by settlement or judgment, and regardless of whether you have been "made whole" by the amounts that you have received. The Plans' rights apply to any funds recovered from another

party by or on behalf of you, your covered dependents, or your estate. FedEx shall also have right to subrogation against the third party for recovery of benefits paid by the Plan.

You are required to sign an agreement acceptable to FedEx in which you agree to repay any money paid to you or to others on your behalf as Plan benefits. If you do not sign this agreement, all benefit payments from the Plans may be stopped, and if you do not honor this agreement, future benefit payments may be withheld until the entire amount due is reimbursed. In addition to withholding future benefits, FedEx may take any other legal action it deems appropriate, such as suing you for the full reimbursement amount. You are solely responsible for paying all legal expenses. The amount of the reimbursement is not reduced because of legal expenses you incur because you do not honor the agreement. Please read the agreement carefully and note that it applies to payments you have received or will receive, and to future benefit payments that will be made from the Plans related to the same illness or injury.

To obtain a Reimbursement/Subrogation Form, contact Vengroff Williams, Inc. at 1.800.813.4054.

Coordination of Benefits and Personal Injury

The Plan also coordinates with personal injury protection coverage in those states with no-fault auto insurance laws. Benefits under this plan are secondary to no-fault auto insurance coverage.

VISION BENEFITS: ACTIVE AND PRE-MEDICARE RETIRED PILOTS

IMPORTANT: *Participation in the Vision Plan requires an enrollment election separate from your medical and dental enrollment elections.*

Your FedEx Express vision coverage provides benefits for active and retired pilots and their covered dependents for vision examinations and eyewear. Davis Vision is the claims paying administrator for this benefit covered under the Federal Express Corporation Group Health Plan for Pilots and Federal Express Corporation Retiree Group Health Plan for Pilots. This benefit is designed to encourage you to have your vision checked regularly and to help you with vision care expenses. Vision care benefits are self-funded, meaning that all claims are paid by FedEx Express.

Note, even if you do not enroll in vision coverage, all eligible active and retired pilots and their covered eligible dependents are eligible to receive discounts provided under the Davis Vision Advantage Eye Care Program. This program is described later in this section.

Coverage

Davis Vision has contracted with licensed optometrists located throughout the country to provide high-quality, comprehensive vision care services at a reduced cost. You may use in-network or out-of-network eye care providers. However, when you use in-network providers for your eye care needs, the amount you pay out of your pocket may be less than if you use out-of-network providers.

Pilots residing in areas that do not have providers who have contracted with Davis Vision can still receive in-network benefits by following a few simple procedures. To be eligible for in-network benefits, you must call Davis Vision at 1.888.60FEDEX (1.888.603.3339) before scheduling an appointment.

In-Network Providers

Steps to Take When Using an In-Network Provider

1. **Call Davis Vision** at 1.888.60FEDEX (1.888.603.3339**)** or visit www.davisvision.com to locate an in-network provider in your area. There are no claim forms to complete.
2. **Contact the provider** of choice to schedule your appointment. Identify yourself as a FedEx Express pilot or a health-covered dependent and provide the pilot's Social Security number. The provider obtains authorization from Davis Vision.
3. **You will pay a small copayment** for eyewear.

Steps to Take to Receive In-Network Benefits in Areas Without In-Network Providers

1. **Call Davis Vision** at 1.888.60FEDEX (1.888.603.3339) before scheduling an appointment.
2. **Ask Davis Vision to locate a provider for you or** give Davis Vision the name and address of a provider of your choice.
3. **Davis Vision will contact you** with authorization.

Out-of-Network Providers

You may receive services from an out-of-network provider and file a claim for reimbursement. Claims must be submitted within one year of the date the charge was incurred.

Steps to Take When Using an Out-of-Network Provider

1. **Schedule an appointment** with the provider of your choice.
2. **Call Davis Vision** at 1.888.60FEDEX (1.888.603.3339) to request a claim form or visit the website at www.davisvision.com to download a form.
3. **You pay all costs** at time of services.
4. **Ask the provider to complete** all applicable areas on the claim form or submit a copy of the itemized receipt with the claim form.
5. **Submit the completed claim form** and itemized receipt within one year to the address on the form.

See the most current Pilot Enrollment Guide or Pre-65 Retiree Enrollment Guide for in-network and out-of-network benefits. The enrollment guides are located under the Educate tab on fedexpilots.bswift.com.

What's Not Covered

The Plan is designed to cover visual needs, not cosmetic materials or processes. These treatments, services, and supplies are not covered:

Medical or surgical treatment of eye disease or injury (see your health plan option for benefit information).

Visual therapy/orthoptics.

Special lens designs or coatings (unless specifically noted).

Replacement of lost or stolen lenses or frames, or repair of broken lenses or frames (except repair/replacement of broken or damaged eyewear covered by Davis Vision's one-year warranty on all Plan eyewear).

Contact lens insurance.

Contact lenses and spectacle lenses in the same calendar year.

Two pairs of eyeglasses instead of bifocals.

Services or materials covered under Workers' Compensation.

Services or materials otherwise payable under your health plan option. Check with your health plan option's claims paying administrator.

Eye examinations required as a condition of employment, such as FAA exam.

Nonprescription eyewear/lenses.

Services rendered in excess of those listed in the most current Pilot Enrollment Guide or Pre-65 Retiree Enrollment Guide.

Claims filed more than one year from date of service.

If You Have Questions or Need Assistance

Member service representatives are available to assist you between 8 a.m. and 11 p.m. ET, Monday through Friday; between 9 a.m. and 4 p.m. ET Saturday; and between 12 p.m. and 4 p.m. ET Sunday. Just call Davis Vision at 1.888.60FEDEX (1.888.603.3339) or visit the website at www.davisvision.com.

Advantage Eye Care Program

FedEx has made arrangements for all employees and dependents to purchase vision care services and eyewear at specially negotiated prices through the Advantage Eye Care Program. Pilots and eligible dependents do not have to be enrolled in vision coverage to utilize the Advantage Eye Care Program. However, dependents must be listed on Pilot Benefits Online at https://fedexpilots.bswift.com.

Pilots and dependents enrolled for vision coverage may also take advantage of the negotiated prices to purchase additional services, such as a second pair of eyeglasses or nonprescription sunglasses. These services must be received from an in-network provider.

How It Works

Call Davis Vision at 1.888.60FEDEX (1.888.603.3339) for authorization prior to making an appointment. You need to provide Davis Vision with the pilot's Social Security number and your covered dependent's date of birth. You must select the type of services you expect to need and make advance payment to Davis Vision by Visa, MasterCard, money order, or personal check.

See the most current Pilot Enrollment Guide or Pre-65 Retiree Enrollment Guide for a list of services available under the Advantage Eye Care Program and the costs. The enrollment guides are located under the Educate tab on https://fedexpilots.bswift.com.

DISABILITY BENEFITS

Your FedEx disability benefits provide important financial protection if an illness or injury prevents you from working. FedEx provides coverage through the Federal Express Corporation Long-Term Disability (LTD) Plan for Pilots. The Hartford Life and Accident Insurance Company (The Hartford) is the claims paying administrator and the appeals administrator.

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If your disability commencement date is prior to May 31, 1999, please refer to the 1998 Your Employee Benefits Book *and the 1999* Supplement to the Your Employee Benefits Book *for a description of your disability benefits.*

WORKERS' COMPENSATION

Workers' Compensation is a state-mandated benefit. If you are injured or become ill as a result of your job at FedEx, Workers' Compensation generally pays all related, reasonable, and necessary medical expenses. Workers' Compensation also helps to replace lost wages while you are unable to work. State laws, which vary significantly, govern the amount of benefits paid. Section 16 and Section 14.F. of the Collective Bargaining Agreement also contain related information.

Eligibility

You are covered by Workers' Compensation if you are a pilot.

Enrollment

Coverage is automatic.

When Coverage Begins

Your coverage begins on your first day of active work as a pilot.

Your Cost for Coverage

Workers' Compensation is provided at no cost to you; FedEx pays the full cost of this coverage.

A Look at the Benefits

For injuries and illnesses that result from your job, Workers' Compensation generally pays all related, reasonable, and necessary medical expenses. Workers' Compensation payments are made according to your state's benefit payment formula.

For Information to File a Claim

See the Claims and Appeals section.

You may be eligible for benefits under the LTD Plan. You are required to file a claim for LTD benefits within 60 days following exhaustion of your sick bank accounts. If you do not file a LTD claim for benefits, you may not be able to receive benefits from the LTD Plan.

Occupational Injury/Illness Bank

Per Section 14.F.1., if you sustain a workers' compensable injury, or illness covered by Section 16 of the Collective Bargaining Agreement, you are eligible for up to 168 credit hours of occupational injury/illness leave for each occupational injury or illness. All the injuries that result from a single accident are regarded as one injury for purposes of the 168 credit hours.

Here's how it works in a typical situation: If you incur an occupational injury or illness, you will first use your accrued regular and disability sick bank credit hours until your Workers' Compensation claim is approved; at that point your sick bank credit hours are reimbursed and deducted from your Workers' Compensation bank. You then draw from remaining credit hours in your Workers' Compensation bank until it is exhausted. If you are still unable to work, you use your accrued regular and disability sick bank, and have the option of drawing on your vacation bank before beginning to draw LTD benefits, if eligible. You will not begin to draw LTD (or start the clock on the LTD benefit period) until after you exhaust your Workers' Compensation and sick bank accounts.

LONG-TERM DISABILITY (LTD) PLAN FOR PILOTS

Eligibility

You are eligible to receive Long-Term Disability (LTD) benefits if:

- Your disability commencement date is on or after May 31, 1999, and
- You are a pilot who has completed 180 calendar days of cumulative active permanent full-time employment and your employment is covered by a collective bargaining agreement that specifically provides for your coverage under the LTD Plan.

You are not eligible to receive LTD benefits if:

- You are not covered by a collective bargaining agreement that specifically provides for your coverage under the LTD Plan.
- You are on an unpaid medical, personal, family (other than for your own illness/injury), unapproved disability, or other leave of absence.
- Your disability results from one of the plan exclusions listed in “LTD Exclusions.”

Enrollment

Enrollment in the Plan is automatic.

When Coverage and Benefits Begin

Once you have satisfied the eligibility requirements of the LTD Plan, you will be eligible for LTD benefits.

Your LTD benefit payments begin once you have exhausted your sick bank accounts and your claim is approved by The Hartford.

Your Cost for Coverage

LTD is provided at no cost to you. FedEx pays the full cost to provide the LTD Plan. Benefits are paid from a trust which is funded by the Company. Pilots working in certain states may be required to contribute to the state for statutory coverage. Contact the PAC or state disability program for details.

For Information to File a Claim

See the Claims and Appeals section. You are required to file a claim with The Hartford for LTD benefits within 60 days following exhaustion of your sick bank accounts. If you do not file a LTD claim for benefits, you will not be able to receive benefits from the LTD Plan.

A Look at the Benefits

If your disability commencement date is on or after October 30, 2006, the LTD Plan provides benefits for:

- **Occupational disability**—When you cannot do your job with FedEx because of physical or mental illness or substance abuse, which may also include loss of required licensing or medical certification to perform your job.

If your disability commencement is between May 31, 1999, and October 29, 2006, the LTD Plan provides benefits for two types of disabilities:

- **Occupational disability**—When you cannot do your job with FedEx because of physical or mental illness or substance abuse, which may also include loss of required licensing or medical certification to perform your job.
- **Total disability**—When, because of physical illness, you cannot engage in any compensable employment for 25 hours per week for which you are reasonably qualified or could reasonably become qualified on the basis of your ability, education, training, or experience.

Benefit Amount

LTD benefits provide 60% of your basic monthly compensation. Basic monthly compensation is calculated using the average of the 12 highest consecutive months in the last 36 months immediately preceding the disability commencement date. The disability commencement date is the first day you begin drawing from your sick bank accounts in conjunction with your disability.

Eligible basic monthly compensation includes:

- All credit hours, including but not limited to:
  - Draft
  - Volunteer
  - Trip make-up for which you receive pay
  - International Override
  - Passover Pay
  - Eligible Training
- Premiums for:
  - Flex Instructors/Proficiency Check Airmen (PCA)
  - Line Check Airmen (LCA)
  - Flex Flight Standards Check Airmen (SCA)
  - Flight Project Specialist (FPS)
  - Technical Advisor/Aircraft (TAA)
  - Passover Retro Pay
  - Flex Premium (FAA)
- Sick leave hours drawn from your sick bank accounts during illness, prior to your disability commencement date
- Vacation pay, excluding vacation buyback

Eligible basic monthly compensation includes pay prior to deductions (e.g., pre-tax health care, dependent care, and your contributions to the PRSP/401(k) Plan).

Exclusions from eligible basic monthly compensation include, but are not limited to:

- Domestic and International Per Diem
- Long-Term Disability payments
- PRSP Employer Matching contributions
- PRSP Employer Sick Bank contributions
- PMPPP contributions
- Excess Life Premiums (Imputed income for Life Insurance coverage)
- Earnings above the IRS compensation limit
- Reimbursed expenses
- Vacation buyback
- Bonuses, including the signing bonus paid in 2006, 2007, 2015, 2016, and 2017
- Overtime
- Incentive Pay

Maximum Monthly Benefit

This maximum monthly benefit amount is subject to the compensation limitation set forth in Internal Revenue Code Section 401(a)(17) (the "compensation limit") and will be indexed based on periodic adjustments to the compensation limit. Effective June 1, 2022 (first day of the plan year), the compensation limit is $305,000; therefore, until the next adjustment to the compensation limit, the maximum monthly benefit amount for disabilities is $15,250.

For example, if your basic monthly compensation (the average of the 12 highest consecutive months in the last 36 months preceding your disability commencement date) is $305,000 or more, your maximum monthly benefit would be $15,250 ($25,416.67 x 60% = $15,250).

Effective October 30, 2006, for pilots whose disability commenced on or after May 31, 1999, the maximum monthly benefit amount will be adjusted at the beginning of each plan year (June 1) as additional adjustments are made to the compensation limit. For pilots whose monthly benefit had been capped pursuant to the compensation limit in effect on their disability commencement date, their LTD benefit is adjusted to reflect the compensation limit each subsequent June 1. However, in the event the compensation limit is decreased, the compensation used to calculate the annual benefit will be the greater of (1) the highest compensation limit in effect prior to the decrease, or (2) the current compensation limit.

LTD benefit checks are paid monthly and are mailed to your home address as reflected in the personnel system unless you elect direct deposit for your LTD benefits. You are responsible for ensuring that changes to your home address are made in the personnel system. The Hartford will send all correspondence to the address listed in the personnel system. Please notify The Hartford and the PAC if your address changes during a period of disability.

Benefit Offset

LTD benefits are reduced by any amount you are entitled to receive from the following sources:

- Workers' Compensation or any similar law to the extent it represents compensation for lost wages
- State-mandated disability benefits (e.g., California, Puerto Rico, New Jersey, New York, and Rhode Island); Other FedEx plans that provide disability benefits
- Federal maritime law

- Social Security income for age (offset is 100% for disabilities commencing before October 30, 2006, and 70% for disabilities commencing on or after October 30, 2006)
- Social Security Disability Income (SSDI) (offset is 100% for disabilities commencing before October 30, 2006, and 70% for disabilities commencing on or after October 30, 2006)
- Amounts paid from other sources due to any injury while on active military reserve or National Guard duty
- No-fault automobile insurance for lost wages (in states where applicable)
- Other earned income from another employer or from self-employment; See “Offsets for Earned Income from Other Employer or Self-Employment” below.

You are responsible for applying for these other benefits. If you fail or refuse to apply for these other benefits within the time and manner required, The Hartford will offset these benefits as though you did apply for and receive them. Also, you are required to appeal any denials from these sources to the full extent permitted by law.

LTD benefits are not offset by any non-employer provided individual, supplemental disability policies.

For information on benefits when a disability is caused by a third party, refer to “Reimbursement Subrogation and Third Party Liability.”

How the Offset Works

If the total benefit from these sources is less than your LTD benefit payment, the LTD Plan pays the difference, up to 60% of your basic monthly compensation. In some cases, LTD benefits may not be payable because the income from these sources exceeds 60% of your basic monthly compensation.

Offsets for Earned Income From Other Employer or Self-Employment—An LTD reduction arising out of other employment or self-employment during the term of your disability will be applied to your benefit only after the disability payments plus the outside income you earn exceed your pre-disability income. For purposes of this provision, your pre-disability income is measured as the average earnings (Company + outside earned income) over the 12 months immediately preceding your disability.

For example, a pilot works programing software as a side business in addition to flying. He breaks his arm on July 1, 2022, and goes on LTD disability after his sick leave runs out on September 1, 2022. Between July 1, 2021, and July 1, 2022, the pilot made $100,000 as a FedEx pilot and $25,000 in his software business, for a monthly average total of $10,416.66. While on disability, the pilot continues to program software and makes $4,000 per month in addition to drawing a monthly disability benefit of $5,000 (for the first 24 months; $4,166 thereafter) from the Company. The $9,000 monthly average income is below the $10,416.66 he earned before his disability, so no offset is required. If, however, the pilot earned $7,000 per month in the software business, then his total monthly earnings ($12,000) would exceed his combined pre-disability monthly income ($10,416.66) by $1,583.34. Because the new combined income exceeds his pre-disability monthly income, the Plan requires a 50% reduction be applied. In this situation, a monthly disability reduction of 50% of the $1,583.34 (the amount which exceeds his pre-disability income), or $791.67 per month, would be required.

Social Security—The Hartford or its designee may ask you to apply for Social Security Disability Income (SSDI). If they ask, you are responsible for applying for this benefit and providing proof that you applied. If you do not provide this information, your disability benefits will be reduced by an estimated SSDI offset. For disabilities commencing prior to October 30,

2006, the offset for SSDI is 100% of the monthly SSDI benefit. For disabilities commencing on or after October 30, 2006, the offset for SSDI is 70% of the monthly SSDI benefit.

If The Hartford or its designee instructs you to do so, you are required to appeal any denial of benefits to the fullest extent permitted by law.

The Hartford provides Social Security Advocacy Assistance through Allsup, Inc. and this is a free service as long as you continue to receive disability benefits. If you decline the services of Allsup, Inc. and hire your own attorney, the attorney fees are your responsibility.

If you receive a retroactive SSDI award from the Social Security Administration, you are required to notify The Hartford immediately and to reimburse the LTD Plan for any overpaid amounts.

You are also required to notify The Hartford if you are receiving Social Security income payable because of your age.

Proof of Disability

You are considered disabled if a physical or mental illness or injury prevents you from doing your job. You or your health care professional must provide proof that you are disabled, based on significant objective findings such as:

- Medical examination findings
- Test results
- X-ray results
- Observation of anatomical, physiological, or psychological abnormalities

Pain, without significant objective findings, is not proof of disability.

You will be asked to submit proof of your continuing disability from time to time during your absence from work. If you fail to submit the information that The Hartford requests or fail to authorize release of information, your LTD benefit will not be approved. You must submit proof of disability even if you are not receiving a LTD benefit payment—for example, when you are receiving disability benefits from other sources (such as state-mandated disability, Workers' Compensation, or Social Security). By providing proof of disability, you may still be eligible for LTD benefits if your benefits from the other source(s) end.

You must remain under the care of a health care professional throughout your disability. A health care professional is a licensed practitioner of the healing arts who acts within the scope of his or her profession, as regulated by the state, and who is not related to you. The Hartford may request proof from your health care professional that you are still disabled. If your health care professional does not provide this information, The Hartford will ask for your help in obtaining the medical data. If you fail to submit the information The Hartford requests, or fail to authorize the release of information, your LTD benefits will be terminated. You are responsible for ensuring that you or your doctor provides information requested by The Hartford. If the information from your health care professional does not prove that you are disabled, The Hartford may ask you to submit to an independent medical exam ("IME") or functional capacity exam ("FCE") by a health care professional of The Hartford's choosing. The Hartford may also ask you to submit to a FAA exam. If you refuse the exam or fail to fully participate, your benefits will end.

A health care professional for The Hartford is involved in reviewing your medical information and The Hartford decides whether LTD benefits are approved.

Benefit Duration

If your claim has been approved, your LTD benefits begin once you have exhausted your sick bank accounts provided you meet all plan requirements. Your disability must be due to illness, disease, or injury.

If you have an occupational disability and all plan requirements are met, LTD payments will continue until the earlier of the end of your occupational disability, 24 months or the maximum benefit age. If your occupational disability exceeds 24 months or if you have experienced a seat change or returned to work in a non-pilot position (covered by the Collective Bargaining Agreement), please refer to “Supplementary Disability Benefit” on page “Disability Plan-13.”

If your disability commenced prior to October 30, 2006, and you have a total disability, provided you meet all plan requirements, LTD benefits continue until either the day you are no longer totally disabled or the later of the day you reach age 65 or the 5th anniversary of the date the disability benefit commenced.

Plan Limitation Due to Drug or Alcohol Abuse—If your disability commencement date is prior to 11/2/2015 and is due to chemical dependency (drug or alcohol abuse), LTD benefits are limited to one occurrence for a maximum of 13 consecutive weeks. Pilots seeking license recertification are allowed up to an additional 13 consecutive weeks, if approved by The Hartford upon recommendation of the Company’s aeromedical advisor. For more information, refer to the Drug & Alcohol Rehabilitation and Recertification Plan for Flight Crew Members located in Appendix H of your FedEx Flight Operations Manual, Section 15.C. of the Collective Bargaining Agreement, or call the PAC.

If your disability commencement date is on or after 11/2/2015 and is due to chemical dependency (drug or alcohol abuse), LTD benefits are limited to one occurrence for a maximum of 12 consecutive months. Pilots seeking license recertification are allowed up to an additional 6 consecutive months, if approved by The Hartford upon recommendation from the Company’s aeromedical advisor. For more information, refer to the Drug & Alcohol Rehabilitation and Recertification Plan for Flight Crew Members located in Appendix H of your FedEx Flight Operations Manual, Section 15.C. of the Collective Bargaining Agreement, or call the PAC.

You are not eligible for a second period of disability for chemical dependency (drug or alcohol abuse) and cannot resume LTD benefits if you recover and have a relapse.

Recurring Disability

If you recover from your period of disability and you have a relapse from the same or related cause(s) within 180 calendar days of returning to active permanent full-time work, you have a “recurring disability.”

If you have a recurring disability and The Hartford determines benefits are payable, your LTD benefits will resume and are considered one period of disability. Since LTD benefits resume, you will not receive additional sick bank pay.

You must contact The Hartford at 1.800.757.0207 to report a recurring disability within 60 days of a relapse.

New Disability

You are considered to have a “new disability” if you recover from your disability and then become disabled again:

- By different and unrelated cause(s) and you had returned to active permanent full-time

work for at least one full day; or

- By the same or related cause(s) and you had returned to active permanent full-time work for more than 180 calendar days.

If you have a new disability, you are eligible for additional sick bank pay and a new LTD period.

You must contact The Hartford at 1.800.757.0207 to report a new disability within 60 days following exhaustion of your sick bank accounts.

LTD Exclusions

LTD benefits are not paid for certain disabilities. You will not receive LTD benefits for any disability caused by:

- Injury or illness that occurs while you are on a personal, family (other than your own illness/injury), unapproved disability, or other leave of absence
- Cosmetic surgery, unless caused by an accidental injury that occurs while you are a pilot and for which treatment began within 90 days of the injury, or is surgery for reconstruction of either breast following a mastectomy
- Intentionally self-inflicted injuries, while sane or insane
- Reverse of sterilization procedure
- Certain medical fertility procedures as determined by The Hartford in accordance with its guidelines, including but not limited to:
  - Artificial insemination
  - In vitro fertilization
  - Gamete or zygote intrafallopian transfer
  - Similar procedures
- Radial keratotomy, or similar procedures—unless covered by the Federal Express Corporation Group Health Plan for Pilots
- Flying a prototype or test aircraft, unless in the course of employment at FedEx
- Flying in an aircraft for crop dusting, spraying, or seeding
- Service in the armed forces of any country while at war, declared or undeclared, or any act or hazard of war unless the covered employee is an expatriate or on temporary assignment in a war area on FedEx business
- Skydiving, hang gliding, or piloting a hot air balloon or lighter than air or ultralight aircraft
- Participation in a serious criminal act that the Plan Administrator determines, in its sole and exclusive discretion, would be a felony

You will not receive LTD benefits for:

- Any disability that occurs before your effective date of coverage and the date you complete the 180 calendar day waiting period
- Any illness or injury for which you did not exhaust your regular, disability, or occupational sick bank accounts

Denial of LTD Benefits

You will be denied LTD benefits if:

- You do not meet eligibility requirements
- You fail to provide or approve the release of requested medical information within the

time specified by The Hartford
- You fail to report your LTD claim to The Hartford within 60 days after exhaustion of your sick bank accounts or your return to seat change position, whichever is earlier
- You fail to report your recurring disability to The Hartford within 60 days following your relapse
- You or your treating provider fails to respond to The Hartford's requests for medical information
- The medical information provided does not initially support or continue to support the disability

When Benefits End

Your LTD benefits end when:

- You recover from your disability
- The medical information provided does not support disability
- You are no longer under the direct care and treatment of a health care professional
- Your employment ends (terminated, retirement, or death)
- You reach the end of 24 months of benefits under this Plan (See Supplementary Disability Benefit later in this section for more information)
- You reach age 65, for disabilities on or after October 30, 2006
- You reach age 60, for disabilities prior to October 30, 2006; however, for disabilities commencing prior to October 30, 2006, if you are deemed totally disabled, your benefit continues until you reach age 65. If your disability began at age 60 or older, and you are deemed to be totally disabled, disability benefits end after 5 years
- For disabilities commencing on or after November 2, 2015, you reach the end of 12 months of benefits for alcohol and substance abuse; For pilots seeking recertification, benefits continue for up to 6 additional months
- For disabilities commencing prior to November 2, 2015, you reach the end of 13 consecutive weeks of benefits for alcohol and substance abuse; For pilots seeking recertification, benefits continue for up to 13 additional consecutive weeks
- You fail to provide or approve the release of requested medical information within the time specified by The Hartford
- You refuse or don't participate fully in an independent medical exam, functional capacity exam, or FAA exam requested by The Hartford
- You fail to follow the treatment prescribed to improve your condition to maximum medical improvement
- You return to work for FedEx in a permanent position
- You return to a seat change or non-crew member position
- You fail to seek restoration of required FAA license or certification to return to work or fail to do anything requested by The Hartford in coordination with the Aeromedical Advisor
- The LTD Plan is discontinued pursuant to the terms of the Collective Bargaining Agreement or any successor collective bargaining agreement
- The day you are placed on an unpaid furlough

When Coverage Ends

Your LTD coverage ends when:

- The day your employment as a FedEx pilot ends
- The day your employment is suspended (if employment is later reinstated, a claim for LTD benefits may be made)
- The day you cease to meet the definition of an eligible pilot
- The day FedEx discontinues the LTD Plan pursuant to the terms of the Collective Bargaining Agreement or any successor collective bargaining agreement
- The day the Collective Bargaining Agreement or a successor collective bargaining agreement no longer provides for coverage under this Plan

Taxes

LTD benefits are subject to federal income tax and state tax, if applicable. These taxes are automatically withheld from your payment by The Hartford. FICA will be withheld during the first six months you are disabled (from the first day of sick bank usage), as required by law. Taxes are automatically withheld from your payment as a single person who claims no withholding allowances until you file a W-4 with The Hartford. The Hartford deducts any mandatory withholdings and issues a W-2 form directly to you.

Other Deductions

Voluntary deductions, such as those for the Credit Association, Pilots' Retirement Savings Plan, Group Health, Group Life, Group Legal Services Plan, Group Long-Term Care Insurance, and other voluntary benefits are not withheld from LTD benefits.

For information on how a disability leave of absence affects your health, life, and other benefits, refer to "Coverage During a Paid Leave of Absence (Disability or Workers' Compensation)", in the What To Do When section of this book.

LTD benefits are paid from a trust fund and generally not subject to garnishment, attachment, or tax levy. LTD benefits are not assignable or transferable in any way.

Overpayments

If you are overpaid by the LTD Plan, you are responsible for reimbursing the LTD Plan—regardless of why you are overpaid. If you are notified that an overpayment has been made, you must immediately reimburse the LTD Plan for the amount of the overpayment. If you do not, the LTD Plan has the right to withhold the amount of the overpayment from future LTD benefits and/or earnings. The Plan Administrator has the right to bring legal action against you if you have been notified of the overpayment and have failed to reimburse the LTD Plan.

If the overpayment is due to a systemic error, the overpayment will be recovered in accordance with the terms outlined in the Agreement between the Company and ALPA concerning the Overpayment Recovery process dated February 7, 2013, as described in Appendix A of the Plan.

Reimbursement/Subrogation and Third Party Liability

If your illness or injury is caused by the actions of a third party, payment of your expenses and lost wages may be the responsibility of that third party. This liability could result from events such as an automobile accident or injury at another place of business. However, the Plan will initially pay your disability benefits as long as you sign an agreement, as described below, requiring you to reimburse the Plan for benefits paid provided you meet all other provisions of the Plan. Therefore, if you receive payment from a third party from any source of recovery,

including but not limited to liability or other insurance covering a third party, uninsured or underinsured motorist insurance, personal injury protection insurance, and no-fault insurance, FedEx expects you to hold the payments in constructive trust for the benefit of the Plan and to fully reimburse the Plan from these funds in the amount of the related benefits paid from the Plan on your behalf. The Plan does not have right of reimbursement from a policy, contract, or other arrangement for which the participant pays 100% of the cost of such coverage (except for a policy, contract, or other arrangement in a no-fault jurisdiction). If the payment you receive from the third party, less your attorney's fees and other legal expenses (net recovery), is not enough to reimburse benefit payments at 100%, you must still reimburse the Plan 100% of what is left after paying your attorney's fees and other legal expenses.

The Plan has the first priority right of recovery from any amounts that you receive from any third party, regardless of whether these amounts were received by settlement or judgment, and regardless of whether you have been "made whole" by the amounts that you have received. The Plan's rights apply to any funds recovered from another party by or on behalf of you or your estate. FedEx also has the right to subrogation against the third party for recovery of benefits paid by the Plan.

You are required to sign an agreement acceptable to FedEx in which you agree to repay any money paid to you as plan benefits. If you do not sign this agreement, all benefit payments from the LTD Plan may be stopped. And if you do not honor this agreement, future benefit payments may be withheld until the entire amount due is reimbursed. In addition to withholding future benefits, FedEx may take any other legal action it deems appropriate, such as suing you for the full reimbursement amount. You are solely responsible for paying all legal expenses. The amount of the reimbursement is not reduced because of legal expenses you incur because you do not honor the agreement. Please read the agreement carefully and note that it applies to payments you have received or will receive and to future benefit payments that will be made from the Plan related to the same illness or injury.

To obtain a Reimbursement/Subrogation Form, contact Vengroff Williams Associates at 1.800.813.4054 or access Pilot Benefits Online at https://fedexpilots.bswift.com.

SUPPLEMENTARY DISABILITY BENEFIT

This coverage provides a benefit extension for occupational disabilities for pilots under and subject to the provisions of the LTD Plan. All provisions of the LTD Plan apply to the Supplementary Disability Benefit unless otherwise specifically stated in this section.

Eligibility

You are eligible for this benefit under the LTD Plan if:

- Your disability commencement date is on or after May 31, 1999,
- You are eligible for LTD benefits,
- You are a pilot who has completed 180 calendar days of cumulative active permanent full-time employment and your employment is covered by a collective bargaining agreement that specifically provides for your coverage under the LTD Plan,
- You are a pilot or you have transferred to a non-pilot position within FedEx and your employment is covered by a collective bargaining agreement that specifically provides for your coverage under the LTD Plan.

A Look at the Benefits

The Supplementary Disability Benefit provision of the LTD Plan (subject to plan limits and plan exclusions):

- Extends LTD benefits for occupational disabilities due to a physical impairment to age 60 for disabilities beginning before October 30, 2006,
- Extends LTD benefits for occupational disabilities due to a physical impairment to the later of age 65 or the fifth anniversary of a pilot's LTD date (provided FedEx still employs Second Officers) for disabilities beginning on or after October 30, 2006,
- Extends LTD benefits for 36 months only for occupational disabilities due to a mental impairment, and,
- Provides partial wage replacement resulting from a medically required seat change or movement to a non-pilot position with FedEx (covered by the Collective Bargaining Agreement) caused by the loss of your medical rating and airman certificate to age 60 for disabilities beginning before October 30, 2006, and to the later of age 65 or the fifth anniversary of a pilot's LTD date (provided FedEx still employs Second Officers) for disabilities beginning on or after October 30, 2006.

Benefit Amount

Supplementary Disability benefits provide 50% of your basic monthly compensation. Basic monthly compensation is calculated using the average of the 12 highest consecutive months in the last 36 months immediately preceding the disability commencement date. The disability commencement date is the first sick day you begin drawing from your sick bank accounts in conjunction with your disability.

For Disabilities Commencing On or After October 30, 2006

Your LTD benefits end the day you attain age 65.

Maximum Monthly Benefit

The maximum monthly benefit amount is subject to the compensation limitation set forth in Internal Revenue Code Section 401(a) (17) (the "compensation limit") and will be indexed based on periodic adjustments to the compensation limit. Effective June 1, 2022 (first day of the plan year), the compensation limit is $305,000; therefore, until the next adjustment to the compensation limit, the maximum monthly benefit amount is $$12,708.33.

For example, if your basic monthly compensation (the average of the 12 highest consecutive months in the last 36 months preceding your disability commencement date) is $305,000 or more, your monthly benefit would be $12,708.33 ($25,416.67 x 50% = $12,708.33).

Effective October 30, 2006, for pilots whose disability commenced on or after May 31, 1999, the maximum monthly benefit amount will be adjusted at the beginning of each plan year (June 1) as additional adjustments are made to the compensation limit. For pilots whose monthly benefit had been capped by the compensation limit in effect on their disability commencement date, their LTD benefit is adjusted to reflect the compensation limit each subsequent June 1. However, in the event the compensation limit is decreased, the compensation used to calculate the annual benefit will be the greater of (1) the highest compensation limit in effect prior to the decrease, or (2) the current compensation limit.

LTD benefit checks are paid monthly and are mailed to your home address as reflected in the personnel system unless you elect direct deposit for your LTD benefits. You are responsible for ensuring that changes to your home address are made in the personnel system. The Hartford will send all correspondence to the address listed in the personnel system. Please notify The Hartford and the PAC if your address changes during a period of disability.

Proof of Disability

Refer to “Disability Plan” for detailed information regarding Proof of Disability.

When Benefits End

Your benefits end when:

- You reach age 60 for disabilities commencing prior to October 30, 2006
- You reach age 65 for disabilities commencing on or after October 30, 2006
- You reach age 65 if your disability commenced prior to October 30, 2006 and were deemed to have a Total Disability
- You recover from your disability or are reinstated in the pilot position you occupied before the seat change or non-pilot position (covered by the Collective Bargaining Agreement)
- The medical information provided does not support disability
- You are no longer under the direct care and treatment of a health care professional
- Your employment ends (termination, retirement, or death)
- You reach the end of the 36 months of supplementary disability benefits for a mental impairment (mental or nervous condition)
- You fail to provide or approve the release of requested medical information within the time specified by the Claims Paying Administrator
- The LTD Plan is discontinued pursuant to the terms of the Collective Bargaining Agreement or any successor collective bargaining agreement
- You refuse or don’t participate fully in an independent medical exam, functional capacity exam, or FAA exam requested by The Hartford
- You fail to follow the treatment prescribed to improve your condition to maximum medical improvement
- You fail to seek restoration of the required FAA license or certification to return to work or fail to do anything requested by The Hartford
- The day you are placed on an unpaid furlough

When Coverage Ends

Your coverage ends on any of the following:

- The day you reach age 60 for disabilities commencing prior to October 30, 2006
- The day you reach age 65 for disabilities commencing on or after October 30, 2006
- The day you reach age 65 for disabilities commencing prior to October 30, 2006 if you were deemed by the Claims Paying Administrator to have a Total Disability
- The day your employment ends, including termination, retirement, or death
- The day your employment is suspended (if employment is later reinstated, a claim for LTD benefits may be made)

- The day you cease to meet the definition of an eligible pilot
- The day FedEx discontinues the LTD Plan, pursuant to the terms of the Collective Bargaining Agreement or any successor collective bargaining agreement
- The day the Collective Bargaining Agreement or a successor collective bargaining agreement no longer provides for coverage under this Plan

ACCOUNTS

To help you pay out of pocket costs for eligible health and dependent care expenses, you have access to various accounts. These accounts are subject to different rules, deadlines and eligibility, due to government regulations.

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General Information

This section provides information about the Health Savings Account (HSA), Health Reimbursement Account (HRA), the Flexible Spending Accounts (FSA), and the Pre-Medicare Retiree HRA (collectively, the Accounts).

HealthEquity administers all of the Accounts described in this section and provides the following:

- The HealthEquity website – To register and access the site, go to https://www.healthequity.com
- HealthEquity Member Services, which is available 24/7/365. To reach Member Services, call 1.844.281.0925
- A free mobile app available for both iOS and Android devices
- Easy-to-use Documentation Library that allows you to upload and store receipts within the member portal

Health Savings Account (HSA)

The HSA is a tax-advantaged savings account that you can only establish with a qualified HSA trustee or custodian. The HSA is used in conjunction with a High Deductible Health Plan (HDHP) to pay expenses not covered by the HDHP such as deductibles and coinsurance. The CDHP Purple HSA and CDHP Orange HSA medical options under the Federal Express Corporation Group Health Plan for Pilots (Plan) qualify as a High Deductible Health Plan. If you meet the HSA eligibility requirements, you and FedEx can contribute money to your HSA.

HealthEquity, an IRS-approved non-bank custodian, administers the HSA, and following your initial enrollment, you will receive a welcome letter at your home with more information including how to set up and use the account and how to use your debit card to pay for eligible health care expenses.

Who Is Eligible to Participate in an HSA

The IRS has strict guidelines for who is eligible to open and contribute to the HSA. Per IRS regulations, you must be enrolled in a qualified HDHP and meet the following requirements:

- You cannot have other health coverage, other than what is permitted under "Other health coverage" as outlined in IRS Publication 969.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on another person's federal tax return.

Electing an HSA option may result in adverse tax consequences

Federal tax law and IRS rules restrict the type of health benefit coverage you may have if you or your employer is making contributions to an HSA on your behalf. You must not elect the CDHP Purple or CDHP Orange HSA option if you will have health benefit coverage that is not permitted under the HSA contribution rules while enrolled in the plan. The Company can verify only that your Company-provided health benefit coverage is permitted coverage. The Company is not responsible for adverse tax consequences that may result, if you have health benefit coverage from other sources that is not permitted under the HSA contribution rules.

Consult your tax advisor if you have questions about whether health benefits provided by sources other than the Company are permitted under the HSA contribution rules.

NOTE: You are not eligible to participate in the HSA if your spouse participates in a full purpose Health FSA through your spouse's employer.

If you are or become ineligible to make contributions to or receive contributions from an HSA, you can still use the funds accumulated in your HSA.

Participating in an HSA is a voluntary choice.

When You Can Enroll

New Hire Enrollment—If you are a new hire pilot, you must enroll by the deadline indicated in your new hire letter provided during new hire orientation. The effective date of coverage under the CDHP is your date of hire.

Annual Benefits Enrollment—You can enroll during the Annual Benefits Enrollment period by going to Pilot Benefits Online at https://fedexpilots.bswift.com. If you make your election by the Annual Benefits Enrollment deadline, benefits become effective on January 1 of the following year. If you fail to make your election by the Annual Benefits Enrollment deadline, you cannot enroll until the next Annual Benefits Enrollment, unless you have a Change in Family Status Event and make your election within 31 days following the event.

See the most recent Pilot Enrollment Guide for more information. The guide is located on the Pilot Benefits Online at https://fedexpilots.bswift.com and on your Company-issued iPad under the secure content locker.

Establishing Your HSA

HSA contributions for eligible Pilots are made by direct deposit to HealthEquity only. HealthEquity is an authorized HSA custodian. You will be provided with the information necessary to establish an HSA at HealthEquity. You will be required to complete the Custodial Agreement before you can receive Company contributions in your HSA.

Contributions

When you enroll in a CDHP and elect an HSA, the Company will make bi-monthly contributions to your HSA (1/24th of the annual contribution). You can also contribute as long as the total contributions made by you and the Company do not exceed the maximum IRS limits. If you are age 55 or older, you can make an additional catch-up contribution. Contributions are made from your paycheck on a before-tax basis, and the money will not be taxed when used for eligible health care expenses.

	Pilot Only Coverage		**Pilot Plus Coverage**	
	CDHP Purple HSA	CDHP Orange HSA	CDHP Purple HSA	CDHP Orange HSA
Company Contributions	$2,000 annually = $83.33 bi-monthly	$1,200 annually = $50 bi-monthly	$4,000 annually = $166.67 bi-monthly	$2,400 annually = $100 bi-monthly
Wellness Reward	$300	$300	$600 (pilot +spouse)	$600 (pilot +spouse)
Your Contribution	You may contribute up to the annual IRS limit less Company Contributions and Wellness Rewards*	You may contribute up to the annual IRS limit less Company Contributions and Wellness Rewards*	You may contribute up to the annual IRS limit less Company Contributions and Wellness Rewards	You may contribute up to the annual IRS limit less Company Contributions and Wellness Rewards
IRS limit Total contributions made by the Company and you cannot exceed the maximum IRS limits.	The IRS limit is updated annually. See the most recent Pilot Enrollment Guide for the current limit			
Catch-up contribution amount if age 55 or older by the end of the year	$1,000		$1,000	

*The amount shown assumes you earned the full wellness reward. If not, you would be able to make additional contributions to your HSA equal to the amount of the wellness reward not earned.

When you make your New Hire or Annual Benefits Enrollment election you may elect to make pre-tax contributions to your HSA. You can elect, drop, increase or decrease your HSA contribution amount anytime during the year. The HSA pre-tax contribution election carries forward each year.

Log on to Pilot Benefits Online to make or change pre-tax contributions to your HSA.

How the HSA works

- You can use money in your account to pay for eligible health care expenses for you, your spouse, and dependents you claim on your federal tax return. Distributions from your HSA will be tax-free if they are for eligible health care expenses. You can use money in your account to pay for eligible health care expenses by using your HSA debit card at the time of service, at the pharmacy, or to pay a bill from a provider. You can also reimburse yourself for payments you have made (up to the available balance in the account).

- Money in your HSA rolls over at the end of each year to cover future health care expenses.
- Your HSA can be invested in select funds once your balance reaches the minimum threshold of $1,000, providing you with another savings vehicle for future qualified medical expenses. For example, if your account balance is $1,500 you can invest $500 if desired. If your HSA cash balance falls below the minimum investment threshold of $1,000, there are no consequences to the investments. It simply means you will not be allowed to invest any more money until your balance exceeds the investment threshold again. The investment balance is separate from the HSA cash balance. Investment earnings made on your account are tax-free.
- The account is yours. If you change plan options, you still have access to funds in your HSA, even if you are not eligible to contribute. If you leave or retire from the Company, the account goes with you. Upon retirement or when you leave the Company, you will be responsible for monthly administrative fees associated with the HSA.
- The HSA can be paired with a Limited Purpose Health Care FSA for additional tax savings. For a list of eligible expenses, see IRS Publication 502.
- If you invest the money in your HSA, you are responsible for paying the investment related fees associated with your account.

NOTE: If you spend your HSA funds for non-medical reasons, such distributions must be included in your taxable income and generally will be subject to an additional 20% excise tax. Also note that although your adult child may be covered under the Federal Express Corporation Group Health Plan for Pilots up to the age of 26, only expenses of an adult child who qualifies as a tax dependent may be reimbursed by an HSA.

The HSA is available for Pilots enrolled in the CDHP Purple HSA or the CDHP Orange HSA medical option under the health plan. Some state's tax laws do not conform to federal HSA tax rules. Please consult with your tax advisor for complete information on the taxation of HSAs in your state.

If you are enrolled in the CDHP Purple HSA or the CDHP Orange HSA medical option and move to a Foreign Duty Assignment or Hawaii during the plan year, you will be moved to the appropriate medical plan and no further HSA contributions will be made. Even though you are no longer eligible to make or receive contributions to your HSA for one of the reasons noted above, you can still use the funds accumulated in your HSA.

See IRS Publication 969 for additional details on the HSA.

Before you elect to participate in the HSA, be sure to consult your financial or tax advisor to determine if the HSA is appropriate for your situation.

Leave of Absence, Termination, Retirement or Death

See the "What to Do When" Section for what happens to your HSA during a Leave of Absence or following Termination, Retirement, or Death

Health Reimbursement Account (HRA)

If you enroll in the CDHP Purple HRA or CDHP Orange HRA plan option, an HRA account will be established for you. The Company will credit the HRA with a certain amount to help cover the costs of your deductible, coinsurance, and eligible health care expenses. You cannot contribute to the HRA.

HealthEquity is the administrator of the HRA and following your initial enrollment, you will receive a welcome letter at your home with more information, including how to use the account. There is no debit card associated with the HRA and substantiation is required. Visit https://www.healthequity.com.

Who Is Eligible to Enroll

The CDHP Purple HRA and CDHP Orange HRA medical options are available to all pilots, regardless of other health benefit coverage, or if you are ineligible for an HSA.

If you elect coverage under one of the CDHP medical options with an HRA, an HRA account will be established for you. HRA credits can be used only by the covered pilot or dependent enrolled in one of the CDHP medical options with an HRA.

When You Can Enroll

New Hire Enrollment—If you are a new hire pilot, you must enroll by the deadline indicated in your new hire letter provided during new hire orientation. The effective date of coverage is your date of hire.

Annual Benefits Enrollment—You can enroll during the Annual Benefits Enrollment period by going to Pilot Benefits Online at https://fedexpilots.bswift.com.

If you fail to make your election by the Annual Benefits Enrollment deadline, you cannot enroll until the next Annual Benefits Enrollment unless you have a Change in Family Status Event and make your election within 31 days following the event.

See the most recent Pilot Enrollment Guide for more information. The guide is located on the Pilot Benefits Online website at https://fedexpilots.bswift.com and on your Company issued iPad under the secure content locker.

Credits

If you elect the CDHP Purple HRA or CDHP Orange HRA, the Company will credit your HRA account with a specified amount monthly (1/12th of the annual contribution).

	Pilot Only Coverage		Pilot Plus Coverage	
	CDHP Purple HRA	CDHP Orange HRA	CDHP Purple HRA	CDHP Orange HRA
Company Credit	$2,000 annually = $166.67 monthly	$1,200 annually = $100 monthly	$4,000 annually = $333.33 -monthly	$2,400 annually = $200 monthly
Wellness Reward	$300	$300	$600 (pilot+spouse)	$600 (pilot+spouse)

How the HRA works

- You can use your HRA to pay for eligible health care expenses for you, your spouse, and dependents enrolled in the CDHP HRA option.
- The Company credits a specified amount to your account monthly. You cannot contribute to the HRA.
- There is no investment feature with the HRA; however, your HRA balance is credited with 4% interest annually. The interest is applied to the HRA within the first 7 to 10 days each month and is based on your account balance on the last day of the prior month.
- Substantiation is required for all eligible expenses. You will be required to submit an itemized invoice, Explanation of Benefits (EOB), or other approved documentation to HealthEquity.
- You have until December 31 to incur eligible charges and until March 31 of the next year to file for reimbursement of those eligible charges. This is called the run-out period.
- Following the end of the run-out period (March 31), credits in your HRA will roll over into the next year's HRA account. See "Rollover of Health Reimbursement Account (HRA) Credits" for more information.

  If you change plan options, Company credits will stop. Your HRA balance will be converted to a Post-Deductible HRA. See "Post-Deductible HRA" for more information. The remaining balance will be available for eligible health care expenses after the IRS deductible is met.
- If you are enrolled in the CDHP Purple HRA or the CDHP Orange HRA medical option and move to a Foreign Duty Assignment or Hawaii during the plan year, you will be moved to the appropriate medical plan and no further HRA credits will be made. Even though you are no longer eligible to receive credits to your HRA for one of the reasons noted above, you can still use the credits accumulated in your HRA.

See IRS Publication 969 for additional details on the HRA.

Post-Deductible HRA

If you are currently enrolled in one of the CDHP HRA medical options and you do not plan to re-enroll in an HRA medical option in the next calendar year, any balance remaining in your HRA on December 31 will be automatically converted to a Post-Deductible HRA.

- You have a 90-day run-out period to file claims on any remaining balance in your HRA before the account is converted to a Post-Deductible HRA. You can file claims for dates of service January 1 through December 31 during the run-out (filing) period. Once the filing period ends on March 31, any remaining balance in your HRA will be converted to a Post-Deductible HRA and can be used for future eligible health care expenses.
- Your Post-Deductible HRA can be used to reimburse any eligible medical, dental, and/or vision expenses. This account can be used for eligible dental and vision expenses at any time. However, you must meet the IRS annual deductible for the HDHP before the Post-Deductible HRA can be used to reimburse any eligible medical expenses. Once you meet this deductible, you can file for reimbursement of eligible medical expenses from your Post-Deductible HRA. The IRS annual deductible will be monitored by HealthEquity to determine when you can use your account to pay for eligible medical expenses.
- Your Post-Deductible HRA also can be used in conjunction with other health care coverage or even if you decline health care coverage altogether. If your medical, prescription, dental and/or vision expenses are processed by another vendor other than

your current plan administrators, you must submit your eligible expenses to HealthEquity for reimbursement.

Rollover of HRA credits

Health care expenses incurred from January 1 through December 31 must be filed with HealthEquity by March 31 of the next calendar year. The balance in your HRA rolls over each year to cover future qualified health care expenses.

If you are currently enrolled in one of the CDHP HRA medical options and you plan to re-enroll in an HRA medical option in the next calendar year, you will start the new year with two HRAs at HealthEquity:

- one account will contain any remaining credits from the prior year.
- a second new account will be created for the new plan year credits and expenses.

This is necessary to allow you to continue to file any eligible health care expenses against your prior HRA through March 31 of the next year. Once the filing period ends on March 31, the remaining balance in your prior HRA will be added to your current HRA and can be used for future health care expenses.

Eligible health care expenses incurred in the current year must be filed against the current year HRA balance.

Accessing your HRA at HealthEquity:

- To register and access the HealthEquity website, go to https://www.healthequity.com.
- HealthEquity Member Services is available 24/7/365. To reach Member Services, call 1.844.281.0925.

Claims and Payments

You can request reimbursement or payment of your eligible HRA expenses through your selected method:

- You can submit eligible health care expenses for reimbursement through the HealthEquity member portal, the HealthEquity mobile app or by submitting a Reimbursement claim form. You must provide your detailed receipt to verify your reimbursement.
- You can also request payment directly to your provider through the HealthEquity member portal. You must attach proof of service to your provider payment request. **NOTE:** Not all providers can be paid through the “Pay Doctor/Provider” option.
- Regardless of the method you choose, you must save your detailed receipts for your records.

Proof of Services and Detailed Receipts

You will be required to submit an itemized invoice, Explanation of Benefits (EOB), or other approved documentation to HealthEquity.

All receipts or documentation must include the following information:

- Provider's name
- Service date(s)
- Patient's name (name of the person who incurred the service or expense)
- Description of service or expense
- Amount of patient responsibility

Helpful tip for submitting documentation: Use your EOB, especially if your insurance paid a portion of the expense.

EOBs contain all the required information and are excellent sources of documentation. Credit card receipts and cancelled checks are not acceptable proof of services.

Keep a copy of all documentation for your records.

Always save your itemized receipts and supporting documentation. HealthEquity offers an easy-to-use Documentation Library that allows you to upload and store receipts within the member portal.

Leave of Absence or Unpaid Suspension

If you go on a Paid Leave of Absence, Unpaid Leave of Absence, Military Leave of Absence, or are on unpaid Suspension, refer to the "What to Do When Section" for more information.

Termination, Retirement, or Death

If you terminate, retire, or die as an active pilot:

- The Company will no longer apply credits to your HRA.
- Your account will convert to an HRA Spend Down and the remaining balance will be available for future use. The account continues to earn 4% interest annually.
- You have a 90-day run-out period to file claims on any remaining balance in your HRA before the account is converted to an HRA Spend Down. You can file claims for dates of service up through your termination, retirement, or date of death during the run-out period.
  - When you die, the remaining balance in your HRA is available for use by your eligible spouse and eligible tax dependents under age 26 as long as they remain enrolled in the CDHP HRA.
  - If you die following retirement, any remaining balance in your HRA Spend Down is eligible for use by your eligible spouse and eligible tax dependents under age 26. If there is no spouse, the HRA Spend-Down Account is forfeited.
- The HRA Spend Down does not have a run out period for filing claims.
- If you do not have a spouse at the time of your death or your spouse dies, the HRA account does not transfer to a tax dependent. The account will be closed and the remaining balance forfeited.

Wellness Credits

If you are enrolled in the CDHP Purple or CDHP Orange options, an additional amount will be credited to your HSA or HRA if you qualify for the wellness reward.

Flexible Spending Accounts (FSA)

Flexible Spending Accounts allow you to pay out-of-pocket eligible health and dependent care expenses with before tax dollars. By contributing to an FSA, you pay less in taxes because your taxable income is lower.

HealthEquity is the administrator of the FSAs, and following your initial enrollment, you will receive a welcome letter at your home with more information, including how to use the account.

Three types of FSAs are explained in this section:

- Dependent Care FSA
- Full Purpose Health Care FSA
- Limited Purpose Health Care FSA

Participation in the Dependent Care FSA and Health Care FSA requires an annual election. You must re-enroll each year as your election cannot be defaulted from one year to the next.

Eligible Expenses

As defined by the IRS, the following expenses are eligible for reimbursement from the:

- **Dependent Care FSA**

  Expenses of dependents who are defined as:
  - Children who are under age 13 for whom you can claim an exemption on your federal income tax return,
  - Spouse who is mentally or physically incapable of self-care, and
  - Your dependent who is physically or mentally incapable of self-care and for whom you can claim an exemption.

  Dependent care eligible expenses are those which allow you and your spouse, if married, to work, look for work, or attend school full-time for at least five months of the year.
- **Full Purpose Health Care FSA**
  - Amounts paid for the diagnosis, cure, mitigation, or treatment of a disease, and for treatments affecting any part of the function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.
- **Limited Purpose Health Care FSA**
  - Dental and vision expenses before you meet the annual deductible and for eligible medical expenses after you meet the annual IRS deductible. If you elect CDHP Purple HSA or CDHP Orange HSA medical options and you enroll in the Health Care FSA, your FSA will be a Limited Purpose FSA.

For a list of eligible expenses, see **IRS Publication 502 for Health Care, IRS Publication 503 for Dependent Care and IRS Publication 969 for more information on FSAs**.

How your FSA is affected when on leave of absence

If you go on a leave of absence after your coverage becomes effective, your FSA will be affected as follows:

- **Dependent Care FSA:** Your deductions will stop. You can continue to submit eligible dependent day care expenses to HealthEquity that were incurred prior to your leave. Your dependent day care expenses incurred during your leave are not eligible for reimbursement. If you go on military leave, you can continue to submit eligible dependent day care expenses that were incurred during the calendar year you went on military leave. For reimbursement of eligible expenses, you must file claims with HealthEquity by March 31 of the following year.
- **Full Purpose and Limited Purpose Health Care FSA:** Your deductions will accumulate for a maximum of 90 days from the date you go on leave. If your leave extends beyond 90 days, your FSA election will be cancelled on the 91st day of leave. If you return to work in the same calendar year, your accumulated FSA deductions will be taken from your paycheck on a prorated basis. Any eligible FSA expenses incurred prior to the 91st day of your leave are reimbursable. For reimbursement of eligible expenses, you must file claims with HealthEquity by March 31 of the following year.

If you return to work in the same calendar year, you may re-elect FSA coverage within 31 days following the date you return to work. If you return to work in the last quarter of the calendar year or a different calendar year, you must wait until the next annual enrollment period to enroll in the FSA.

If you made a Dependent Care FSA and/or Health Care FSA election during Annual Benefits Enrollment but are or will be on a leave of absence as of January 1 of the new plan year, your Dependent Care FSA and/or Health Care FSA election will be changed to zero. Following your return to work, you will have 31 days to re-enroll at the annual election amount chosen during Annual Benefits Enrollment. Otherwise you must wait until the next Annual Benefits Enrollment period to enroll in the FSA.

How your FSA is affected when on an unpaid suspension

If you are enrolled in the Dependent Care FSA or Health Care FSA and you are placed on an unpaid suspension after your coverage becomes effective, your payroll deductions will cease immediately. Any eligible expenses must be filed with HealthEquity by March 31 of the following year

If you return to work in the same calendar year, you may re-elect FSA coverage within 31 days following the date you return to work. If you return to work in the last quarter of the calendar year or a different calendar year, you must wait until the next Annual Benefit Enrollment period to enroll in the FSA.

Dependent Care Flexible Spending Account Plan

The Dependent Care Flexible Spending Account (FSA) Plan is designed to help you save tax dollars on childcare services, elder care, or care for a disabled spouse or dependent that you usually pay with after-tax dollars. Amounts set aside for the Dependent Care FSA will reduce your taxable income, therefore lowering your taxes. To qualify for reimbursement, the care must be necessary to enable you and your spouse, if you are legally married, to work.

This benefit is for dependent care expenses only; it is not for health care expenses of your dependent(s).

Who Is Eligible to Enroll

You must be a pilot and actively at work during the time your eligible dependent(s) are receiving care. If you are married, your spouse must:

- Work,
- Attend school full-time for at least 5 months during the year while you are working, or
- Be disabled and unable to provide for his or her own care.

Pilots who live in Puerto Rico, Guam, and the U.S. Virgin Islands are not eligible to participate in the Dependent Care Flexible Spending Account Plan.

When You Can Enroll

New Hire Enrollment—If you are a new hire pilot, you must enroll by the deadline indicated in your new hire letter provided during new hire orientation. The effective date of coverage is your date of hire.

Annual Benefits Enrollment—You can enroll during the Annual Benefits Enrollment period by going to Pilot Benefits Online at https://fedexpilots.bswift.com. If you make your election by the Annual Benefits Enrollment deadline, benefits become effective on January 1 of the following year. Your payroll deductions will begin with the first pay period in the new tax year.

If you fail to make your election by the Annual Benefits Enrollment deadline, you cannot enroll until the next Annual Benefits Enrollment unless you have a Change in Family Status Event and make your election within 31 days following the event.

See the most recent Pilot Enrollment Guide for more instructions. The guide is located on Pilot Benefits Online at https://fedexpilots.bswift.com and on your Company issued iPad under the secure content locker

Participation in the Dependent Care FSA requires an annual election. You must re-enroll each year as your election cannot be defaulted from one year to the next.

It is important to review your expenses each year to make sure that your election is appropriate, based on the actual expenses you expect to have.

Important

You are not required to participate in the FedEx Health Coverage to participate in the Dependent Care Flexible Spending Account Plan.

Eligible Dependents

Your eligible dependent(s) must be a regular member of your household who requires care in order for you to work. You or your spouse must be considered the primary caregiver during the time you are not at work.

Eligible dependents include:

- Your qualifying child under age 13, or
- Your spouse, qualifying child (even if over age 13), parent, or other qualifying relative who is a dependent for tax purposes and who is mentally or physically incapable of providing for his/her own care.

Dependent care expenses incurred after a child's 13th birthday no longer qualify for reimbursement unless the child is physically or mentally impaired. In determining your annual Dependent Care FSA contribution, it is your responsibility to calculate the correct number of weeks of eligibility for a child who turns 13 during the calendar year.

Eligible Expenses

Eligible dependent care expenses are those incurred for the care of a person who can be claimed as a tax exemption for federal tax purposes, or for the care of any dependent who is mentally or physically unable to care for themselves.

Eligible expenses are those which allow you (and your spouse, if married) to work, look for work, or attend school as a full-time student. Some examples are:

- Child under age 13 at a day camp or day care, or child care by a private sitter for children.
- Elder care for an incapacitated adult who lives with you at least 8 hours a day.
- Expenses for pre-school (but not including kindergarten) and after-school child care. These expenses must be kept separate from any tuition expenses.
- Cost of a housekeeper whose duties include the care of a qualified dependent (income must be claimed for tax purposes by your care provider).
- Day care facility fees.

See the list of eligible dependent care expenses at http://healthequity.com/learn/dependent-care-expenses or refer to **IRS Publication 503**.

Ineligible Expenses

Expenses not eligible for reimbursement include:

- Expenses for overnight camps
- Expenses for education or tuition

- Placement fees for finding a dependent care provider (e.g., au pair)
- Sports lessons, field trips, clothing or transportation
- Expenses incurred for medical treatment

Eligible Providers

Your child or elder care provider must meet the business and licensing requirements of your state. The services may be as informal as care provided by your neighbor, as long as the provider claims the money received for services as income when determining their taxes at the end of the year. You will also need to obtain the provider's federal identification/Social Security number for inclusion on your own tax filing form.

Ineligible Providers

The following providers are not eligible to receive reimbursement from the Dependent Care FSA Plan:

- Your spouse
- Someone who is your dependent for income tax purposes, or
- One of your children under age 19

Important: FedEx is not responsible for ensuring that your dependent care expenses under this program meet all of the eligibility requirements set forth under IRS guidelines. You should call your financial or tax advisor if you have questions.

Dependent Care FSA highlights:

- You may contribute up to $5,000 (pre-tax) to pay for eligible dependent day care expenses. The maximum annual contribution if married and filing a separate return is $2,500. The minimum annual contribution is $250 each plan year.
- Your Dependent Care FSA election amount is deducted from your paycheck in equal amounts during the plan year.
- FedEx Express does not contribute to the Dependent Care FSA.
- You will receive dependent care reimbursement up to the amount that has been contributed to your Dependent Care FSA.
- For reimbursement of eligible expenses, you must file claims with HealthEquity by March 31 of the following year.
- The Dependent Care FSA requires re-enrollment each year. Unused funds at the end of the year are forfeited.

Each pay period, the Dependent Care FSA amount you elected is deducted from your paycheck before your taxes are calculated. Generally, amounts reimbursed to you from your Dependent Care FSA are tax-free to you. However, federal law provides that the amount excluded from your gross income cannot exceed the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns)
- Your annual income, or

- Your spouse's annual income

If your spouse is a full-time student or physically and/or mentally incapable of self-care, there is a special rule to determine his or her annual income. Your spouse will be deemed to have earned income of either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents) for each month in which your spouse is a full-time student or physically and/or mentally incapable of self-care.

By making an election under the Dependent Care Flexible Spending Account Plan, you are representing to the Company that your contributions to your Dependent Care Flexible Spending Account Plan are not expected to exceed the above limits.

The Dependent Care FSA amount will appear in a special block on your W-2 form. This is an IRS requirement to ensure taxpayers do not claim the same expenses in two places. If you are using both the tax credit and the Dependent Care Flexible Spending Account Plan, you must reduce the amount of dependent care expenses that qualify for the tax credit by the amount you received from the Dependent Care Flexible Spending Account Plan.

Changing Your Election

You may change your election only if you have a Change in Family Status event during the calendar year and make your election within 31 days following the qualifying event. To make your election, access Pilot Benefits Online at https://fedexpilots.bswift.com. Your request to change your election must be consistent with the change in status (e.g., the birth of a child will allow you to increase or decrease your contributions).

Change in Family Status events include:

- Birth or adoption of a child (and both parents are either working or attending school)
- Marriage or divorce
- Death of your spouse or an eligible dependent
- Legal custody or guardianship of a child
- Significant cost change in your dependent care expenses
- Your spouse's gain or loss of employment
- Leave of absence taken by you or your spouse

Estimating Your Savings

The tax savings you can expect will vary depending on your individual tax-filing situation. Before you elect to participate in the Dependent Care Flexible Spending Account Plan, be sure to consult your financial or tax advisor to determine if the Dependent Care Flexible Spending Account Plan is appropriate for your situation.

To estimate your contributions for the Dependent Care FSA, access the HealthEquity member portal.

"Use It or Lose It" Rule

Under this rule, you must use the money in your Dependent Care FSA for eligible expenses incurred during the year in which the contributions are made. You have until March 31 of the following year to request reimbursement for eligible expenses incurred before the end of the year by filing a Reimbursement claim. If you terminate employment during the year, you can only request reimbursement for expenses incurred through your termination date.

If you have a balance left in your Dependent Care FSA after the deadline for requesting reimbursement, it will be forfeited.

Accessing Your Account

HealthEquity administers the Dependent Care FSA. Online information regarding your Dependent Care FSA is available at https://www.healthequity.com.

You can register on the HealthEquity member portal and have access to:

- Each contribution made to your account
- Reimbursement claims you have filed, and
- Reimbursements that have been issued to you

HealthEquity Member Services is available 24/7/365 by calling 1.844.281.0925.

Claims and Payments

Request payment of your eligible Dependent Care FSA expenses through your selected payment method:

- You may submit expenses for reimbursement through the HealthEquity member portal, the HealthEquity mobile app, or by submitting the Dependent Care FSA Reimbursement claim form. You must provide detailed receipts to verify your reimbursement.
- You can also request payment directly to your provider through the HealthEquity member portal. You must attach proof of service to your prover payment request.
  - There must be sufficient funds available in your account to remit the entire payment. No partial payments can be issued from the account.
  - Advance reimbursement of future or projected dependent care expenses is not permitted.

You will receive dependent care reimbursement up to the amount of your year-to-date payroll deductions, which have been contributed to your Dependent Care Flexible Spending Account Plan for Pilots.

You are responsible for maintaining documentation (e.g., detailed receipts) to verify your expenses (the nature of each expense, the amount and the date incurred). Keep these with your other important tax papers for the calendar year.

Proof of Service/Detailed receipts

For reimbursement of Dependent Care expenses, proof of service is a signed receipt from your dependent care provider as proof of payment of services. The receipt must include:

- Dates of services
- Name(s) of dependent(s) for whom care was provided
- Total amount charged for the care
- Provider's name and taxpayer identification number or Social Security number (once per calendar year)

FedEx is not responsible for ensuring that your dependent care expenses submitted for reimbursement meet all eligibility requirements.

NOTE: Canceled checks are not acceptable proof of services in lieu of a signed receipt from the care provider. If a receipt is not available, your provider may sign the Dependent Care Flexible Spending Account reimbursement form to certify the amounts paid for services rendered are accurate.

Keep a copy of all documentation for your records.

Always save your itemized receipts and supporting documentation.

HealthEquity offers an easy-to-use Documentation Library that allows you to upload and store receipts within the member portal.

When Coverage Ends

Your coverage in the Dependent Care FSA ends whenever the first of the following events occur:

- The calendar year for which you have elected to participate ends
- You no longer meet the eligibility requirements to participate (for example, termination of employment or no longer a pilot)
- You go on a leave of absence or unpaid suspension
- Federal Express Corporation discontinues the benefit in accordance with the Agreement
- You die

If you terminate, retire, or are no longer eligible to participate in the Dependent Care FSA, any eligible expenses incurred prior to the date you become ineligible to participate in the Dependent Care FSA (due to retirement or termination of employment or are no longer a pilot) are eligible for reimbursement—you cannot be reimbursed for any expenses incurred after you become ineligible to participate in the Dependent Care FSA.

If you terminate employment during the year, you can only request reimbursement for expenses incurred through your termination date.

You will need to plan carefully and estimate conservatively since the IRS requires that any unused money left in your account be forfeited.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account Plan for Pilots (Health Care FSA) allows you to set aside money from your paycheck on a pre-tax basis (that reduces your taxable income) to pay for eligible health care expenses incurred by you and/or your eligible family members. It is a cost-effective way to pay for such items as medical and dental deductibles, copayments, and health-related expenses that are not covered by your health plan.

There are two types of Health Care FSAs under the Plan:

- Full purpose
- Limited purpose

If you participate in a Plan option with an HSA, you cannot participate in the full purpose FSA.

When You Can Enroll

New Hire Enrollment—If you are a new hire pilot, you must enroll by the deadline indicated in your new hire letter provided during new hire orientation. The effective date of coverage is your date of hire.

Annual Benefits Enrollment—Make your Health Care FSA election during the Annual Benefits Enrollment period by going to Pilot Benefits Online at https://fedexpilots.bswift.com. If you make your election by the Annual Benefits Enrollment deadline, your enrollment becomes effective on January 1 of the following year. Your paycheck deductions will begin with the first pay period in the new year.

If you fail to make your election by the Annual Benefits Enrollment deadline, you cannot enroll until the next Annual Benefits Enrolment.

Participation in the Health Care FSA requires an annual election. You must re-enroll each year as your election cannot be defaulted from one year to the next.

It is important to review your expenses each year to make sure that your election is appropriate, based on the actual expenses you expect to have.

Important

You are not required to participate in the Federal Express Corporation Group Health Plan for Pilots to participate in the Health Care Flexible Spending Account Plan for Pilots. This means if you opt out of FedEx Express Health coverage because you have other group health coverage (e.g., coverage provided by your spouse, another employer, etc.), you are eligible to participate in the Health Care FSA.

Participation in the Limited Purpose FSA is only for Pilots electing the HSA. If you enroll in the HSA and elect a Health Care FSA, a Limited Purpose FSA will be established for you.

Eligible Dependents

You can use the Full Purpose and Limited Purpose Health Care FSA to pay for eligible expenses for:

- You
- Your legal spouse
- Your children (including stepchild and adopted children) under age 27

Full Purpose Health Care FSA

The Full Purpose Health Care FSA allows you to set aside pre-tax money from your paycheck to pay for eligible health care expenses. It is a cost effective way to pay for deductibles, copayments, and other eligible expenses not covered by the health plan.

Who Is Eligible to Enroll

Pilots enrolled in the Buy Up, CDHP Purple HRA, CDHP Orange HRA, HMSA, Health Plan Hawaii HMO, International Plan, or if you choose to opt-out of medical coverage, you can elect the Full Purpose Health Care FSA. Pilots who live in Puerto Rico, Guam, or the U.S. Virgin Islands are not eligible to participate.

The Full Purpose Health Care FSA is not compatible with the CDHP Purple HSA or CDHP Orange HSA. If you participate in the CDHP Purple HSA or CDHP Orange HSA then you may not participate in the Full Purpose FSA.

Full Purpose Health Care FSA highlights:

- Annual Contribution Limit: The Health Care FSA contribution limit may change annually. See the most recent Pilot Enrollment Guide for the current contribution limit. You may contribute up to the annual limit (pre-tax). The minimum annual contribution is $250.
- Your Full Purpose Health Care FSA election amount is deducted from your paycheck in equal amounts during the plan year.
- FedEx Express does not contribute to the Full Purpose Health Care FSA.
- The Full Purpose Health Care FSA has a carryover feature, which allows participants to carry over an amount specified by the IRS to pay for eligible expenses in the next plan year. The carryover amount may change annually. See the most recent Pilot Enrollment Guide for the current carryover amount.
- Be sure to estimate your expenses carefully as any unused balance in excess of the carryover amount left in your account after the deadline for requesting reimbursement will be forfeited.
- The Full Purpose Health Care FSA requires re-enrollment each year.
- Once you enroll in the Full Purpose Health Care FSA, you cannot drop your coverage for the remainder of the calendar year. You cannot increase or decrease your deduction amount for the remainder of the calendar year unless one of your dependents dies and you need to make a change. The change request must be within 31 days following the death.

- If you are enrolled in the Full Purpose Health Care FSA and move to a different medical plan option within the same year, you will only be allowed to enroll in a plan that is compatible with the Full Purpose FSA. For example, if you are on Foreign Duty Assignment and return to the United States, or you reside in Hawaii and move to the mainland, you may only enroll in the Buy Up, CDHP Purple HRA, or CDHP Orange HRA for the remainder of the year. Or you may choose to decline medical coverage following your move. Regardless of whether you enroll or decline medical coverage following your move, you will remain in the Full Purpose Health Care FSA through the end of the year.

Limited Purpose Health Care FSA

The Limited Purpose Health Care FSA allows you to set aside pre-tax money from your paycheck to pay for eligible health care expenses. Funds can be used to pay for eligible dental and vision expenses; and for eligible medical expenses after you meet the IRS annual deductible for the HDHP.

The IRS annual deductible will be monitored by HealthEquity to determine when you can use your account to pay for eligible medical expenses.

Who Is Eligible to Enroll

Pilots enrolled in the CDHP Purple HSA or the CDHP Orange HSA medical option can elect the Limited Purpose Health Care FSA. Pilots who live in Puerto Rico, Guam, or the U.S. Virgin Islands are not eligible to participate.

Limited Purpose Health Care FSA highlights:

- The Limited Purpose Health Care FSA can be used for dental and vision expenses; and for eligible medical expenses after the IRS annual deductible for the HDHP is met.
- Annual Contribution Limit: The Health Care FSA contribution limit may change annually. See the most recent Pilot Enrollment Guide for the current contribution limit. You may contribute up to the annual limit (pre-tax). The minimum annual contribution is $250.
- Your Limited Purpose Health Care FSA election amount is deducted from your paycheck in equal amounts during the plan year.
- FedEx Express does not contribute to the Limited Purpose Health Care FSA. The Limited Purpose Health Care FSA has a carryover feature, which allows participants to carry over an amount specified by the IRS to pay for eligible expenses in the next plan year. The carryover amount may change annually. See the most recent Pilot Enrollment Guide for the current carryover amount.
- Be sure to estimate your expenses carefully as any unused balance in excess of the carryover amount left in your account after the deadline for requesting reimbursement will be forfeited.
- For reimbursement of eligible expenses, you must file claims with HealthEquity by March 31 of the following year.
- The Limited Purpose Health Care FSA requires re-enrollment each year.
- Once you enroll in the Limited Purpose Health Care FSA, you cannot drop your coverage for the remainder of the calendar year. You cannot increase or decrease your deduction amount for the remainder of the calendar year unless one of your dependents

dies and you need to make a change. The change request must be within 31 days following the death.

- If you are enrolled in the Limited Purpose FSA and move to a different medical plan option within the same year, you will remain in the Limited Purpose Health Care FSA account until the next annual enrollment. For example, if you move to a Foreign Duty Assignment or Hawaii, regardless of whether you enroll or decline medical coverage following your move, you will remain in the Limited Purpose Health Care FSA through the end of the year.

Accessing Your Account

HealthEquity administers the Health Care FSA. Online information regarding your FSA is available at https://www.healthequity.com.

You can register on the HealthEquity member portal and have access to:

- Each contribution made to your account
- Reimbursement claims you have filed, and
- Reimbursements that have been issued to you

HealthEquity Member Services is available 24/7/365 by calling 1.844.281.0925.

Claims and Payments

You have three options to pay for eligible health care expenses from your Full Purpose or Limited Purpose Health Care FSA with HealthEquity:

- Pay with your HealthEquity debit card.
  - Works like a debit card (but without a PIN)
  - Pay for eligible health care products and services at point of purchase, and funds are automatically deducted from your FSA
  - No claim forms to file
- Use HealthEquity's online bill pay to pay your doctor or provider at https://www.healthequity.com. You must attach proof of service to your provider payment request.
- Pay up front and submit a receipt to HealthEquity for reimbursement. You must provide your detailed receipts and complete a claims form to verify your reimbursement.

Proof of Services and Detailed Receipts

When requesting payment to a provider or filing a claim for reimbursement, you will be required to submit an itemized invoice, Explanation of Benefits (EOB), or other approved documentation to HealthEquity.

All receipts or documentation must include the following information:

- Provider's name
- Service date(s)

- Patient's name (name of the person who incurred the service or expense)
- Description of service or expense
- Amount of patient responsibility

Helpful tip for submitting documentation: Use your EOB, especially if your insurance paid a portion of the expense.

EOBs contain all the required information and are excellent sources of documentation. Credit card receipts and cancelled checks are not acceptable proof of services.

Keep a copy of all documentation for your records

Always save your itemized receipts and supporting documentation.

HealthEquity Documentation Library allows you to upload and store receipts within the member portal.

Debit Card Transactions

IRS regulations require that HealthEquity verify each and every card transaction to ensure your account is used only to pay for eligible health care products and services. Keep your card and account in good standing by quickly resolving any unverified card transactions.

If HealthEquity is unable to automatically approve a card transaction based on the information available, you have several options to resolve it. Your options range from submitting a detailed receipt to show you paid for an eligible expense to paying back your account for the amount not verified.

Be sure to validate all card transactions where HealthEquity is requesting additional support as all debit card transactions not validated will be included as taxable income on your W-2.

Changing Your Election

It is important that you give careful consideration to the amount you elect to have deducted from your paycheck for the calendar year since you cannot increase, decrease, or stop your contributions during the year. The death of a dependent is the only qualified life event that allows you to change the amount of your Health Care FSA election outside of the annual enrollment period.

If your dependent dies, you can process a change within 31 days by calling Pilot Benefits Administration at 1.866.795.6353.

Eligible Expenses

For a list of eligible and ineligible health care expenses, review the IRS Publication 502 or visit https://www.healthequity.com.

You cannot receive a reimbursement from the Health Care FSA Plan that you also claim as a deduction on your federal income tax return or that is reimbursed from another plan.

Your pre-tax payroll deductions for health coverage are not eligible expenses for reimbursement.

Estimating Your Savings

The tax savings you can expect will vary depending on your individual tax-filing situation. Before you elect to participate in the Health Care Flexible Spending Account Plan for Pilots, be sure to consult your financial or tax advisor to determine if the Health Care Flexible Spending Account Plan for Pilots is appropriate for your situation.

To estimate your contributions for the Health Care FSA Plan, access the HealthEquity member portal.

Claim Filing Deadline and Carryover

You will have until March 31 of the following year to file Health Care FSA claims for expenses incurred from January 1 to December 31 of the previous year.

The Health Care FSA debit card and provider payment options cannot be used after the end of the calendar year; you must file a claim for reimbursement.

If you retire or terminate during the year, you can only request reimbursement for expenses incurred through your retirement or termination date, unless you elect COBRA.

At the end of the calendar year, you can carry over an amount specified by the IRS to the following year. See the most recent Pilot Enrollment Guide for the current carryover amount.

Carryover funds will be available for use after the claims filing deadline period ends on March 31 of the following year.

After March 31, your carryover balance will be added to your current year Health Care FSA. Even if you do not elect a Health Care FSA for the current year, your carryover balance is available.

Carryover is not available if you leave the Company or retire.

If you have a balance greater than the carryover amount left in your Health Care FSA after the deadline for requesting reimbursement (March 31 of the following calendar year), it will be forfeited.

When Coverage Ends

Your coverage in the Health Care FSA ends whenever the first of the following events occurs:

- The calendar year for which you have elected to participate ends. (Please note you have until March 31 of the following year to file claims for expenses for the prior calendar year.)
- You no longer meet the eligibility requirements to participate (e.g., cease to be a pilot).
- On the 91st day of your leave of absence or the 1st day of an unpaid suspension.

- The plan is terminated in accordance with the Agreement.
- You die.

Any eligible expenses incurred prior to the date you become ineligible to participate in the Health Care FSA (due to retirement or termination of employment from FedEx Express) are eligible for reimbursement. Expenses incurred after your Health care FSA coverage ends are not eligible for reimbursement unless you elect COBRA.

You have until March 31 of the next year to submit claims for eligible expenses incurred between January 1 and the date you become ineligible.

When you terminate, retire, or become ineligible to participate, you are eligible to continue participation in the Full Purpose or Limited Purpose Health Care FSA under COBRA, until the end of the plan year in which the qualifying event occurs. If you elect COBRA, you will make after-tax contributions to your account. COBRA continuation allows you to receive reimbursement of eligible expenses beyond the date you become ineligible.

If you do not elect COBRA continuation, you cannot receive reimbursement for expenses incurred after the date you become ineligible to participate.

Pre-Medicare Retiree HRA (offered under the Federal Express Corporation Retiree Group Health Plan for Pilots)

In lieu of the retiree medical plan options, you have the option to elect the Pre-Medicare Retiree HRA.

The Company will credit your Retiree HRA with $4,813 for you and an additional $4,813 for a covered spouse in a separate account (or domestic partner in California only) annually each January. You can use this account to purchase health insurance outside the Company and pay for eligible health care expenses.

HealthEquity is the administrator of the Pre-Medicare Retiree HRA, and following your initial enrollment, you will receive a welcome letter at your home with more information, including how to use the account. There is no debit card associated with the HRA and substantiation is required.

Who Is Eligible to Enroll

If you (and your spouse) meet the age and service requirements for eligibility under the Retiree Group Health Plan for Pilots, you (and your spouse) are eligible to enroll in the Pre-Medicare Retiree HRA.

When You Can Enroll

Termination or Retirement: If you (or your spouse) are under age 65, you must enroll by the deadline indicated in your Personalized Retiree Letter. The effective date for the Pre-Medicare Retiree HRA is the day after your termination/retirement date. You can make your election online at https://fedexpilots.bswift.com or by calling PBA at 1.866.795.6383.

Annual Benefits Enrollment—If you or your spouse are under age 65 (and will be under age 65 as of January 1 of the next year), you can enroll during the Retiree Annual Benefits Enrollment period by going to Pilot Benefits Online at https://fedexpilots.bswift.com.

IMPORTANT: If you decide to elect the Pre-Medicare Retiree HRA option, you are not allowed to elect any other medical plan option during a future Annual Benefits Enrollment period. You may elect to drop the Pre-Medicare Retiree HRA option at any time but may not re-elect the option in the future. You may also elect dental and vision coverage with the Pre-Medicare Retiree HRA option.

Credits

The Company will credit your Retiree HRA $4,813 for you and an additional $4,813 for a covered spouse in a separate account (or domestic partner in California only).

Company credits are deposited annually at the beginning of the calendar year, except for the year of retirement, in which case the Company credits are prorated to the month of retirement.

Company credits stop when you or your covered spouse turn age 65.

How the Pre-Medicare Retiree HRA works

- The HRA can be used for eligible medical expenses for the pilot, spouse, and eligible tax dependents under age 26.
- Eligible health care expenses incurred in one calendar year must be filed with HealthEquity by March 31 of the next calendar year.
- Credits in your Pre-Medicare Retiree HRA roll over at the end of each year, after the March 31 run-out period, and can be used to cover future qualified health care expenses.
- There is no debit card associated with the Pre-Medicare Retiree HRA and substantiation is required. To substantiate the expense, you will be required to submit an itemized invoice, Explanation of Benefits (EOB), or other approved documentation to HealthEquity.

Pre-Medicare Retiree HRA Rollover credits

End of Plan Year:

If you (and/or your spouse) are currently enrolled in the Pre-Medicare Retiree HRA option and you remain enrolled in the next calendar year, you (and/or your spouse) will start the new year with two HRAs at HealthEquity:

- One account will contain any remaining credits from the prior year
- A second new account will be created for the new plan year credits and expenses

This is necessary to allow you to continue to file any eligible prior year's health care expenses. Once the filing period ends on March 31 the remaining balance in your prior year's Pre-Medicare Retiree HRA will be added to your current year Pre-Medicare Retiree HRA and can be used for future health care expenses.

Eligible health care expenses incurred in the current year must be filed against the current year's HRA balance.

Turning Age 65:

When you (or your spouse) turn age 65, you will no longer receive the annual $4,813 in Company credits in your HRA. The termination date for your HRA is the last day of the month prior to the month you turn age 65.

Any credits remaining in the Pre-Medicare Retiree HRA will be rolled into a Non-Funded Pre-Medicare Retiree HRA, after a 90-day run-out period. The run-out period affects the dates claims can be filed with HealthEquity:

- There is a 90-day run-out period to allow you and/or your spouse to file any eligible health care expenses against the Pre-Medicare Retiree HRA. The 90-day run-out period starts on the first day of the month you or your spouse turn 65.
- Once the 90-day run-out period ends, any remaining balance in the Pre-Medicare Retiree HRA will be rolled over to a Non-Funded Pre-Medicare Retiree HRA and can be used for future health care expenses.

- The Non-Funded Pre-Medicare Retiree HRA is not subject to a run-out period and credits are available for use by the retired pilot, spouse, and eligible tax dependents under age 26.

Accessing your HRA at HealthEquity:

To register and access the HealthEquity website, go to https://www.healthequity.com.

HealthEquity Member Services is available 24/7/365. To reach Member Services, call 1.844.281.0925.

Claims and Payments

Request reimbursement or payment of your eligible HRA expenses through your selected method:

- You can submit eligible heath care expenses for reimbursement through the HealthEquity member portal, the HealthEquity mobile app or by submitting a Reimbursement claim form. You must provide your detailed receipt to verify your reimbursement.
- You can also request payment directly to your provider through the HealthEquity member portal. You must attach proof of service to your Pay Doctor/Providers request.
  NOTE: Not all providers can be paid through the "Pay Doctor/Provider" option.
- Regardless of the method you choose, you must save your detailed receipts for your records.

Proof of Services and Detailed Receipts

When requesting payment to a provider or filing a claim for reimbursement, you will be required to submit an itemized invoice, Explanation of Benefits (EOB), or other approved documentation to HealthEquity.

All receipts or documentation must include the following information:

- Provider's name
- Service date(s)
- Patient's name (name of the person who incurred the service or expense)
- Description of service or expense
- Amount of patient responsibility

Helpful tip for submitting documentation: Use your EOB, especially if your insurance paid a portion of the expense.

EOBs contain all the required information and are excellent sources of documentation. Credit card receipts and cancelled checks are not acceptable proof of services.

Keep a copy of all documentation for your records

Always save your itemized receipts and supporting documentation as part of your tax records. With the HealthEquity Documentation Library you can upload and store receipts within the member portal.

Death of the pilot and/or spouse

If you or your spouse have a balance in an HRA at the time of death, ownership of the account passes to the surviving pilot/spouse. If your spouse also has the Pre-Medicare Retiree HRA, the two accounts will not be combined.

The survivor pilot/spouse can use remaining credits in both accounts to pay for eligible health care expenses for themselves and eligible tax dependents.

The remaining balance in the HRA of the deceased pilot/spouse will move from the Pre-Medicare Retiree HRA to a Pre-Medicare Retiree Non-Funded HRA after a 90-day run-out (filing) period.

- There is a 90-day run-out period to allow the surviving pilot/spouse to file any eligible health care expenses against the deceased pilot/spouse Pre-Medicare Retiree HRA. The 90-day run-out period starts on the day following the date of death.
- Once the 90-day run-out period ends, any credits that remain in the Pre-Medicare Retiree HRA will be rolled over to a Non-Funded Pre-Medicare Retiree HRA and can be used for future health care expenses.

The Non-Funded Pre-Medicare Retiree HRA will no longer receive $4,813 in Company credits.

If both the pilot and spouse die, ownership does not pass to a surviving dependent, but rather the account is forfeited.

LIFE INSURANCE

Life and accident insurance provides your family with financial security in case of your death or covered injury.

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RULES APPLICABLE TO ALL INSURANCE PLANS

The life and accident insurance plans sponsored by the Company are fully insured benefit plans, which means the insurance carriers, not the Company, are responsible for the risk associated with losses covered under the plans. The terms and conditions of the master policy issued by Securian Life Insurance Company, an affiliate of Securian Financial (the Insurance Company), govern the plan provisions. If there are any discrepancies between this summary and the policy or if any point is not covered by this summary, the terms and conditions of the policy shall govern.

The Company is responsible only for the payment of premiums either from corporate funds or as collected from payroll deductions. Securian Financial is responsible for payment of the benefit.

Life Insurance Enrollment and Beneficiary Designation on Pilot Benefits Online

To make your life insurance enrollment elections and beneficiary designations, log in to Pilot Benefits Online at https://fedexpilots.bswift.com. This is where you can view your current life insurance coverage, make initial elections, make changes to your life insurance coverage, and access the beneficiary section to designate your beneficiaries for your life insurance benefits.

Eligibility

As a pilot, you are automatically covered by the Company-paid Basic Life Insurance, Basic AD&D Insurance and Business Travel Accident Insurance Plans. You also have the opportunity to enroll in Optional Life Insurance and Optional AD&D Insurance for yourself and your eligible dependents.

Beneficiary

You are required to designate a beneficiary for each plan in which you participate, including Company-paid life insurance. A beneficiary is the person(s) you wish to receive the money from your life insurance in the event of your death.

NOTE: This beneficiary is not the same as the beneficiary designation required for the Pilots' Retirement Savings Plan, or the FTL Variable Annuity Pension Plan for Pilots. The beneficiary of all dependent life insurance coverage is automatically the pilot.

If there is a beneficiary designated for pilot coverage, proceeds are payable to that beneficiary. Any amount of insurance for which there is no beneficiary at your death will be payable to the first of the following:

1. Your lawful spouse, if living; otherwise
2. Your natural or legally adopted child(ren) in equal shares, if living; otherwise
3. Your parents in equal shares, if living; otherwise
4. Your natural or legally adopted sibling(s) in equal shares, if living; otherwise
5. Your estate

In the event a beneficiary is not living at the time of your death, that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

Designate or Change a Beneficiary for All Insurance Plans

You may change your beneficiary designations AT ANY TIME through Pilot Benefits Online at https://fedexpilots.bswift.com. You should periodically review your beneficiary designations. Certain events may dictate a change in your beneficiary designations (e.g., death of your designated beneficiary, marriage, divorce, or the birth of a child). After you designate your beneficiaries, you can print a confirmation of your beneficiary designations.

If you are designating a Trust or an Absolute Assignment, please contact Pilot Benefits Administration at 1.866.795.6353 or in Memphis, 1.901.375.6353 for assistance in completing the beneficiary designation online. You will also need to complete specific forms provided by the insurance carrier.

Designation of Multiple Beneficiaries for All Plans

You may designate anyone you wish to be a beneficiary. Be sure to keep the following in mind:

- If you designate a minor child(ren) as beneficiary(ies), a legal guardian must be established before any benefits will be paid.
- You should contact an attorney for complex beneficiary designation(s) or those that involve a trust.
- You may designate your estate as your beneficiary.
- You CANNOT designate YOURSELF as your beneficiary for life insurance benefits.
- If your eligible dependents are covered for Optional Life Insurance or Optional AD&D Insurance, you are automatically the beneficiary in the event of their death.

You may designate as many beneficiaries as you wish for each life insurance plan in which you participate. If you designate two or more beneficiaries for the same life insurance benefit, you must specify the percentage that you want each of your primary and secondary beneficiaries to receive. The total of all percentages (in whole percentages) must equal 100%. Primary

beneficiary(ies) will share the specified benefits payable from your insurance in the event of your death. Secondary beneficiary(ies) will receive benefits only if all primary beneficiaries are deceased at the time of your death. You can designate a beneficiary as primary or secondary but not both. You are not required to designate a secondary beneficiary.

Continuation of Insurance Coverage

Basic and Optional Life Participants: If you terminate your FedEx employment prior to age 55 and are actively at work immediately prior to termination, you can enroll in the Basic and/or Optional Life Portability Insurance Plans offered by Securian Financial. Your coverage is not portable if you:

1. have attained age 55; or
2. have converted coverage to an individual policy under the conversion rights of the policy; or
3. are not actively at work due to sickness or injury on the date immediately preceding your portability date; or
4. are a spouse and are totally disabled; or
5. lose eligibility due to the termination of the group policy.

The Basic and Optional Life Insurance Portability Plans allow you to continue your life insurance coverage under a separate group contract provided by Securian Financial. Coverage is also available for your covered spouse (under age 80), provided he or she is not totally disabled, and any eligible children. A spouse will be considered totally disabled if he or she is medically unable to engage in any full-time or part-time occupation for which he or she is reasonably suited by education, training, or experience. How much coverage can be ported and for how long?

For Pilots

For pilot coverage, you can elect a coverage amount up to or less than your Basic and/or Optional Life Insurance coverage amount as an active pilot. The minimum amount of coverage that you can port is $10,000 and the maximum is the lesser of your pre-termination coverage or $1,000,000. Benefits will reduce to 65% at age 65 and 50% at age 70 with coverage terminating altogether at age 80. The reduction occurs on the anniversary of the effective date of your portability section of the policy coinciding with or next following the attainment of that age. You can elect to reduce the amount of coverage you had in place on the date of termination.

For Spouse and Child coverage

For Spouse Optional Life and Child Optional Life, the minimum amount of coverage a dependent can port is $1,000. The maximum amount of coverage a spouse can port is $150,000 and the maximum amount of coverage that can be ported for a child is the amount of coverage they had in place on the date coverage ended. Though there are no age reductions in spousal coverage, the coverage will terminate at age 80. Child Portability ends at age 26.

Retiree Optional Life (Term) Insurance: If you retire or terminate your FedEx employment at age 55 or older and are actively at work immediately prior to your termination and you were an Optional Life participant, you can enroll in the Retiree Optional Life Insurance Plan offered through Securian Financial. You are not eligible if you are not actively at work (i.e., on LTD or Medical Leave of Absence beyond the period for which you are paid medical absence/sick bank days), on military or other leave of absence, or are receiving Workers Compensation benefits immediately prior to your termination. This coverage can be purchased in increments of $100,000 to the lesser of $300,000 or the pre-retirement coverage, as you elect. Retiree Optional Life will be reduced by 8% beginning on your 65th birthday until you reach age 70. Once you have enrolled, you can decrease coverage but you can never increase the coverage. If you were enrolled in spouse coverage prior to retirement, you may elect to continue the $25,000 or $50,000 coverage not to exceed the amount in force prior to your retirement, provided that he or she is not totally disabled on the day of your retirement/termination. The pilot and spouse coverage will terminate at age 80, and there are no age reductions.

The Retiree Optional Life Insurance is an insured group term policy. See “Retiree Optional Life Insurance Plan.”

Portability or Conversion to Individual Policy:

Portability is group term life insurance, which provides coverage for a period of time. The premiums charged are age-banded rates, which increase as you age. They are lower than Conversion premiums; however, no cash value is accrued from which you can take loans or receive a cash refund if you surrender the policy.

Conversion is an individual policy which provides coverage for life (as long as premiums are paid), which can accrue a cash value from which you can take loans or receive a cash refund upon surrender. The premiums are generally higher than Portability but are fixed.

The Basic Life and Optional Life are eligible for Portability or Conversion. Basic AD&D, and Optional AD&D are eligible for Portability only. You must elect portability for Basic Life coverage to elect Basic AD&D Portability. However, you can elect stand-alone Portability for Optional AD&D.

When Pilot Benefits Administration is notified of your loss of coverage, you and/or your dependents enrolled in Basic Life, Basic AD&D, Optional Life, and Optional AD&D Insurance coverage will be sent instructions by the Insurance Company on your options to continue coverage through Portability, Conversion, and/or Retiree Optional Life, based on your eligibility and the coverage in place at time of loss of coverage.

For Basic or Optional Life Insurance Portability or Retiree Optional Life Insurance coverage, as well as Basic Life Insurance and Optional Life Insurance conversion policy, you will have 31 days from the date of termination to submit the proper application and your first premium to the Insurance Company.

For Basic AD&D and Optional AD&D Insurance, you will have 31 days from your coverage termination date to submit a portability application and your first premium to the Insurance Company. Ported Basic AD&D coverage amount cannot exceed the ported basic life coverage

amount. Coverage begins upon receipt of premium and application within 31 days after coverage ends. You are responsible for paying all premiums.

If an Insured Person covered under Basic Life or Optional Life Insurance dies during the 31-day conversion period and is eligible to purchase a conversion policy, benefits equal to the amount eligible for conversion are payable.

If written notice of portability or conversion rights has not been provided, the individual will be given an additional period during which to port or to convert Basic Life or Optional Life.

Any such extension of the portability or conversion period will expire the later of:

- the 31st day after the Insured Person ceases to be insured: or
- the 31st day after the Insured Person has been given written notice of the conversion privilege. If the Insured Person does not receive written notice at least 15 days prior to the end of the 31 days election period, they will have an additional 15 days to elect. In no event, will the period exceed 60 days after the end of the conversion period. If an individual dies within 31 days after coverage ended, and meets all conversion eligibility requirements, a death benefit is payable.

State Regulation

If you are a resident of Minnesota, you may elect to continue coverage at your expense if your employment is terminated voluntarily or involuntarily, or if you are laid off, as long as the group policy is in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from lay-off; however, the maximum period that coverage may be continued is 18 months. Coverage will cease when the required premium is not received timely or when the part of the Group Contract providing the insurance ends.

The portability policy is administered by Securian Financial. Premium rates are subject to change at any time. Notice of changes of premium rates will be provided prior to such change.

Portability and Conversion for Survivors of Pilots Who Die as an Active Pilot

When Pilot Benefits Administration is notified of your death, your dependents enrolled in Optional Spouse/Child Life and Optional Spouse/Child AD&D will be sent information about their option to enroll in the Optional Life Portability plan or to obtain a conversion policy. To obtain coverage:

- For Optional Life Portability coverage as well as an Optional Life conversion policy, your eligible dependents will have 31 days from the notice date to submit the proper application and the first premium to the appropriate party at Securian Financial. The notice date is the date on the letter sent by Securian Financial.
- For Optional AD&D, your dependents will have 31 days from their coverage termination date to submit a portability application and the first premium to Securian Financial.

Coverage begins upon receipt of premium and application within 31 days after coverage ends.

If an Insured Person covered under Optional Spouse/Child Life dies during the 31-day conversion period and is eligible to purchase a conversion policy, benefits equal to the amount eligible for conversion are payable.

If written notice of portability or conversion rights has not been provided, the dependent will be given an additional period during which to port Optional Life coverage or convert Optional Life. Any such extension of the port or conversion period will expire on the later of:

- the 31st day after the Insured Person ceases to be insured: or
- the 31st day after the Insured Person has been given written notice of the conversion privilege. If the Insured Person does not receive written notice at least 15 days prior to the end of the 31 days election period, they will have an additional 15 days to elect. In no event, will the period exceed 60 days after the end of the conversion period. If an individual dies within 31 days after coverage ended, and meets all conversion eligibility requirements, a death benefit is payable.

If an individual dies within 31 days after coverage ended, a death benefit is payable. If an individual dies more than 31 days even though the right to convert or elect Portability was extended, no death benefit is payable.

With respect to the Basic or Optional Life Insurance Plan, an individual may elect either to convert coverage or to port coverage but may not elect both.

For Leaves of Absence (Disability, Medical, Personal, and Workers' Compensation)

Basic Life Insurance and Basic Accidental Death and Dismemberment (AD&D)

Coverage continues at no cost under the same policy.

Optional Life Insurance and Optional Accidental Death and Dismemberment (AD&D)— Coverage continues under the same policies as long as the required premium is paid. This cost is the same as when you were actively at work. The cost automatically accrues for the first 90 days. Thereafter, a monthly billing invoice will be sent to your home address as listed in the HR system and a monthly premium payment will be required to continue coverage. Costs accrued during the first 90 days will be payroll deducted when you return to active work. Failing to make required insurance payments, making partial payments, or having checks returned due to insufficient funds will result in cancellation of all coverage as of last paid through date. If your policy is cancelled and you want to reenroll when you return to active work from Disability, Medical, Personal or Workers' Compensation Leaves of Absence, you and your spouse must provide Evidence of Insurability (EOI) for Optional Life coverage. This EOI is subject to review for approval or denial by medical underwriting. Coverage will resume once you have been approved. Optional AD&D coverage does not require EOI; coverage will resume on the first of the month following your request.

Business Travel Accident—Coverage ends but is reinstated when you return to active work.

For Military Leave of Absence

Basic Life Insurance—Coverage continues at no cost under the same policy.

Optional Life Insurance—Coverage continues under the same policy as long as the required premium is paid. This cost is the same as when you were actively at work. The cost automatically accrues for the first 90 days. Thereafter, a monthly billing invoice will be sent to your home address as listed in the HR system, and a monthly premium payment will be required to continue coverage. Costs accrued during the first 90 days will be payroll deducted when you return to active work. Failing to make required insurance payments, making partial payments, or having checks returned due to insufficient funds will result in cancellation of all coverage as of last paid through date. If you want to reenroll when you return to active work from a Military Leave of Absence, you must enroll within 31 days after you return to active work, or EOI forms and evidence satisfactory to the Insurance Company will be required.

If you are not presently enrolled in Optional Life and want to enroll, you must enroll prior to beginning your military leave. There will be no prejudice due to your activation status. However, the approval process may require a request for medical records and a physical exam **which must be completed prior to the beginning of your leave**. A dependent spouse or child in active military service of any country is not an eligible dependent. If covering a spouse or child who enters active military service, you must notify Pilot Benefits Administration.

Basic Accidental Death and Dismemberment (Basic AD&D)—During a military leave you continue to participate in the plan at no cost. Please reference the certificate for details on exclusions under this policy. Losses resulting from war or any act of war, whether declared or undeclared, are excluded. This exclusion applies only within the geographic limits, territorial waters of, or airspace above geographical limits or territorial waters of the United States and the insured's country of domicile. However, your death or injury during the first 60 days of active service in the National Guard or Reserve Unit will be covered unless caused by or resulting from declared or undeclared war or an act of either within the geographic limits, territorial waters, or the airspace above the United States.

Optional Accidental Death and Dismemberment (Optional AD&D)—Optional AD&D coverage during a military leave is the same as Basic AD&D. Losses resulting from war or any act of war, whether declared or undeclared, are excluded. This exclusion applies only within the geographic limits, territorial waters of, or airspace above geographical limits or territorial waters of the United States and the insured's country of domicile. Dependent coverage continues as long as the required Pilot & Child(ren) premium is paid. A dependent spouse or child on active military service of any country is not an eligible dependent. If covering a spouse or child who enters active military service, you must notify Pilot Benefits Administration. This cost is the same as when you were actively at work. The cost automatically accrues for the first 90 days. Thereafter, a billing invoice will be sent to your home address as listed in the HR system and a monthly premium payment will be required to continue coverage. Costs accrued during the first 90 days will be payroll deducted when you return to active work. Failing to make required insurance payments, making partial payments or having checks returned due to insufficient funds will result in cancellation of all coverage as of last pay through date. If you want to reenroll

when you return to active work, coverage will resume on the first day of the month following your request to reenroll.

If you are not enrolled in Optional AD&D and want to enroll, coverage will begin on the first day of the month following your request as long as you are actively at work on the effective date.

Business Travel Accident—Losses caused by or resulting from injuries sustained while serving in the armed forces are excluded. Coverage resumes when you return to active work.

For Suspension with Pay

Basic Life Insurance and Basic Accidental Death and Dismemberment (AD&D)—will continue at no cost with no exclusions.

Optional Life Insurance and Optional Accidental Death and Dismemberment (AD&D)— Coverage continues under the same policy if you pay the full cost monthly from the first day of suspension. Failing to make required insurance payments, making partial payments, or having checks returned due to insufficient funds will result in cancellation of coverage as of last pay through date. If you want to reenroll in Optional Life Insurance when you return to work, you must provide EOI satisfactory to Securian Financial. If coverage is denied, you will not be eligible to reenroll until you satisfactorily provide EOI as approved by the Securian Financial. Optional AD&D coverage does not require EOI; coverage will resume on the first of the month following your request.

Business Travel Accident—Coverage ends but is reinstated when you return to active work.

For Suspension without Pay

If you are on an unpaid suspension and are participating in Optional Life or Optional AD&D, you must pay the full costs of these benefits if you want to continue coverage.

Filing a Claim

Upon notification of a covered participant’s death, Pilot Benefits Administration contacts the designated beneficiary(ies) and provides information on the applicable life insurance benefits. The Company will submit the employer portion of the death claim and Securian Financial will contact the beneficiary(ies) and provide information on how to file a death claim. A copy of a certified death certificate and other applicable documents will be requested by Securian Financial.

BASIC LIFE INSURANCE PLAN

The Company's Basic Life Insurance Plan provides a level of financial protection at no cost to you so that your family can maintain their standard of living for a reasonable adjustment period in case of your death. Basic Life Insurance covers death from any cause. If you are diagnosed with a terminal illness with a life expectancy of 12 months or less, you may be able to request an advance payment before your death.

Eligibility

Eligible employees are any pilots covered by the collective bargaining agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective November 2, 2015. Deaths occurring prior to November 2, 2015 are governed by the previous agreement.

Securian Financial was implemented as the Insurance Carrier effective January 1, 2018. Any deaths occurring prior to January 1, 2018, are administered under the previous Insurance Carrier.

Enrollment

Participation in the plan is automatic. However, you must designate your beneficiary(ies) in the enrollment system. If you fail to update beneficiaries, benefits will be paid in accordance with the plan.

When Coverage Begins

Coverage begins on your first day of active work.

You must be actively at work for newly elected coverage (or an increase in coverage) to become effective. If you are not actively at work on the day coverage is to begin, your coverage will start on your next active workday.

A Look at the Benefits and Cost

FedEx pays the full cost of Basic Life Insurance. You automatically have $800,000 of Company-paid Basic Life Insurance. You can elect to decrease the coverage amounts to $300,000, $400,000, $500,000, $600,000, or $700,000 within 31 days following your date of hire or during any Annual Benefits Enrollment period. If you wish to increase coverage at any time in the future, you can request to increase during Annual Benefits Enrollment and EOI will be required.

Accelerated Benefit Option

If your life expectancy is 12 months or less, as certified by your physician, you may receive up to 50% of your Basic Life Insurance benefit, to a maximum of $200,000 in a lump sum. The minimum amount is $10,000.

To be eligible, the following conditions apply:

- Benefits will be paid only to you unless you validly assign it otherwise. If you die before the accelerated benefit payment is processed, the benefits will be paid to the beneficiary(ies).
- The Accelerated Benefit Option is requested in writing in a form satisfying the requirements of Securian Financial.
- You must provide Securian Financial with satisfactory proof of your terminal condition, including certification by a health care professional acceptable to the Securian Financial. Securian Financial retains the right to request an independent medical exam to verify the medical condition.
- The insurance must be in force and all premiums current.
- You must be the sole owner of the certificate, and the ownership cannot be assigned.
- The certificate cannot have an irrevocable beneficiary.
- You may choose to accelerate a partial accelerated benefit; however, the total amount of the benefits cannot exceed $200,000.
- Your request is made on a voluntary basis only. This benefit is not available if you are required by law to use this to meet claims of creditors, whether in bankruptcy or otherwise, or you are required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

You should get advice from your personal tax advisor or an attorney about how this option may affect your taxable income. This benefit will be paid to you in a lump sum.

When you choose this option, the total amount of Basic Life Insurance that is ordinarily paid upon your death is reduced by the amount already paid as an Accelerated Benefit Option. When you leave the Company, if eligible, you may port or convert any amount that was not paid to you under the Accelerated Benefit Option. Contact Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area for further information.

Imputed Income for Basic Life Insurance Coverage

Under current federal tax laws, an employee is required to pay tax on the value of Company-paid Basic Life Insurance in excess of $50,000. The value of the insurance is determined by the employee's age as of December 31 of the calendar year during which the benefit is taxable. If applicable, state income tax may apply. This imputed income (also known as Excess Life) must be added to your gross wages and is reported on your W-2. The imputed income is based on your age and calculated using "Uniform Premiums for $1,000 of Group-term Life Insurance Protection" of the Income Tax Regulations governing group-term life insurance below.

Uniform Premiums for $1,000 of Group-Term Life Insurance Protection	
5-year Age Bracket	**Cost per $1,000 of Protection for One Month**
Under 25	$ 0.05
25-29	$ 0.06

Uniform Premiums for $1,000 of Group-Term Life Insurance Protection	
5-year Age Bracket	**Cost per $1,000 of Protection for One Month**
30-34	$ 0.08
35-39	$ 0.09
40-44	$ 0.10
45-49	$ 0.15
50-54	$ 0.23
55-59	$ 0.43
60-64	$ 0.66
65-69	$ 1.27
70+	$ 2.06

The imputed income is provided on https://fedexpilots.bswift.com. The imputed income amount is reflected on your paycheck stub under the code IMPINCLIFE and on the W-2 at year end in Box 12 code C. It does not represent a cash payment to you and, therefore, is not included in your net pay calculation. The taxes associated with these earnings, however, are withheld from your check and do reduce your net pay amount.

Example: Pilot is 40 years old and coverage amount is $800,000. The taxable Life Insurance benefit is calculated as follows:

Basic Life Insurance Value	$800,000
Less Tax-Free Amount	$ 50,000
Amount of Life Insurance Beyond Tax-Free Amount	$750,000
$750,000/$1,000 IRS Specified Premium for a 40-year-old individual per $1,000 coverage	$ 750.00 x $ .10
Monthly amount subject to taxation Amount reported as IMPINCLIFE on bi-monthly paycheck stub each pay period	$ 75.00 $ 37.50

When Coverage Ends

Your coverage ends on the earliest of:

- The day you cease to be a pilot eligible for coverage
- The day you no longer work for the Company
- The day the group policy terminates; however, benefits will continue to be provided pursuant to the terms of the Collective Bargaining Agreement, if applicable
- The day you no longer receive furlough pay, after you are placed on furlough
- FedEx Express discontinues the plan, which could only be done pursuant to the Collective Bargaining Agreement or a successor collective bargaining agreement

- When, if ever, the Collective Bargaining Agreement or a successor collective bargaining agreement no longer provides for this coverage

OPTIONAL LIFE INSURANCE PLAN

Optional Life Insurance is group term life insurance. It pays life insurance benefits to your beneficiary(ies) or estate in the event of your death. Through the Optional Life Insurance Plan, you can purchase additional life insurance protection. If you elect Optional Life Insurance, you pay the premiums with after-tax dollars. FedEx Express has negotiated competitive rates for this coverage, and your payments are made through convenient payroll deductions.

Eligibility

Pilot Coverage

Eligible employees are any pilots covered by the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective November 2, 2015. Deaths occurring prior to November 2, 2015, are governed by the previous agreement.

Securian Financial was implemented as the Insurance Carrier effective January 1, 2018. Any deaths occurring prior to January 1, 2018, are administered under the previous Insurance Carrier.

Dependent Coverage

If you are an active pilot with Optional Life Insurance, you may purchase additional coverage for your dependents.

Spouse Optional Life: You must elect Optional Life coverage for yourself in order to elect Spouse Optional Life coverage. You can elect as a new hire or at any time in the future. If you elect coverage at any time outside of your initial eligibility period, or increase coverage, your spouse is required to provide EOI and be approved by medical underwriting. If you elect coverage for your spouse within the initial eligibility period, you should only have to provide EOI for amounts over the guaranteed issue amount of $75,000. If you have questions call Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area.

Dependents eligible to be covered under your Optional Life Insurance include your:

- Legally married spouse (as defined by federal law), who is not legally separated from you.
- Common-Law Spouse (as defined by the state where Common-Law status is established), who is not legally separated from you.
- You or your spouse’s natural, legally adopted stepchildren or children for whom you have legal guardianship who are less than 26 years old.
- A child who is legally placed for adoption with you.

- Children age 26 or older who are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on you for more than one-half of their support and maintenance.
- Child eligibility begins at live birth (stillborn or unborn children are not eligible).

If your spouse is added to your Optional Life coverage within 31 days following your date of marriage, your spouse will only have to provide EOI for any amounts over the guarantee issue amount of $75,000.

Your spouse/child(ren) cannot be covered as an eligible dependent if:

- He or she is also eligible for Optional Life Insurance coverage as a permanent full-time or permanent part-time employee of FedEx Corporation or a participating employer in any FedEx insurance Plan, or
- On active duty in the armed forces of any country, or
- Your coverage has ended, except during the conversion and portability grace periods.
- Coverage ends automatically on a child's 26th birthday unless incapacitated as previously described.

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would have otherwise become effective, the effective date will be delayed until he or she is released from hospitalization or confinement.

Dependents listed on Pilot Benefits Online are not necessarily eligible for or enrolled in coverage under the life insurance plans. The Dependent Verification Center 1.800.953.5393 may request to provide with proof of eligibility, such as a birth certificate, marriage license, adoption form, or any other legal documentation for any dependent. Documentation may also be requested by the carrier for further proof of eligibility.

The pilot is the beneficiary of all dependent coverage.

Married to Another Pilot/Employee Who Is Also Eligible to Participate in the Optional Life Insurance Plan

If you are a pilot and you are married to another pilot of FedEx Express, your pilot spouse cannot be covered as an eligible dependent but may elect to participate in the Optional Life Insurance Plan as a pilot.

Dependent children may not be covered as eligible dependents of more than one pilot. If both you and your pilot spouse or you and another pilot have the same dependents and are a pilot with Optional Life Insurance coverage, benefits are payable to only one pilot. Absent any written agreement designating which pilot will cover the children, the pilot who first enrolled in the Optional Life Insurance Plan will be the beneficiary of dependent coverage.

Enrollment

You must enroll on Pilot Benefits Online at https://fedexpilots.bswift.com within 31 days following your hire date. If you enroll past that date, you must provide EOI to the Insurance Company. EOI is also required when applying for increased coverage unless there is an Optional Life open enrollment period. However, if you or your spouse have ever been denied Optional Life coverage by the Insurance Company, EOI will be required for those previously denied.

You must be actively at work to enroll in the plan. If you are not actively at work on the day you would be eligible to enroll, your enrollment date would be the next active workday in which you return.

You must designate your beneficiary(ies) on Pilot Benefits Online at https://fedexpilots.bswift.com. If you do not designate a beneficiary(ies) on Pilot Benefits Online website, benefits will be paid according to the ordering rules established in the policy in this order:

- Your lawful spouse if living; otherwise
- Your natural or legally adopted child(ren) in equal shares, if living; otherwise
- Your parents, in equal shares, if living; otherwise
- Your natural or legally adopted sibling(s) in equal shares, if living; otherwise
- Your estate

Evidence of Insurability (EOI)

In some situations, documentation is required by Securian Financial to substantiate that you are in good medical condition. EOI is required if:

- You enroll more than 31 days following initial eligibility,
- Your coverage ends due to nonpayment of required premiums (to reinstate coverage, you would need to reenroll and provide acceptable EOI),
- You wish to enroll or increase coverage and are beyond the 31-day enrollment period, or
- You wish to enroll but have been denied coverage because of failure to meet a previous EOI requirement for this plan.

EOI is required for your spouse if:

- He or she is added to your Optional Life Insurance coverage more than 31 days following your date of marriage or date of initial eligibility,
- He or she was previously denied Optional Life Insurance coverage by the Insurance Company, or
- His or her coverage ended because you did not pay the required premium and you want to resume his or her coverage.

- To provide EOI when enrolling in Optional Life or increasing your coverage, you will be emailed a notification from Securian Financial to complete your EOI online. When enrolling in Optional Spouse Life, your spouse will also be required to complete an EOI and return to Securian Financial for review. You have the option to provide the spouse's email address and profile information through the online site which allows Securian Financial to email login credentials to the online EOI site for completion. Otherwise, the spouse will receive EOI notification by mail at your address in the HR system and will be required to complete and return the form to Securian Financial for review. Approval or denial of coverage will be made by Securian Financial after reviewing your completed EOI form and any requested information needed for a decision. If you are an FDA pilot, this exam must be obtained in the United States.

When Coverage Begins

If you enroll within 31 days following your initial eligibility, your coverage begins on your first day of eligibility for any coverage which does not require EOI. You must be actively at work on the day coverage (or a change in coverage) becomes effective. If you are not actively at work on the day coverage (or a change in coverage) is to begin (i.e., on LTD or Medical Leave of Absence beyond the period for which you are paid medical absence/sick bank days), on military or other leave of absence, or are receiving Workers Compensation benefits, your coverage (or change in coverage) will start on the next active workday in which you meet these requirements. Any amount of coverage which requires medical underwriting will be effective on the date the underwriter approves.

If you do not enroll within the 31 days following your initial eligibility, your coverage (or change in coverage) will begin on the date Securian Financial completes review of your EOI and approves the coverage.

Check your payroll deductions to ensure that the proper amounts are being deducted for coverage. If the deductions are not correct within two pay periods, notify Pilot Benefits Administration. If no deductions have been made from your check, there is no insurance coverage. It is your responsibility to ensure that the appropriate payroll deduction begins after making your election.

If you do not enroll within the 31-day eligibility period, you must submit EOI to Securian Financial. Contact Securian Financial at 1.800.872.2214 between 7:00 a.m. and 7:00 p.m. CST if you have questions regarding the medical underwriting process.

A Look at the Benefits and Cost

Coverage

Based on the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective November 2, 2015, Optional Life Insurance coverage is available in increments of $100,000 to a maximum of $2,000,000 of coverage, not to exceed ten (10) times your basic annual salary. Up to the lesser of 10 times your basic salary or $1,000,000 is guaranteed, without providing EOI, if you elect coverage within 31 days following your date of hire.

Optional Life Insurance	
Coverage Amount Available to Pilots	You may elect coverage in increments of $100,000 up to a maximum of $2,000,000—but not to exceed 10 times basic annual salary.
Coverage Amount Available to Eligible Dependents	● You have the option to elect Spouse Optional Life in increments of $25,000, $50,000, $75,000, $100,000, $200,000, $300,000, $400,000, or $500,000 for the eligible spouse (not to exceed 100% of the amount of optional life elected for the pilot). Up to $75,000 (not to exceed 100% of the amount of optional life coverage elected for pilot) is guaranteed, without providing EOI, if the spouse coverage is elected within 31 days following date of hire or within 31 days of marriage. ● You have the option to purchase Child Optional Life in $5,000 increments, up to $20,000, not to exceed 100% of the amount of optional life elected for the pilot. All coverage is guaranteed and there is no EOI required. After the initial eligibility period, you can only add or increase Child Optional Life coverage during an annual enrollment period.* ● Your first eligible newborn child is automatically covered for $5,000 for 31 days from the child's live birth. To continue coverage on the first child, you must elect child coverage within the 31-day period. ● Please ensure all eligible dependents are added to Pilot Benefits Online at https://fedexpilots.bswift.com.
Enrollment	You can newly elect to add or increase Optional Life or Spouse Optional Life any time throughout the year. To newly elect coverage or increase the coverage amount, you must provide Evidence of Insurability and be approved by Securian Financial medical underwriting. You must be actively at work for coverage to become effective or to increase Optional Life Insurance coverage. After the initial eligibility period, you can only add or increase Child Life coverage during an annual enrollment period or within 31 days of a qualified status change. Coverage can be decreased for Optional Life, Spouse Optional Life, or Child Optional life at any time.
Effective Date of Coverage	● If your election is made within your new hire eligibility period, coverage is effective on your date of hire for all guaranteed issue coverage. ● If your election is made after your new hire eligibility period, your elected coverage is effective the date your Evidence of Insurability is approved by Securian Financial. ● If on Leave of Absence when coverage would otherwise go into effect, coverage will not become effective until you return to active work. ● Any amounts of coverage which require medical

Optional Life Insurance	
	underwriting will be effective on the date approved by Securian Financial.
*Children must meet all eligibility criteria including age and relationship.	

Refer to the most recent Pilot Enrollment Guide for current rate information. The guide is located under the Educate tab on https://fedexpilots.bswift.com.

Basic Annual Salary

You may elect coverage in increments of $100,000 up to a maximum of $2,000,000—but not to exceed 10 times basic annual salary. Your basic annual salary is based on the annualized average of the last three months (six full pay periods) you worked prior to the last day you were available to work including:

- All credit hours, including but not limited to:
  - Draft
  - Volunteer
  - Trip make-up for which you receive pay
  - International Override
  - Passover Pay (POP)
- Premiums for:
  - Flex Instructors/Proficiency Check Airmen (PCA)
  - Line Check Airmen (LCA)
  - Flex Flight Standards Check Airmen (SCA)
  - Flight Project Specialist (FPS)
  - Technical Advisor/Aircraft (TAA)
  - Passover Retro Pay (POR)
  - FAA Designee (FAA)
- Sick leave hours drawn from your sick bank during illness
- Vacation pay, except vacation hours used following your last day available to work

Basic annual salary includes pay prior to deductions (i.e., pre-tax health care, dependent care, and your PRSP/401(k) contributions).

For new hire pilots, basic annual salary is 12 times the monthly salary.

After the initial new hire period, the salary is annualized and frozen each year prior to annual enrollment. It will be updated at the same time each calendar year and increases in coverage will be based on the most recent annualized salary.

Exclusions from basic annual salary include but are not limited to:

- Domestic and International Per Diem
- Long-Term Disability (LTD) payments
- Sick bank hours drawn from your sick bank following your last day available to work
- PRSP Employer Matching contributions
- PRSP Employer Sick Bank contributions
- Non-elective Employer contributions to the PRSP
- Excess Life Premiums (Imputed income for life insurance coverage)
- Reimbursed expenses

Accelerated Benefit Option

If you or your dependents have a life expectancy of 12 months or less as certified by a physician, you may receive up to 50% of the Optional Life, Spouse Optional Life, or Child Optional Life Insurance benefit, to a maximum of $800,000 and will be paid in a lump sum.

To be eligible, the following conditions apply:

- Benefits for Optional Life will be paid only to you unless you validly assigned. If death occurs before the accelerated benefit payment is processed, the benefits will be paid to the beneficiary(ies).
- The Accelerated Benefit Option is requested in writing in a form satisfying the requirements of Securian Financial.
- You must provide Securian Financial with satisfactory proof of the claimant's terminal condition, including certification by a health care professional acceptable to Securian Financial. Securian Financial retains the right to request an independent medical exam to verify the medical condition.
- The insurance must be in force and all premiums current.
- You must be the sole owner of the certificate and the ownership cannot be assigned.
- The certificate cannot have an irrevocable beneficiary.
- You may choose to accelerate a partial accelerated benefit; however, the total amount of the benefits cannot exceed 50% of the coverage amount to a maximum of $800,000.
- Your request is made on a voluntary basis only. This benefit is not available if you are required by law to use this to meet claims of creditors, whether in bankruptcy or otherwise, or you are required by a government agency to use this option in order to apply for, obtain or keep a government benefit or entitlement.
- Benefits for dependents will be payable to you.

You should get advice from your personal tax advisor or an attorney about how this option may affect your taxable income. This benefit will be paid to you in a lump sum.

When you choose this option, the total amount of life insurance that is ordinarily paid upon death is reduced by the amount already paid as an Accelerated Benefit Option. When you leave the Company, if eligible, you may port or convert any amount that was not paid to you under the

Accelerated Benefit Option. Call Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area for more information.

When Coverage Ends

Your coverage ends on the earliest of:

- The day you cease to be a pilot eligible for coverage
- The day you no longer work for the Company
- The last day for which you have paid premiums for Optional Life
- The day the group policy terminates
- The day you no longer receive furlough pay, after you are placed on furlough
- The day FedEx Express discontinues the plan, which could only be done pursuant to the Collective Bargaining Agreement or a successor collective bargaining agreement
- When, if ever, the Collective Bargaining Agreement or a successor collective bargaining agreement no longer provides for this coverage

Your dependents' coverage ends on the earliest of the dates listed above or the day your dependent no longer meets the eligibility requirements.

In the event of death, a conversion period extends your coverage 31 days. See "Rules Applicable to All Insurance Plans."

If your coverage ends, and your spouse is a pilot and participates in the Optional Life Insurance Plan, you may be eligible for coverage as a dependent under the applicable Plan. Contact Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area within 31 days of the end of your coverage.

Refer to "Rules Applicable to All Insurance Plans" for details on how certain events, such as termination, retirement, or leaves of absence affect your coverage under this plan and portability and conversion options available.

If you no longer have an eligible dependent, **it is your responsibility to change your Spouse or Child life coverage so the appropriate premium will be deducted.**

It is your responsibility to ensure that payroll deductions end. If they do not end within two pay periods, notify Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area. There is a 3-month time limit for requesting refunds of Optional Life Insurance payroll-deducted overpayments due to cancellation of coverage.

RETIREE OPTIONAL LIFE INSURANCE PLAN

Pursuant to the terms of the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective November 2, 2015, pilots age 55 or older and actively at work who retire (or terminate) will have the opportunity to enroll in Retiree Optional Life Insurance through a group term policy issued and administered by Securian Financial. Enrollment will be based on your being actively at work at the time of retirement (or termination) and your active participation in the Federal Express Corporation Optional Life Insurance plan prior to retirement (or termination).

How much coverage can I purchase through Retiree Optional Life Insurance?

You will be able to enroll in Retiree Optional Life Insurance for:

- **Pilot coverage.** You may purchase coverage in increments of $100,000, to the lesser of $300,000 of coverage or your pre-retirement Optional Life coverage level, as you elect. However, once you have enrolled and elected your level of Retiree Optional Life Insurance coverage, you cannot increase your coverage at a later date. You can decrease your coverage from $300,000 to $100,000 or $200,000 at any time.
- **Spousal coverage.** You may purchase spousal coverage, provided you had pre-retirement Spouse Optional Life Insurance coverage on that spouse and you enroll in Retiree Optional Life Insurance. Your spouse is not eligible if home or hospital-confined on your retirement date or over age 80. If you were enrolled in spouse coverage prior to retirement, you may elect to continue either $25,000 or $50,000 coverage, not to exceed the pre-retirement amount, after retirement. If you terminate your coverage at a later date, your spouse's coverage also terminates.

There is no coverage available for dependent children through the Retiree Optional Life Insurance plan. Benefits are subject to the same age reductions as an active employee. Beginning on the pilot's 65th birthday, the benefits will reduce by 8% each year until age 70 and will terminate at age 80. Though there are no age reductions in the spouse's coverage; the coverage will terminate at age 80.

You are not eligible for Retiree Optional Life if you are not actively at work (i.e., on LTD or Medical Leave of Absence beyond the period for which you are paid medical absence/sick bank), on military or other leave of absence or receiving Workers Compensation benefits immediately prior to your retirement/termination. For spousal coverage, Securian Financial will request verification that your spouse was not home or hospital confined on the day of your retirement/termination.

How do I enroll in Retiree Optional Life Insurance?

If you are actively at work immediately prior to termination and were an Optional Life Insurance participant age 55 or older when you retire or terminate on or after November 2, 2015, you will receive notification from Securian Financial regarding your eligibility for Retiree Optional Life Insurance and enrollment instructions. You will have 31 days from the later of your retirement

date or the eligibility notice date to contact Securian Financial to enroll yourself and your eligible spouse.

If you die or divorce, your covered spouse under age 80 not hospital or home confined will be eligible to continue $25,000 or $50,000 in Retiree Optional Life Spousal coverage, provided this coverage had been elected prior to the retired pilot's death or divorce. Your spouse will receive notification from Securian Financial regarding eligibility and enrollment instructions. Your spouse will have 31 days from the date of your death or divorce or the eligibility notice date to contact Securian Financial to continue coverage.

Retiree Optional Life Insurance Premiums

The pilot premium for Retiree Optional Life Insurance is based on the pilot's age and rate per $1,000. If a pilot elects Pilot and Spouse coverage, the total premium is the spouse's premium (based on the spouse's age and rate per $1,000) added to the pilot's premium. Refer to the most recent Pre-65 Retiree Pilot Enrollment Guide for current rate information. The guide is located under the Educate tab on https://fedexpilots.bswift.com.

NOTE: Your spouse is eligible for coverage only if you enroll for coverage.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT (BASIC AD&D) PLAN

You have additional financial protection available through the Basic AD&D Plan, if you are injured or die in a covered accident. Accidental death and dismemberment is limited coverage. Coverage will provide benefits only when your loss, death, or dismemberment results directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected, and unforeseen. Please reference the certificate for exclusions under this policy.

Eligibility

Eligible employees are any pilots covered by the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective November 2, 2015.

Pilots continue to be eligible for coverage:

- When performing Civil Reserve Air Fleet (CRAF) missions, or
- For a covered injury suffered due to a terrorist act worldwide.

Enrollment

Participation is automatic. However, you must designate your beneficiary(ies). Refer to “Designate or Change a Beneficiary for All Insurance Plans.” If you do not designate a beneficiary(ies) on Pilot Benefits Online website, benefits will be paid according to the ordering rules established in the policy in this order:

- Your lawful spouse if living; otherwise
- Your natural or legally adopted child(ren) in equal shares, if living; otherwise
- Your parents, in equal shares, if living; otherwise
- Your natural or legally adopted sibling(s) in equal shares, if living; otherwise
- Your personal representative of your estate.

When Coverage Begins

Basic AD&D coverage begins on your first day of active work.

You must be actively at work for coverage to become effective. If you are not actively at work on the day coverage is to begin, your coverage will start on the next active workday.

A Look at the Benefits and Cost

The Company pays the full cost of Basic AD&D benefits.

Death Benefit

If you die accidentally or if a covered injury results in your death within 365 days of the covered accident, Basic AD&D provides your beneficiary(ies) a benefit of $15,000.

Dismemberment Benefit

If a covered injury results in any of the following losses within 365 days of a covered accident, you receive a percentage of your death benefit amount as shown in the following chart:

Type of Loss	Percentage of Pilot Death Benefit Amount
Loss of both hands, both arms, both legs, both feet, both eyes, or any combination	100%
Loss of speech and hearing in both ears	
Loss of one arm or one leg	70%
Loss of speech, hearing in both ears, one hand, one foot, or entire sight in one eye	50%
Loss of thumb and index finger of the same hand	25%

Loss is defined as:

- Loss of an arm or leg—Actual and complete severance at or above elbow or knee.
- Loss of a hand or foot—Actual and complete severance through or above the wrist or ankle joint.
- Loss of sight—Irrecoverable loss of the entire sight in that eye.
- Loss of the thumb and index finger—Actual and complete severance through or above the metacarpophalangeal joints (joint closest to the palm of the hand).
- Loss of speech—Complete and irrecoverable loss of the entire ability to speak.
- Loss of hearing—Complete and irrecoverable loss of the entire ability to hear in both ears.

Benefits may be paid for more than one accidental loss but the total amount of AD&D payable under this certificate for any one accident, not including amounts paid under the Additional Benefits section, will never exceed the full amount of the insured's AD&D Insurance.

Paralysis Benefit

Basic AD&D pays a benefit equal to the percentage of the benefit amount shown if:

- As the result of a covered injury, you sustain a type of paralysis listed below,
- Such paralysis occurs within 365 days of the date of the covered accident, and
- Competent medical authority determines paralysis is complete and irreversible.

Type of Loss	Percentage of Pilot Death Benefit Amount
Quadriplegia (total paralysis of both upper and both lower limbs)	100%
Triplegia (total paralysis of three limbs)	75%
Paraplegia (total paralysis of both lower limbs)	50%
Hemiplegia (total paralysis of upper and lower limbs on same side of body)	50%
Uniplegia (total paralysis of a single limb)	25%
Coma	11%
NOTE: Limb is defined as an entire arm or entire leg	

If the Insured Person suffers more than one type of paralysis as a result of the same covered accident, only one amount, the largest, will be paid. Basic AD&D will not pay more than 100% of your benefit amount for any combination of paralysis, coma, dismemberment, and death as the result of the same covered accident.

Additional Basic AD&D Benefits		
This additional benefit…	**Pays….**	**When...**
Coma	Monthly benefit to the lesser of: 1. 1% of the AD&D benefit amount; or, 2. 1% of the difference between insured's amount of AD&D Insurance and the amount of any benefits paid under the loss schedule for the same accident (if the full AD&D benefit has been paid, no benefit is payable under this section).	You sustain a covered injury that results in a coma within 31 days of a covered accident and the coma continues for a minimum of 31 consecutive days.
Felonious Assault	Additional 10% of pilot's death benefit amount to a maximum of $25,000.	If Pilot dies or suffers a covered dismemberment as a result of a covered accident caused by a felonious assault, while acting on behalf of the Company, an additional benefit will be paid.
Rehabilitative Physical Therapy Benefits	Reimbursement of reasonable and necessary expenses up to a maximum of $10,000/covered accident.	You suffer an injury which results in a covered dismemberment, additional benefits will be paid for rehabilitative physical therapy prescribed by physician or surgeon.
Seat Belt and Air Bag	Seat belt: Additional 10% of pilot's death benefit amount to a maximum of $25,000. Air bag: Additional 5% of pilot's death benefit amount to a maximum of $10,000.	Seat belt: You suffer loss of life as a result of a covered accident which occurs while driving or riding in private passenger car, an additional benefit may be payable. The car must have been equipped with seatbelts, in proper use by the insured, as documented in the official

Additional Basic AD&D Benefits		
This additional benefit…	**Pays….**	**When...**
		accident report by the investigating officer and the driver of the car must not have been intoxicated, impaired, or under the influence of alcohol or drugs. Air bag: You suffer loss of life as a result of a covered accident which occurs while driving or riding in a private passenger car, an additional benefit may be payable. The seat in which the insured was seated must have been equipped with a properly installed air bag at the time of the accident, the car must have been equipped with seatbelts in proper use by the insured, as documented in the official accident report or by the investigating officer, and the driver must not have been intoxicated, impaired, or under the influence of alcohol or drugs.
Exposure and Disappearance Benefit	The amount payable according to the loss schedule for exposure The employee's death benefit amount for disappearance	If by reason of a covered accident, you are unavoidably exposed to the elements and as a result of such exposure suffer a loss for which a benefit is otherwise payable, the loss will be covered. If the body has not been found within one year of the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which you were an occupant, the accidental death benefit is payable.
Reserve-National Guard Benefit	Benefits will be paid for a covered loss while the insured is a member of an organized Reserve Corps or National Guard Unit	Benefits will be paid if the insured is attending or en route to a regularly scheduled training for less than 60 days, a service school operated by or on behalf of the United States of America or Canada, no matter how long, or taking part in any authorized inactive duty training or taking part as a unit member in a parade or exhibition authorized by official orders. No benefit is payable for a loss that occurs during active duty.
Hospital/ Extended Care Facility Benefit	An additional benefit equal to the lesser of 2% of the pilot's death benefit amount or $3,000 per month or actual charges made by the hospital/extended care facility, up to a maximum of 12 months.	If an insured requires hospitalization as a result of a covered accident, an additional benefit is payable after 7 consecutive days of hospital confinement due to a covered injury, a benefit will be payable retroactive to the 1st day of

Additional Basic AD&D Benefits		
This additional benefit…	**Pays….**	**When...**
		confinement and pro-rated daily, to a maximum of 12 months.

NOTE: Pilot is required to provide proof of incurred expenses to obtain applicable benefits as described in above chart.

For purposes of this Policy, a covered accidental injury means a bodily injury:

1. Which is sustained as a direct result of an unintended, unexpected, and unforeseen accident that is external to the body and that occurs while your coverage under the Policy is in force,
2. Which directly (independent of sickness, disease, or any other cause) causes a covered loss, and
3. You suffer the covered loss within 365 days after the date of the covered accidental injury.

Basic AD&D Exclusions

AD&D will not pay an accidental death or dismemberment benefit when the accident, injury, loss, death, or dismemberment is caused directly or indirectly, results in whole or in part from, or there is contribution from any of the following, whether sane or insane:

- Intentionally self-inflicted injury, self-destruction, or autoeroticism whether sane or insane; or
- Suicide or attempted suicide whether sane or insane; or
- Your participation in, or attempt to commit a crime, assault, felony, or any illegal activity, regardless of any related legal proceedings; or
- Bodily or mental infirmity, illness, or disease; or
- The use of alcohol, prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes, or other substances taken absorbed, inhaled, ingested, or injected. This does not include involuntary inhalation of gases and fumes, or the involuntary taking of poison; or
- Motor vehicle collision or accident where the insured is the operator of the vehicle and their blood alcohol level meets or exceeds the level of intoxication as defined in the state where the accident occurred, regardless of any related legal proceedings; or
- Infection, other than infection occurring simultaneously with, and a direct result of a covered accidental injury; or
- Medical or surgical treatment or diagnostic procedures or any resulting complications including from medical misadventure; or
- Travel in or decent from any aircraft except:
    a. as a fare paying passenger on a scheduled commercial flight on a licensed passenger aircraft; or

b. as a pilot, who is performing his or her normal job duties for the employer in any aircraft with a current and valid Airworthiness Certificate (“Standard” and issued by the Federal Aviation Agency of the United States of America or its equivalent government authority having jurisdiction over civil aviation in the country of registry) owned, leased, or operated by the policyholder; or

c. as a pilot, who is performing his or her normal job duties for the employer while performing Civil Reserve Air Fleet (CRAF) missions or Air Mobility Command (AMC).

- War or any act of war, whether declared or undeclared. This exclusion applies only within the geographic limits or territorial water of, or airspace above the geographic limits of or the territorial waters of the United States of America and the insured’s country of domicile.

Please reference the policy for further details on the exclusions.

When Coverage Ends

Your coverage ends on the earliest of:

- The day you cease to be a pilot eligible for coverage
- The day you no longer work for the Company
- The day the group policy terminates; however, benefits will continue to be provided pursuant to the terms of the Agreement
- The day you no longer receive furlough pay, after you are placed on furlough
- The day FedEx Express discontinues the plan, which could only be done pursuant to the Collective Bargaining Agreement or a successor collective bargaining agreement
- When, if ever, the Collective Bargaining Agreement or a successor collective bargaining agreement no longer provides for this coverage

Option to Purchase Basic AD&D Portability

When coverage ends under Basic AD&D, Portability is available prior to age 55 and is contingent upon electing Portability for Basic Life coverage. Coverage under Portability ends at age 80. Coverage begins upon receipt of premium and application within 31 days after coverage ends under Basic AD&D. The minimum amount of Basic AD&D coverage that can be continued on an employee is $10,000 with the maximum amount no more than the lesser of $15,000 or the amount of Basic Life coverage ported. You will receive information from Securian Financial regarding your option to continue coverage under Portability.

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (OPTIONAL AD&D) PLAN

Eligibility

Eligible employees are any pilots covered by the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective November 2, 2015.

Pilots continue to be eligible for coverage:

- When performing Civil Reserve Air Fleet (CRAF) missions, or
- For a covered injury suffered due to a terrorist act worldwide.

Pilots are eligible for Optional AD&D on the first day of active work.

If you are an active pilot with Optional AD&D, you may purchase additional Optional AD&D coverage for your eligible dependents. You may enroll in Pilot Only or Pilot & Child(ren) coverage. You must list your dependents on Pilot Benefits Online (https://fedexpilots.bswift.com) and validate their eligibility.

Dependents eligible to be covered under your Optional AD&D Insurance include your:

- Legally married spouse (as defined by federal law), who is not legally separated from you.
- Common-Law Spouse (as defined by the state where Common-Law status is established), who is not legally separated from you.
- You or your spouse's natural, legally adopted stepchildren or children for whom you have legal guardianship who are less than 26 years old.
- A child who is legally placed for adoption with you.
- Children age 26 or older who are physically or mentally incapable of self-support, were incapable of self-support prior to age 26, and are financially dependent on you for more than one-half of their support and maintenance.
- Child eligibility begins at live birth (stillborn or unborn children are not eligible).

Your spouse/child(ren) cannot be covered as an eligible dependent if:

- He or she is also eligible as a pilot of FedEx Express or on active duty in the armed forces of any country.

Please ensure your eligible dependents are listed on Pilot Benefits Online at https://fedexpilots.bswift.com. Dependents listed on Pilot Benefits Online are not necessarily eligible for or enrolled in coverage under the life insurance plans. You may be requested to provide the Dependent Verification Center 1.800.953.5393 with proof of eligibility, such as a

birth certificate, marriage license, adoption form, or any other legal documentation for any dependent. Documentation may also be requested by the carrier for further proof of eligibility.

The pilot is the beneficiary of all dependent coverage.

Married to Another Pilot Who Is Also Eligible to Participate in the Optional AD&D Insurance Plan

If you are a pilot and you are married to another pilot of FedEx Express, your pilot spouse cannot be covered as an eligible dependent but may elect to participate in the Optional AD&D Insurance Plan as a pilot.

Dependent children may not be covered as eligible dependents of more than one pilot. If both you and your pilot spouse or you and another pilot have the same dependents and are a pilot with Optional AD&D Insurance coverage, benefits are payable to only one pilot. Absent any written agreement designating which pilot will cover the children, the pilot who first enrolled in the Optional Life Insurance Plan will be the beneficiary of dependent coverage.

Enrollment

To enroll in Optional AD&D, log in to Pilot Benefits Online at https://fedexpilots.bswift.com. If you do not designate a beneficiary(ies) on Pilot Benefits Online, benefits will be paid according to the ordering rules established in the policy in this order:

- Your lawful spouse if living; otherwise
- Your natural or legally adopted child(ren) in equal shares, if living; otherwise
- Your parents, in equal shares, if living; otherwise
- Your natural or legally adopted siblings in equal shares, if living; otherwise
- Your natural or legally adopted sibling(s) in equal shares, if living; otherwise
- Your estate

You can enroll in Optional AD&D or increase coverage at any time during the year without EOI. You must be actively at work to enroll in the plan. If you are not actively at work on the day you would be eligible to enroll, your enrollment date would be the next active workday in which you return.

You may drop or reduce the amount of coverage at any time.

When Coverage Begins

If you elect Optional AD&D coverage within your initial eligibility period, as a new hire, your coverage will be effective first of the month following date of hire. If you add or change coverage after the initial eligibility period your coverage will be effective first of the month following your date of election.

If you are not actively at work on the day coverage is to begin or increase, your coverage will start on the next active workday. If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date would be delayed until he or she is released from the hospitalization or confinement (except in the case of a newborn).

Check your payroll deductions to ensure that the proper amounts are being deducted for coverage. If the deductions are not correct within two pay periods, notify Pilot Benefits Administration. If no deductions have been made from your check, there is no insurance coverage. It is your responsibility to ensure that the appropriate payroll deduction begins after making application. Please ensure your eligible dependents are listed on Pilot Benefits Online at https://fedexpilots.bswift.com if you are electing Optional AD&D Pilot & Child(ren) coverage.

A Look at the Benefits and Premiums

Optional AD&D provides the following benefits if you or a covered dependent dies:

Optional AD&D Insurance Coverage	
Coverage Amount Available to Pilots	From $50,000 to $750,000 (in increments of $50,000)
Coverage Amount Available to Eligible Dependents	• 75% of pilot's coverage for eligible spouse to a maximum of $375,000 • 30% of pilot's coverage for eligible children to a maximum of $70,500 for a child
Enrollment	• You can newly elect, increase or decrease coverage anytime throughout the year. Evidence of Insurability is not required. • You must be actively at work for coverage to become effective or to increase optional coverage. Dependents cannot be hospitalized or confined on the effective date of coverage.
Effective Date of Coverage	First day of the month following the date of your election

Refer to the most recent Pilot Enrollment Guide for current rate information. The guide is located under the Educate tab on https://fedexpilots.bswift.com.

Death Benefit

If you die accidentally or if a covered injury results in your death within 365 days of the covered accident, Optional AD&D provides your beneficiary(ies) a benefit of 100% of the coverage amount elected if you elect Pilot Only coverage. If you elect Pilot & Child(ren) coverage, the death benefit is 75% of the amount elected for a covered spouse and 30% of the amount elected for covered children.

Dismemberment Benefit

If you or a covered spouse suffers a covered loss within 365 days of a covered accident, you will receive benefits as shown in the following chart:

Type of Loss	Percentage of Death Benefit Amount
Loss of both hands, both arms, both legs, both feet, both eyes or any combination	100%
Loss of speech and hearing in both ears	
Loss of one arm or one leg	70%
Loss of speech, hearing in both ears, one eye, one hand or one foot	50%
Loss of thumb and index finger of the same hand	25%

If your covered child suffers a covered loss within 365 days of a covered accident, you will receive a benefit as shown in the following chart:

Child Dismemberment or Paralysis Benefit	
Type of Loss	**Percentage of Child Death Benefit Amount**
Loss of both arms, legs, hands, feet, eyes or any combination; or quadriplegia	100%
Loss of speech and hearing in both ears	
Triplegia	100%
Loss of one arm or leg	70%
Loss of speech, hearing, one hand, one foot, or sight in one eye; paraplegia or hemiplegia	50%
Loss of thumb and index finger of the same hand; or uniplegia	25%

NOTE: Payment of benefit is subject to the terms and conditions of the Paralysis Benefit.

Loss is defined as:

- Loss of an arm or leg—Actual and complete severance at or above elbow or knee.
- Loss of a hand or foot—Actual and complete severance through or above the wrist or ankle joint.
- Loss of sight—Irrecoverable loss of the entire sight in that eye.
- Loss of the thumb and index finger—Actual and complete severance through or above the metacarpophalangeal joints (joint closest to the palm of the hand).
- Loss of speech—Complete and irrecoverable loss of the entire ability to speak.
- Loss of hearing—Complete and irrecoverable loss of the entire ability to hear in both ears.

Benefits may be paid for more than one accidental loss but the total amount of AD&D payable under this certificate for any one accident, not including amounts paid under the Additional Benefits section, will never exceed the full amount of the insured's AD&D Insurance.

Paralysis Benefit

Optional AD&D pays a benefit equal to the percentage of the benefit amount shown in the prior chart for children and the following chart for adults if:

- As the result of a covered injury, you or your covered spouse sustains a type of paralysis listed below,
- Such paralysis occurs within 365 days of the date of the covered accident, and
- Competent medical authority determines paralysis is complete and irreversible.

Type of Loss	Percentage of Death Benefit Amount
Quadriplegia (total paralysis of both upper and both lower limbs)	100%
Triplegia (total paralysis of three limbs)	75%
Paraplegia (total paralysis of both lower limbs)	50%
Hemiplegia (total paralysis of upper and lower limbs on same side of body)	50%
Uniplegia (total paralysis of one limb)	25%

NOTE: Limb is defined as an entire arm or entire leg.

If Insured Person suffers more than one type of paralysis as a result of the same covered accident, only one amount, the largest, will be paid.

Optional AD&D will not pay more than 100% of your elected benefit amount for any combination of paralysis, coma, dismemberment, and death as the result of the same covered accident.

Additional Optional AD&D Benefits		
This additional benefit…	**Pays…**	**When…**
Adaptive Home and Vehicle Benefit	$10,000 maximum/covered accident provided modifications comply with applicable laws or standards. These one-time alterations expenses must be incurred within two years from the date of the accident.	If Insured Person suffers a loss, other than life, and a benefit is payable under AD&D, a benefit will be paid for medically necessary alterations to the insured's principal residence and modifications to his or her private automobile to make it drivable or rideable.
Coma Benefit	**Monthly** benefit to the lesser of: 1. 1% of the AD&D benefit amount; or, 2. 1% of the difference between insured's amount of AD&D Insurance and the amount of any benefits paid under the loss schedule for the same accident (if the full AD&D benefit has been paid, no benefit is payable under this section).	**You** sustain a covered injury that results in a coma within 31 days of a covered accident and the coma continues for a minimum of 31 consecutive days.

Additional Optional AD&D Benefits		
This additional benefit…	**Pays…**	**When…**
Common Accident Benefit*	Spouse's benefit is increased from 75% to 100% of the pilot's death benefit amount.	Pilot and insured spouse die in the same covered accident or a separate covered accident within a 24-hour period. Both must die within 180 days from the covered accident.
Child Care Benefit	Lesser of 5% of the pilot's death benefit amount or $5,000/year payable annually for up to 4 years or until the child reaches age 13, whichever is earlier.	Pilot suffers loss of life as a result of a covered injury and is survived by one or more insured dependent children under age 13 who are or will be attending an accredited day care center. Benefits will be paid to the surviving parent. No expenses paid more than 4 years from the date of your death.
Extended Dependents Insurance Benefit*	Optional AD&D coverage for insured dependents of pilot is continued for 18 months from death of insured pilot at no charge.	Pilot suffers loss of life as a result of a covered accident.
Child Dismemberment Double Benefits	Twice the AD&D benefit amount listed, to a maximum of $70,500.	Insured dependent child suffers a covered loss, other than loss of life, the amount payable will be twice AD&D benefit, to a maximum of $70,500.
COBRA Benefit	Lesser of 5% of the pilot's death benefit or $5,000.	Pilot suffers loss of life and is survived by insured spouse and/or insured dependent children, a benefit will be paid annually to provide medical benefits through COBRA. This will continue until the earlier of 3 years or the date the dependents cease to be a COBRA participant.
Felonious Assault Benefit	Additional 10% of the pilot's death benefit amount to a maximum of $25,000.	If Pilot dies or suffers a covered dismemberment as a result of a covered accident caused by a felonious assault, while acting on behalf of the Company, an additional benefit will be paid.
Hospital/ Extended Care Facility Benefit	An additional benefit equal to the lesser of 2% of the pilot's death benefit amount or $3,000 per month or actual charges made by the hospital/extended care facility up to a maximum of 12 months.	If an insured requires hospitalization as a result of a covered accident, an additional benefit is payable after 7 consecutive days of hospital confinement due to a covered injury, a benefit will be payable retroactive to the 1st day of confinement and pro-rated daily, to a maximum of 12 months.

Additional Optional AD&D Benefits		
This additional benefit…	**Pays…**	**When…**
Therapeutic Counseling Benefit	An additional benefit for therapeutic counseling up to the lesser of 5% of the Insured Person's death benefit amount or $5,000.	Insured Person requires medically necessary therapeutic counseling provided by a licensed therapist or certified counselor, within 90 days after the date of loss, as a result of a covered injury. Reasonable and customary charges allowed.
Reasonable Accommodation Benefit	Up to $5,000 per covered accident payable to the Company for pre-approved work site accommodations within 12 months of covered accident.	Pilot suffers a loss due to a covered injury and work site changes are required in returning the insured pilot to work.
Permanent Disfigurement Benefit	Additional benefit equal to 10% of the Pilot's death benefit amount, to a maximum of $23,500.	Pilot is critically burned and disfigured to the point of requiring reconstructive or cosmetic surgery, as a result of a covered accident while performing duties at the employer's business or at other places which the Company requires the pilot to travel.
Rehabilitative Physical Therapy Benefit	Reimbursement of reasonable and necessary expenses up to a maximum of $10,000/covered accident.	You suffer an injury which results in a covered dismemberment additional benefit will be paid for rehabilitative physical therapy prescribed by physician or surgeon.

Additional Optional AD&D Benefits		
This additional benefit…	**Pays…**	**When…**
Seat Belt and Air Bag	Seat belt: Additional 10% of Insured Person's death benefit amount to a maximum of $25,000. Air bag: Additional 5% of Insured Person's death benefit amount to a maximum of $10,000.	Seat belt: You suffer loss of life as a result of a covered accident which occurs while driving or riding in private passenger car, an additional benefit may be payable. The car must have been equipped with seatbelts, in proper use by the insured, as documented in the official accident report by the investigating officer and the driver of the car must not have been intoxicated, impaired, or under the influence of alcohol or drugs. Air bag: You suffer loss of life as a result of a covered accident which occurs while driving or riding in a private passenger car, an additional benefit may be payable. The seat in which the insured was seated must have been equipped with a properly installed air bag at the time of the accident, the car must have been equipped with seatbelts in proper use by the insured, as documented in the official accident report or by the investigating officer, and the driver must not have been intoxicated, impaired, or under the influence of alcohol or drugs.
Dependent Child Education Benefit*	Lesser of the actual tuition charged, less room and board, or 5% of pilot's death benefit amount or $10,000, for a maximum of four consecutive years or until the child turns age 26.	If you suffer a loss, an education benefit will be payable on behalf of your insured children who are, at time of death, is a full-time student at an accredited post-secondary educational institution (no benefit will be payable for the current year). A benefit will also be payable for insured dependent children who enroll on a full-time basis in an accredited post-secondary educational institution within one year of your death. The benefit will be paid annually at the beginning of each school year for a maximum of 4 consecutive years for each covered dependent child, or until the child reaches age 26. The benefits are payable to the insured child unless the child is not of legal age. If not, it will be paid to the person who provides proof they will pay the tuition for the child.

Additional Optional AD&D Benefits		
This additional benefit…	**Pays…**	**When…**
Spouse Education Benefit*	Up to the lesser of the actual tuition charged or $5,000/year for a maximum of 4 consecutive years if surviving covered spouse enrolls as a student in an accredited institution within 36 months of insured Pilot's death.	Covered spouse provides proof of enrollment for that term in an accredited institution.
Reserve-National Guard Benefit	Benefits will be paid for a covered loss while the insured is a member of an organized Reserve Corps or National Guard Unit.	Benefits will be paid if the insured is attending or en route to a regularly scheduled training for less than 60 days, a service school operated by or on behalf of the United States of America or Canada, no matter how long, or taking part in any authorized inactive duty training or taking part as a unit member in a parade or exhibition authorized by official orders. No benefit is payable for a loss that occurs during active duty.
Newborn Children Benefit	The amount of benefit will be the smallest amount available for dependent coverage under the group policy.	If a newborn child is born to you and you have not elected dependent coverage, such child will be insured from the moment of live birth, for 31 days. At the end of 31 days, the child will cease to be covered unless you elect dependent coverage.

This additional benefit…	Pays…	When…
Survivor Benefit*	Additional 2% of pilot's death benefit amount, up to a maximum of $5,000 for each covered child.	Pilot suffers loss of life as a result of a covered accident and is survived by insured spouse and/or insured dependent children.
Exposure or Disappearance Benefit	Pilot's death benefit amount	If by reason of a covered accident, you are unavoidably exposed to the elements and as a result of such exposure suffer a loss for which a benefit is otherwise payable; the loss will be covered. If the body has not been found within one year of the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which you were an occupant, the accidental death benefit is payable.

*Applicable only if you have Pilot & Child(ren) coverage.

NOTE: Insured Person is eligible pilot, spouse, or dependent child who is covered by the plan. Insured Person is required to provide proof of eligible expenses to obtain applicable benefit as described in above chart.

For purposes of this Policy, a covered accidental injury means a bodily injury:

1. Which is sustained as a direct result of an unintended, unexpected, and unforeseen accident that is external to the body and that occurs while your coverage under the Policy is in force,
2. Which directly (independent of sickness, disease, or any other cause) causes a covered loss, and
3. You suffer the covered loss within 365 after the date of the covered accidental injury.

Optional AD&D Exclusions

AD&D will not pay an accidental death or dismemberment benefit when the accident, injury, loss, death, or dismemberment is caused directly or indirectly, results in whole or in part from or there is contribution from any of the following, whether sane or insane:

- Intentionally self-inflicted injury, intentional self-destruction, or autoeroticism whether sane or insane; or
- Suicide or attempted suicide whether sane or insane; or
- Your commission of, or attempt to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation; or
- Bodily or mental infirmity, illness, or disease; or

- The use of alcohol, prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes, or other substances taken, absorbed, inhaled, ingested, or injected. This does not include involuntary inhalation of gases and fumes, or the involuntary taking of poisons; or
- Motor vehicle collision or accident where the insured is the operator of the vehicle and their blood alcohol level meets or exceeds the level of intoxication as defined in the state where the collision occurred, regardless of any related legal proceedings; or
- Infection, other than infection occurring simultaneously with, and a direct or independent result of a covered accidental injury; or
- Medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
- Travel in or decent from any aircraft except:
    a. as a fare paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft; or
    b. as a pilot, who is performing his or her normal job duties for the employer in any aircraft with a current and valid Airworthiness Certificate (“Standard” and issued by the Federal Aviation Agency of the United States of America or its equivalent government authority having jurisdiction over civil aviation in the country of registry) owned, leased, or operated by the policyholder; or
    c. as a pilot, who is performing his or her normal job duties for the employer while performing Civil Reserve Air Fleet (CRAF) missions or Air Mobility Command (AMC).
- War or any act of war, whether declared or undeclared. This exclusion applies only within the geographic limits or territorial water of, or airspace above the geographic limits of or the territorial waters of the United States of America and the insured’s country of domicile.

Please reference the policy for further details on the exclusions.

When Coverage Ends

Your coverage ends on the earliest of:

- The day you cease to be a pilot eligible for coverage
- The day you no longer work for the Company
- The last day for which you have paid premiums for Optional AD&D
- The day the group policy terminates; however, benefits will continue to be provided pursuant to the terms of the Collective Bargaining Agreement
- The day you no longer receive furlough pay, after you are placed on furlough
- FedEx Express discontinues the plan, which could only be done pursuant to the Collective Bargaining Agreement or a successor collective bargaining agreement
- When, if ever, the Collective Bargaining Agreement or a successor collective bargaining agreement no longer provides for this coverage

Your dependent(s) coverage ends on the earliest of the dates listed above or the day your dependent no longer meets the eligibility requirements.

If your coverage ends, and your spouse is a pilot for the employer and participates in the Optional AD&D Plan, you may be eligible for coverage as a dependent. Contact Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis, within 31 days of the end of your coverage. Refer to the “Rules Applicable to All Insurance Plans” for details on how certain events such as termination, retirement, or leaves of absence affect your coverage under these plans and conversion options available.

If you no longer have eligible dependents, it is your responsibility to change your Optional AD&D coverage to Pilot Only and pay the corresponding premium for Pilot Only coverage. See “Life Insurance Enrollment and Beneficiary Designation on Pilot Benefits Online” (https://fedexpilots.bswift.com). It is your responsibility to ensure that payroll deductions end. If they do not end within two pay periods, notify Pilot Benefits Administration at 1.866.795.6353 or 1.901.375.6353 in the Memphis area.

Option to Purchase AD&D Portability

You may be eligible to purchase coverage when coverage ends under Optional AD&D if you or your spouse meets all eligibility guidelines. You must be actively at work and under age 55 on the date coverage terminates. Coverage begins upon receipt of premium and application within 31 days after coverage ends under Optional AD&D. The minimum amount of Optional AD&D coverage that can be continued on an employee is $10,000 and $1,000 for dependents. The maximum amount of AD&D Insurance that can be continued is the amount in force on the insured’s portability date for the Pilot but not more than $1,000,000 and $150,000 for the spouse. You will receive information from Securian Financial regarding your option to continue coverage under Portability.

Reenrolling in the Plan

Reenrollment in the Optional AD&D Plan does not require EOI. However, coverage is not effective until the first day of the month following the date of your election.

For any questions, contact Pilot Benefits Administration at 1.866.795.6353 in the Memphis area.

BUSINESS TRAVEL ACCIDENT PLAN

If you die or become dismembered as a result of a covered accident while traveling on Company business or on a Company aircraft, FedEx provides additional financial protection under Business Travel Accident Insurance. Company aircraft is defined as an aircraft owned, rented, chartered, or leased by the Company.

Civil Reserve Air Fleet (CRAF) Mission Coverage

Pilots continue to be eligible for coverage when performing Civil Reserve Air Fleet (CRAF) missions for a coverage injury by an insured person.

In the event of a pilot's death while performing a CRAF mission or Air Mobility Command (AMC), an additional $200,000 will be paid to those surviving person(s) designated as such pilot's beneficiaries under the FedEx Corporation Accidental Death and Dismemberment Insurance Plan (AD&D Plan) up to an aggregate limit of $2,000,000 per aircraft accident. Payment to multiple or contingent beneficiaries will be made in accordance with the terms of the AD&D Plan.

Eligibility

Pilot Eligibility

Eligible employees are any pilots covered by the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective November 2, 2015.

Dependent Eligibility

Business Travel Accident Insurance covers your spouse and dependent children who are accompanying you on a business trip or on a Company aircraft.

Enrollment

Participation in the plan is automatic. Your beneficiary is the same as the beneficiary you designate for AD&D benefits.

When Coverage Begins

Coverage begins on your first day of active work. You are covered from the time you start your business trip from either work or home—whichever occurs last—until you complete your trip and return home or to work—whichever occurs first. Commuting to and from work is not covered. Deadheading and deviation are included regardless of the mode of transportation used. Any period of time when you are on an authorized leave of absence or vacation or travel to and from the insured's regular place of employment is excluded.

Your Cost for Coverage

The Company pays the full cost of the plan.

A Look at the Benefits

Pilot Death Benefit

If you die within 365 days of a covered accident and your death is the direct result of such accident that occurred while traveling on Company business or on a Company aircraft, your beneficiary will receive $150,000. Your beneficiary will receive $150,000 plus an additional $200,000 if you are performing CRAF or AMC duties.

Dependent Death Benefit

If your spouse or dependent children die within 365 days of a covered accident and the death is the direct result of such accident that occurred while traveling on Company business or on a Company aircraft, your spouse's death benefit is $100,000 and your dependent children's death benefit is $50,000 for each dependent child.

Aggregate Limit: The maximum total liability for all losses for any one accident will not exceed $10,000,000.

Dismemberment Benefit

If the Insured Person suffers a loss within 365 days of a covered accident and the covered injury is a direct result of such accident that occurred while traveling on Company business or on a Company aircraft, that individual will receive benefits as follows:

Type of Loss	Percentage of Death Benefit Amount
Loss of both hands, both arms, both legs, both feet, both eyes or any combination	100%
Loss of speech and hearing in both ears	
Loss of one arm or one leg	70%
Loss of speech, hearing in both ears, one hand, one foot, or entire sight in one eye	50%
Loss of thumb and index finger of the same hand	25%

Loss is defined as:

- Loss of an arm or leg—Actual and complete severance at or above elbow or knee.
- Loss of a hand or foot—Actual and complete severance through or above the wrist or ankle joint.
- Loss of sight—Irrecoverable loss of the entire sight in that eye.

- Loss of the thumb and index finger—Actual and complete severance through or above the metacarpophalangeal joints (joint closest to the palm of the hand).
- Loss of speech—Complete and irrecoverable loss of the entire ability to speak.
- Loss of hearing—Complete and irrecoverable loss of the entire ability to hear in both ears.

Benefits may be paid for more than one accidental loss but the total amount of AD&D payable under this certificate for any one accident, not including amount amounts paid under the Additional Benefits section, will never exceed the full amount of the insured's AD&D Insurance.

Paralysis Benefit

Business Travel Accident pays a benefit equal to the percentage of the benefit amount shown below if:

- As the result of a covered injury, you or your covered dependent sustains a type of paralysis listed below,
- Such paralysis occurs within 365 days of the date of the covered accident, and
- Competent medical authority determines paralysis is complete and irreversible.

Type of Loss	Percentage of Death Benefit Amount
Quadriplegia (total paralysis of both upper and both lower limbs)	100%
Triplegia (total paralysis of three limbs)	75%
Paraplegia (total paralysis of both lower limbs)	50%
Hemiplegia (total paralysis of upper and lower limbs on same side of body)	50%
Uniplegia (total paralysis of one limb)	25%

NOTE: Limb is defined as an entire arm or entire leg.

Business Travel Accident will not pay more than 100% of the Insured Person's benefit amount for any combination of paralysis, coma, dismemberment, and death as the result of the same covered accident.

Additional Business Travel Accident Insurance Benefits		
This Additional Benefit…	**Pays…**	**When…**
Coma Benefit	Monthly benefit to equal to 1% of the amount of BTA insurance for a maximum of the earliest of the date the insured recovers and is no longer in a coma or the date of death or 100 months have been paid. In the event of death, the benefit will be reduced	You sustain a covered injury that results in a coma within 365 days of a covered accident and the coma continues for a minimum of 31 consecutive days.

Additional Business Travel Accident Insurance Benefits		
This Additional Benefit…	**Pays…**	**When…**
	by the amount of the travel accident benefit payable for death.	
Therapeutic Counseling Benefit	Reasonable expenses for the cost of therapy which exceeds benefits provided by another plan, up to the lesser of 5% of the Insured Person's death benefit amount or $5,000/covered accident	Insured Person requires medically necessary therapeutic counseling provided by a licensed therapist or certified counselor and must begin within 90 days after the loss and incurred no later than one year after the date of the loss, for a covered injury.
Rehabilitative Physical Therapy Benefit	Reimbursement of expenses up 20% of the death benefit amount to a maximum of $10,000	If insured suffers an injury which results in a covered loss, an additional benefit will be paid for rehabilitative physical therapy which is prescribed but the attending physician or surgeon.
Seat Belt and Air Bag Benefit	Seat belt: Additional 10% of Insured Person's death benefit amount Air bag: Additional 5% of Insured Person's death benefit amount Combined benefit maximum of $50,000	Seat belt: You suffer loss of life as a result of a covered accident which occurs while driving or riding in private passenger car, an additional benefit may be payable. The car must have been equipped with seatbelts, in proper use by the insured, as documented in the official accident report by the investigating officer and the driver of the car must not have been intoxicated, impaired, or under the influence of alcohol or drugs. Air bag: You suffer loss of life as a result of a covered accident which occurs while driving or riding in a private passenger car, an additional benefit may be payable. The seat in which the insured was seated must have been equipped with a properly installed air bag at the time of the accident, the car must have been equipped with seatbelts in proper use by the insured, as documented in the official accident report or by the investigating officer, and the driver must not have been intoxicated, impaired, or under the influence of alcohol or drugs.

Additional Business Travel Accident Insurance Benefits		
This Additional Benefit…	**Pays…**	**When…**
Exposure or Death Benefit	The amount pertaining to and as noted in the loss schedule	If by reason of a covered accident, you are unavoidably exposed to the elements and as a result of such exposure suffer a loss for which a benefit is otherwise payable; the loss will be covered.
	Pilot's death benefit amount	If the body has not been found within one year of the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which you were an occupant, the accidental death benefit is payable.

For purposes of this Policy, covered injury means bodily injury:

1. Which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the Insured Person's coverage under the Policy is in force,
2. Which occurs under the circumstances described in a Hazard (as defined in the Policy) applicable to that person, and
3. Which directly (independent of sickness, disease, or any other cause) causes a covered loss under a Benefit applicable to such Hazard.

Accidental death, dismemberment, and paralysis benefits are only paid with respect to an injury or a covered loss to the Insured Person which results within 365 days of the date of the accident that caused the injury or a covered loss.

Additional Covered Hazards

Business Travel Accident benefit pays if the Insured Person suffers a loss due to any of the following:

- Bomb Scare/Explosion Hazard
- Felonious Assault Hazard
- Hijacking Hazard
- War Risk Hazard

Please reference the Certificate for more detailed explanations of the hazards mentioned above.

Business Travel Accident AD&D Exclusions

BTA AD&D will not pay an accidental death or dismemberment benefit when the accident, injury, loss, death, or dismemberment is cause directly or indirectly, results in whole or in part from or there is contribution from any of the following, whether sane or insane:

- Intentionally self-inflicted injury, self-destruction, or autoeroticism whether sane or insane; or
- Suicide or attempted suicide whether sane or insane; or
- Your participation in, or attempt to commit a crime, assault, felony, or any illegal activity, regardless of any related legal proceedings; or
- Bodily or mental infirmity, illness or disease; or
- The use of alcohol, prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases fumes, or other substances taken, absorbed, inhaled, ingested, or injected. This does not include involuntary inhalation of gases and fumes, or the involuntary taking of poisons; or
- Motor vehicle collision or accident where the insured is the operator of the vehicle and their blood alcohol level meets or exceeds the level of intoxication as defined in the state where the accident occurred, regardless of any related legal proceedings; or
- Infection, other than infection occurring simultaneously with, and a direct result of a covered accidental injury; or
- Medical or surgical treatment or diagnostic procedures or any resulting complications including complications from medical misadventure; or
- Travel in or decent from any aircraft except:
    a. as a fare paying passenger on a scheduled commercial flight on a licensed passenger aircraft; or
    b. as a pilot, who is performing his or her normal job duties for the employer in any aircraft with a current and valid Airworthiness Certificate (“Standard” and issued by the Federal Aviation Agency of the United States of America or its equivalent government authority having jurisdiction over civil aviation in the country of registry) owned, leased, or operated by the policyholder; or
    c. as a pilot, who is performing his or her normal job duties for the employer while performing Civil Reserve Air Fleet (CRAF) missions or Air Mobility Command (AMC).
- War or any act of war, whether declared or undeclared. This exclusion applies only within the geographic limits or territorial water of, or airspace above the geographic limits of or the territorial waters of the United States of America and the insured’s country of domicile.

Please reference the policy for further details on the exclusions.

When Coverage Ends

Your coverage ends on the earliest of:

- The day you cease to be a pilot eligible for coverage
- The day you no longer work for the Company
- The day the group policy terminates, however benefits will continue to be provided pursuant to the terms of the Collective Bargaining Agreement
- FedEx Express discontinues the plan, which could only be done pursuant to the Collective Bargaining Agreement or a successor collective bargaining agreement
- When, if ever, the Collective Bargaining Agreement or a successor collective bargaining agreement no longer provides for this coverage
- The day you no longer receive furlough pay, after you are placed on furlough

LIFESTYLE BENEFITS

Travel Assistance

Travel Assistance Services are provided through Redpoint WTP LLC for active pilots and retirees covered under the group life programs, their spouses and dependent children. The services are available while the Insured Person is traveling on personal or business travel a distance of 100 miles or more away from that individual's primary home. Before obtaining medical and non-medical assistance, call one of the following:

- In the U.S. or Canada, 1.855.516.5433
- All other locations, 1.415.484.4677
- LifeBenefits.com/travel
- Available 24 hours a day, 7 days a week, 365 days a year
- Pre-trip planning and trip support
- Medical professional locator services
- Medical evacuation services
- Security evacuation services
- Provides assistance replacing lost or stolen luggage, medication, or other critical items
- Provides repatriation of mortal remains

Legal, Financial, and Grief Resources

These services are available for active Pilots and Retirees covered under the group life programs and provided by LifeWorks.

- Access LifeBenefits.com/Lfg, User Name; lfg, Password: resources
- Please call 1.877.849.6034
- Provides unlimited telephonic guidance and consultation with professionals in each area
- Provides comprehensive web and mobile resources
- Provides 30-minute face-to-face consultation with an attorney for each unique legal issue (additional services provided at 25% discount)

Legacy Planning Resources

These services are available for insured active Pilots, Retirees, their spouses and dependent children. This is an online tool from Securian Financial which provides access to a variety of information and resources to work through end-of-life issues.

- Please reference securian.com/legacy
- Access to online information and resources including:

  - End-of-life planning
  - Final arrangements
  - Funeral planning
  - Important directives
- Funeral directives
- Funeral concierge for direct payment to a funeral home
- Same-day funeral home assignment services

Beneficiary Financial Coaching

This service is provided through PricewaterhouseCoopers (PwC) for beneficiaries who receive proceeds of $25,000 or more. These beneficiaries will receive information about this no-cost service at the time of claim payment. Telephonic financial guidance is available for those receiving $100,000 or more.

- Assists beneficiaries in making sound financial decisions during this difficult time
- This resource is voluntary and beneficiaries have telephonic access to a dedicated financial coach for 12 months
- Access to PwC Envision™, which provides 12 months of mobile-enabled web application with budgeting, planning tools, and content
- Provides a financial fitness assessment
- Includes survivor guide workbooks to help make financial and legal decisions less overwhelming

RETIREMENT

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FEDEX RETIREMENT PLANS

The FedEx retirement programs help you work toward financial security in your retirement during your working career at FedEx. First, FedEx provides the FedEx Corporation Employees' Pension Plan (the Pension Plan), the Federal Express Corporation Non-Qualified Pension Plan for Pilots (the Compensation Limit Plan) and the Federal Express Corporation Non-Qualified Section 415 Excess Pension Plan for Pilots (the 415 Limit Plan). FedEx also provides the Pilots' Retirement Savings Plan (PRSP), which includes Pre-tax/401(k), Employer Matching, Catch-up, After-tax, Sick Bank, Roth, Roth Catch-up and Employer Nonelective contributions. FedEx pays half the cost (you pay the other half) for your Social Security benefits.

Flying Tiger and Seaboard Retirement Programs

If you are a former employee of Flying Tiger and/or Seaboard (SWA), when you retire you will receive pension benefits that accrued (were earned) while you were covered under their pension plans. Statements detailing the amount of accrued pension benefits were sent during the spring of 1990. If you have misplaced your original statement, contact the FedEx Retirement Service Center at 1.855.604.6221. Copies of the pension plans, their summary plan descriptions and plan merger documents, if applicable, are available from the FedEx Retirement Service Center. Copies are available upon receipt of a nominal charge for duplication.

Special Note to Former Employees

If you are a vested former employee, some provisions of the retirement plans described in this chapter may not necessarily apply to you. You are covered by the provisions of the plans in effect on the date you terminated employment with FedEx and/or the date you are no longer covered under a collective bargaining agreement, which provides for your participation in the plan. You should refer to the Pilot Benefit Book or Your Employee Benefits book in effect on your termination date for relevant plan provisions.

Special Note to Pilots Who Participated in Non-Pilot Retirement Plan(s)

If you are a pilot who had a period of employment as a non-pilot, you may have a benefit in the FedEx Corporation Retirement Savings Plan. In this case, you should refer to the **Your Retirement Benefits** book for relevant plan provisions. In addition, if you accrued a benefit in the FedEx Corporation Employees' Pension Plan under the Portable Pension Account formula, you may be able to take a portion of your Pension Plan benefit as a lump sum.

Qualified vs. Non-Qualified Plans

A "qualified" plan is a plan that meets the extensive requirements imposed by the Internal Revenue Code (IRC) and provides significant tax advantages to both employees and employers. When employers make contributions to qualified plans, the earnings on those contributions grow tax-free, and the employees do not pay income tax on either the employer contributions or the investment earnings until the employee receives payments from the plan. Among the protections provided by qualified plans is the requirement that contributions be held in a trust, separate and apart from the employer's assets, and protected from the employer's or

employee's creditors. The Pension Plan and the Pilots' Retirement Savings Plan are both qualified plans.

"Non-Qualified" plans do not qualify for certain tax benefits and protections like qualified plans, but they are very useful for the FedEx Pilots. Limits imposed under IRC Sections 415 and 401(a)(17) prevent the Pension Plan from being able to pay the full amounts promised by that Plan's benefit formula. Non-Qualified plans are not required to follow all the detailed and rigorous requirements imposed on qualified plans, and they can therefore be tailor-made to fill in gaps left by the qualified plans, such as those explained above. Benefits from the Non-Qualified plans are paid from the general assets of FedEx.

When the non-qualified benefits are considered "reasonably ascertainable," generally upon termination of employment, FICA taxes are due and payable by both you and FedEx on the total present value of the Non-Qualified benefits. The Compensation Limit Plan and the 415 Limit Plan are both non-qualified plans.

Assignment of Benefits—Qualified Plans

The Pension Plan and the PRSP do not permit you to assign, alienate, transfer, pledge, encumber, commute or anticipate any interest in the Trust Fund or in any payments to be made under these plans, except in the case of a Qualified Domestic Relations Order (QDRO). Your benefits under the Pension Plan or PRSP are not in any manner subject to levy, attachment or other legal process to enforce payment of any claim against you, as a participant in the Pension Plan or PRSP, except that the Internal Revenue Service (IRS) may levy benefits payable to you to satisfy a federal tax lien.

Assignment of Benefits—Non-Qualified Plans

Benefits under the Compensation Limit Plan and the 415 Limit Plan shall not be assignable or transferable in any manner, nor shall they be subject to garnishment, attachment or other legal process, except as provided by applicable law.

PENSION PLAN AND NON-QUALIFIED PLANS

Federal Express Corporation is a Participating Employer in the Pension Plan (this is a qualified defined benefit plan), and sponsors two non-qualified plans (collectively the Non-Qualified Plans)—the Compensation Limit Plan and the 415 Limit Plan to help you build financial security for the future.

The Pension Plan pays the portion of your benefit (up to the Section 415 annual benefit limit) based on your average earnings for your highest five years of earnings (each limited to the appropriate annual compensation limit as noted in the "Maximum Compensation Limit" section) or based on your average annual benefit amount. The 415 Limit Plan will pay any portion of your benefits that is not payable from the Pension Plan due to the Section 415 annual benefit limit. The Compensation Limit Plan will pay the excess, if any, of your benefit based on the average of your annual earnings without regard to the annual compensation limits, up to a maximum average of $260,000 less the benefit paid from the 415 Limit Plan. The Compensation Limit Plan also will pay any actuarial increases from age 60 to 62 that are not paid in the Pension Plan due to the change in Normal Retirement Age made in 2016. The Compensation Limit and the Section 415 benefit limit are subject to indexing annually based on increases in the cost of living.

Participating Employers

Participating Employers are listed below.

FedEx Corporation Employees' Pension Plan Participating Employers
FedEx Corporation
Federal Express Corporation (FedEx Express)
FedEx Ground Package System, Inc.
FedEx Corporate Services, Inc.
FedEx Logistics, Inc.
FedEx Trade Networks Transport & Brokerage, Inc.
FedEx Trade Networks Trade Services, LLC
World Tariff, Limited
FedEx Freight Corporation
FedEx Custom Critical, Inc.
Federal Express Virgin Islands, Inc.
FedEx Cross Border Holdings, Inc.
FedEx Cross Border Technologies, Inc.
FedEx Forward Depots, Inc.

If you are a resident of Puerto Rico, different tax rules may apply.

Plan Year

The Pension Plan and the Non-Qualified Plans have a Plan Year that runs from June 1 through May 31.

Eligibility

Pension Plan

As a Pilot, you automatically become a plan participant on the first day of the month coincident with or next following:

- Your attainment of age 21, and
- The first anniversary date of your employment with a Participating Employer, if you were credited with at least 1,000 hours of service during your first year of employment. If you do not complete 1,000 hours of service during your first employment year, you may do so during any Plan Year starting with the first Plan Year beginning after your date of hire. You enter the Plan on the first day of the month coincident with or next following fulfillment of the required 1,000 hours of service.

Employment Within FedEx Corporation Controlled Group Members

If you were previously employed by a FedEx Controlled Group Member, all service during your previous employment with that Controlled Group Member will be combined to determine your eligibility for the Pension Plan.

If you are an eligible employee of a Participating Employer, you will begin participating in the Pension Plan on your date of employment, if, immediately prior to your date of employment:

- You were employed by a Controlled Group Member
- You have attained age 21, and
- You have completed at least one Year of Service with the Controlled Group Member

In addition, your Years of Service with Controlled Group Members will also be counted toward your total years of credited service for vesting purposes under the Pension Plan.

An individual who is classified by a Participating Employer as an independent contractor, owner operator or leased employee is not eligible to participate in any benefit plans sponsored by the employer, even if such person is later determined by a court or administrative agency having competent jurisdiction to be a common law employee of the employer.

You are eligible for the Pension Plan if your employment is covered by a collective bargaining agreement that provides for your participation in this plan.

If You Are Reemployed

If you terminate your employment with a Participating Employer and are later reemployed by a Participating Employer, the following rules apply to your eligibility for Pension Plan participation:

- If you were a participant in the Pension Plan prior to your termination date, you will reenter the Pension Plan on your reemployment date.
- If you had met all the Plan eligibility requirements and terminated your employment with a Participating Employer, and then are reemployed:
  - Before your expected entry date, you would enter the Pension Plan upon reaching your entry date.
  - After your expected entry date, you would enter the Pension Plan on your reemployment date.
- If you had not met all eligibility requirements prior to your termination date, your hours of service prior to your termination are considered and you are eligible on the first of the month coincident with or next following the date you meet all eligibility requirements.

Non-Qualified Plans

If you are employed as a pilot by FedEx on or after February 4, 1999, are an active participant in the Pension Plan and have five or more years of vesting service, you automatically become a participant in both Non-Qualified Plans.

Enrollment

Once you have met all the Plan eligibility requirements, participation in the Pension Plan and Non-Qualified Plans is automatic.

Your Cost

The Pension Plan's Participating Employers, which include FedEx Express, pay the full cost of the Pension Plan. FedEx Express pays the full cost of the Non-Qualified Plans.

Retirement Dates

You may commence retirement benefits on any of the dates described below after you have completed application requirements.

Normal Retirement Date

Effective February 1, 2016, your normal retirement date is the first day of the month coincident with or next following the date on which you attain age 62, after:

- Completing five years of credited service for vesting, or
- Reaching your fifth anniversary of plan participation.

If you retire on or after age 60, you are eligible to receive an unreduced monthly benefit.

The normal retirement age of 62 will apply to any benefits you accrue on and after February 1, 2016. Benefits you accrued prior to February 1, 2016, will continue to be administered with a normal retirement age of 60.

Early Retirement Date

You may decide to retire any time on or after age 55, once you become vested.

Your early retirement date is the first day of the month coincident with or next following the date on which you decide to retire between ages 55 and 62 after completing five years of credited service for vesting. If you retire before age 60, you are eligible to receive a reduced monthly benefit.

NOTE: Any early retirement reduction will be based on the date your benefit commences prior to age 60. For example, a participant terminates at age 55 and elects not to commence his pension benefit until age 58; therefore, his pension benefit would be reduced by 6%. (There is a 3% reduction for each year that his benefit commenced prior to age 60 or .0025 (1/12th of 3%) for each month his benefit commenced prior to age 60.)

Active Employees Age 70½ or Older

If you continue to work after you reach age 72 (if you reach age 70½ after December 31, 2019), by law you will be eligible to begin to receive your vested retirement benefits before you retire. You will have a one-time option of commencing your payments or postponing them until your actual retirement (separation from service). If you elect to commence payments, they must start on April 1st of the year following your attainment of age 72 (if you reach age 70½ after

December 31, 2019). The FedEx Retirement Service Center will send you a retirement packet at the appropriate time for you to make a decision about benefit commencement. You should carefully consider which form of payment you desire, since the form of payment selected may not be changed at a later date, nor can your benefit be stopped for a later commencement. Your accrued benefit will be recalculated when you actually retire. This accrued benefit recalculation will consider all eligible earnings and years of credited service for benefit accrual. The recalculation also will take into account the accrued benefits already received. Therefore, upon actual retirement your monthly benefit may or may not increase.

Deferred Benefit Commencement

You may retire or terminate and elect to delay the commencement of your pension benefits to any date up to age 72 (if you reach age 70½ after December 31, 2019). If you do not commence prior to age 72, the FedEx Retirement Service Center will send your retirement packet at the appropriate time for you to make a decision about benefit commencement. Your vested benefit accrued through February 1, 2016, if any, will be actuarially increased if you terminate employment with all Controlled Group Members and defer your commencement past age 60. Your vested benefit accrued after February 1, 2016, if any, will be actuarially increased if you terminate employment with all Controlled Group Members and defer your commencement past your normal retirement date. If you terminate after February 1, 2016, and defer your commencement to a date between age 60 and 62, then any actuarial increase you would have received under the Pension Plan had the normal retirement age remained age 60 will be paid as a lump sum at age 62 from the Non-Qualified Plans.

Working Past Your Normal Retirement Date (Age 62)

If you work past your Normal Retirement Date, your retirement benefits will not be actuarially increased to account for the fact that you choose to delay your retirement. However, while you remain employed with a Participating Employer you will continue to receive a year of credited service for benefit accrual for any Plan Year (June 1 through May 31) in which you are credited with at least 1,000 hours of service (subject to the maximum of 25 years of credited service for benefit accrual). Eligible Earnings past your Normal Retirement Date will be considered when determining the earnings used in the calculation of your retirement benefit.

If You Are Reemployed After Retirement by Any Controlled Group Member

The FedEx Corporation Employees' Pension Plan does not preclude a retiree who is receiving a pension plan benefit from being rehired by any FedEx company. However, the Pension Plan does have specific rules that apply to your participation in the Pension Plan upon your reemployment by a Participating Employer.

Benefit Commencement Date (also known as the Annuity Starting Date)

The Benefit Commencement Date is the first day of the month that a monthly pension benefit can commence following the fulfillment of all plan application requirements.

Credited Service

Your years of credited service are used to determine your Plan eligibility, benefit amount and vesting.

Year of Credited Service

You earn one year of credited service for each Plan Year (June 1 through May 31) in which you have been credited with at least 1,000 hours of service.

Hours of Service

Pilots are credited with 95 hours per pay period while actively employed.

In addition, any vacation hours that are paid to an employee in lieu of actual vacation time are counted as hours of service even if the employee has terminated employment.

Crediting Hours During Active Military Service

Your period of qualifying military service in the U.S. armed services will be included in calculating your years of credited service if you return to work and have satisfied the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA) within the period specified after the date you are released from active duty. You must present to your Assistant Chief Pilot proof of your activation date and release from active duty date.

In the event of death during your Military Leave of Absence (MLOA), your accrued benefit will be based on your years of credited service up to the date of your death

Credited Service for Benefit Accrual

Your credited service for benefit accrual is the total number of your years of credited service with a Participating Employer(s) (not including service with Flying Tiger). You may accrue up to a maximum of 25 years of credited service for benefit accrual.

Credited Years of Service During a Disability

Hours of credited service for disability leave periods are calculated at 45 hours per week for any week in which the pilot is on disability.

If the Disability Began Prior to July 2, 1989

You will receive credited service under the Pension Plan for a disability period that began prior to July 2, 1989, if:

- You were totally disabled from any occupation,
- You received Social Security Disability benefits, and
- You remained on disability continuously to normal retirement age (age 60) or beyond.

If the Disability Began On or After July 2, 1989 but Before June 1, 1992

You will receive credited service under the Pension Plan for a disability period that began on or after July 2, 1989, but before June 1, 1992, if:

- You were totally disabled from any occupation, you received Social Security Disability benefits and you remained on disability continuously to normal retirement age (age 60) or beyond,

  or
- You were entitled to and received benefits under the Pilots'/Crew Members' Supplementary Disability Coverage. You do not receive credited service for the period in which you received Federal Express Corporation Short Term Disability Plan (STD) benefits or the first two years of Federal Express Corporation Long Term Disability Plan (LTD) benefits.

If the Disability Began On or After June 1, 1992

You will receive credited service under the Pension Plan for a disability period that began on or after June 1, 1992, if you were eligible for a disability benefit under the terms of the Federal Express Corporation Short Term Disability Plan (STD), the Federal Express Corporation Long Term Disability Plan (LTD), Pilots'/Crew Members' Supplementary Disability Coverage or Workers' Compensation.

Credited Service for Vesting

Vesting refers to your right to receive a pension benefit after you terminate or retire from a Participating Employer—even if you terminate employment before retirement age.

Your credited service for vesting equals your total number of years of credited service with a FedEx Corporation Controlled Group Member. This also includes any service recognized for vesting purposes with a preceding employer of which FedEx Corporation is the successor, such as the Flying Tiger Line, Inc. (FTL) and Seaboard World Airlines (SWA).

You will be 100% vested in your Pension Plan benefit after you complete five years of credited service for vesting.

Breaks in Service

A one-year break in service occurs during any Plan Year in which you do not receive credit for at least 501 hours of service. If you have a break in service and are rehired, the following applies:

- If you were **vested** when you terminated employment and your benefit has not been paid, you receive credit for all your years of credited service for benefit accrual and again begin participating in the Plan on your reemployment date.
- If you were **vested** when you left and your benefit was **paid** to you in full, upon reemployment you will be treated as a new employee for benefit accrual service but you will retain your vesting service and again begin participating in the Plan on your reemployment date. You may be eligible to repay the distribution with interest and recapture your prior benefit accrual service. Please contact the FedEx Retirement Service Center, 1.855.604.6221, for more information if you are considering repayment. If eligible for repayment, you have until the earlier of five years from your reemployment date, or the close of your fifth consecutive break in service from the date of distribution to repay the distribution.
- If you terminated employment before you were vested and, you worked for a Participating Employer for at least one hour after December 31, 1984, you will lose your pre-break benefit accrual service and vesting service if you are reemployed **after** having the greater of:
  - Five consecutive one-year breaks in service, or
  - One-year breaks in service equal to the years of service you had before you terminated.
- If you terminated employment prior to May 31, 1985, and you were not vested, and if upon reemployment the number of consecutive one-year breaks in service equals or exceeds the number of years of credited service you had before you terminated, you will lose your pre-break benefit accrual and vesting service.
- If you terminated employment **before** you were vested and you are reemployed **before** having the number of one-year breaks in service previously described, your pre-break service counts for benefit accrual and vesting. You will begin participating on your rehire date.

- If you were not participating prior to your termination date, refer to “Eligibility—If You are Reemployed.”

In order to prevent a break in service, up to 501 hours may be credited for time spent on a family medical leave. You will receive this credit in either the year you began your leave or the following year to prevent a one-year break in service.

Components of the Benefit Formulas

The Pension Plan provided by FedEx is a defined benefit plan. This means your benefit is based on the greater of specific, defined formulas in place when you retire or terminate employment with a Participating Employer. The major components of these formulas are:

- Years of credited service
- Years of vesting service
- Eligible Earnings (also referred to as Compensation)
- Average Earnings
- Age/Service Multiplier
- Additional Benefit Percentage
- Average Annual Benefit Amount

Following are definitions of the major components of the formulas used in the calculation of your benefit. In addition, there are appendices at the end of the Pension section, which are used in the calculation of your benefit.

Eligible Earnings

Eligible earnings include, but are not limited to the following:

- All credit hours, including but not limited to:
  - Draft
  - Volunteer
  - Trip make-up for which you receive pay
  - International Override
  - Passover Pay (POP)
- Premiums for:
  - Flex Instructors/Proficiency Check Airmen (PCA)
  - Line Check Airmen (LCA)
  - Flex Flight Standards Check Airmen (SCA)
  - Flight Project Specialist (FPS)
  - Technical Advisor/Aircraft (TAA)
  - Passover Retro Pay (POR)
  - FAA Designee (FAA)
- Sick leave hours drawn from your sick banks (except non-taxable hours drawn from your Occupational Illness/Injury Sick Bank (OII) on or after January 1, 2007, as a result of a worker’s compensation illness or injury)
- Amounts distributed from the Pilots’ Retirement Savings Plan’s unused Sick Bank Account because of the limits imposed by Section 415 of the IRC
- Past Profit Sharing paid in cash*
- Vacation pay
- Signing bonuses paid in 2006, 2007, 2015, 2016 and 2017

- Lump Sum bonus paid in 2011
- Vacation buybacks

Eligible earnings include pay prior to deductions, *e.g.*, pre-tax health care, dependent care and your PRSP Pre-tax/401(k) contributions.

*Effective June 1, 1999, Pilots are ineligible to receive allocations of profit sharing contributions.

Exclusions from eligible earnings include, but are not limited to:

- Domestic and International Per Diem
- Long Term Disability payments
- PRSP Employer Matching contributions
- PRSP Sick Bank contributions
- PRSP Employer Nonelective contributions
- Excess Life Premiums
- Earnings above the IRS compensation limit (earnings above this limit may be considered for the Non-Qualified Plans)
- Reimbursed expenses
- Non-taxable amounts from a Pilot's Occupational Illness/Injury Sick Bank (OII) on or after January 1, 2007, as a result of a worker's compensation illness or injury
- End of Career Sick Leave/Advance Notice of Planned Retirement Bonus

Average Earnings means the average of your Eligible Earnings for the highest five whole calendar years while you were employed by any Participating Employer. If you have less than five whole calendar years with any Participating Employer when you retire or terminate employment, your Eligible Earnings for all whole calendar years are averaged. If your Eligible Earnings during your last partial calendar year of employment are greater than your lowest whole calendar year of Eligible Earnings, the partial year will replace your lowest year in calculating your benefit. In no event shall the Average Earnings taken into account under the Pension Plan and the Non-Qualified Plans exceed $260,000. Annual Eligible Earnings for the Pension Plan are subject to the limit under Code Section 401(a)(17) (the compensation limit).

Maximum Compensation Limit [Section 401(a)(17)]

The IRS limits the maximum compensation that can be used to determine your benefits under the Pension Plan. The limit may be indexed by the Secretary of the Treasury based on increases in the cost of living.

Year	Annual Compensation Limit
2009	$245,000
2010	$245,000
2011	$245,000
2012	$250,000
2013	$255,000
2014	$260,000
2015	$265,000
2016	$265,000
2017	$270,000

Year	Annual Compensation Limit
2018	$275,000
2019	$280,000
2020	$285,000
2021	$290,000

Age/Service Multiplier

Your Age/Service Multiplier is based on your age and years of credited service for vesting as of June 1, 1999, as determined from Appendix 2. For former Flying Tiger Line, Inc. (FTL) Pilots, your FTL years of credited service for vesting count in determining your Age/Service Multiplier, but FTL years of service do NOT count toward your credited service for benefit accrual.

Determining the Age/Service Multiplier – Examples

Let's look at two examples of calculating the Age/Service Multiplier. One example shows a pilot who has worked with FedEx his whole career, and the other shows a pilot who previously worked with Flying Tiger.

Example of FedEx Only Service

Let's assume you are a pilot who has 30 years of credited service for vesting as of May 31, 2016, all with FedEx. On June 1, 1999, you were 45 years old with 13 years of credited service for vesting. Using the chart in Appendix 2, your Age/Service Multiplier would be 2.08%. Your Age/Service Multiplier only applies to credited service for benefit accrual as of June 1, 1999.

Your total credited service for determining your benefit accrual would be 25—your total years of credited service with FedEx (total credited service for benefit accrual at FedEx is limited to 25 years). Your credited service for benefit accrual as of June 1, 1999, would be 13 and credited service for benefit accrual after June 1, 1999, would be 12.

Example of Flying Tiger and FedEx Service

Now, let's assume you are a pilot who has 30 years of credited service for vesting as of May 31, 2016, but 3 of those years are with Flying Tiger. And, as with the earlier example, you were 45 years old with 13 years of credited service for vesting on June 1, 1999 (3 with FTL and 10 with FedEx). Using the chart in Appendix 2, your Age/Service Multiplier would be 2.08%, the same as in the first example, because you count all years of credited service for vesting—both with FedEx and with the Flying Tiger—to determine your Age/Service Multiplier. Your Age/Service Multiplier only applies to credited service for benefit accrual with FedEx as of June 1, 1999.

Your total credited service for benefit accrual would be 25—your total years of credited service with FedEx (total credited service for benefit accrual at FedEx is limited to 25 years). Your credited service for benefit accrual as of June 1, 1999, would be 10 and credited service for benefit accrual after June 1, 1999, would be 15.

Additional Benefit Percentage

Your Additional Benefit Percentage is based on your age and years of credited service for vesting as of October 30, 2006, as determined from Appendix 3. For former Flying Tiger Line, Inc. (FTL) pilots, your FTL years of credited service for vesting count in determining your Additional Benefit Percentage, but FTL years of service do NOT count toward your credited service for benefit accrual.

Determining the Additional Benefit Percentage—Examples

Let's look at two examples of calculating the Additional Benefit Percentage. One example shows a pilot who has worked with FedEx his whole career, and the other shows a pilot who previously worked with Flying Tiger.

Example of FedEx Only Service

Let's assume you are a pilot who has 30 years of credited service for vesting as of May 31, 2016, all with FedEx. On October 30, 2006, you were 52 years old with 20 years of credited service for vesting.

Using the chart in Appendix 3, your Additional Benefit Percentage would be 0.03%. Your Additional Benefit Percentage only applies to credited service for benefit accrual as of October 30, 2006.

Your total credited service for determining your benefit accrual would be 25—your total years of credited service with FedEx (total credited service for benefit accrual at FedEx is limited to 25 years). Your credited service for benefit accrual as of October 30, 2006, would be 20 and credited service for benefit accrual after October 30, 2006, would be five.

Example of Flying Tiger and FedEx Service

Now, let's assume you are a pilot who has 30 years of credited service for vesting as of May 31, 2016, but 3 of those years are with Flying Tiger. And, as with the earlier example, you were 52 years old with 20 years of credited service for vesting on October 30, 2006 (3 with FTL and 17 with FedEx). Using the chart in Appendix 3, your Additional Benefit Percentage would be 0.03%, the same as in the first example, because you count all credited service for vesting—both with FedEx and with the Flying Tiger—to determine your Additional Benefit Percentage. Your Additional Benefit Percentage only applies to credited service for benefit accrual with FedEx as of October 30, 2006.

Your total credited service for benefit accrual would be 25—your total years of credited service with FedEx (total credited service for benefit accrual is limited to 25 years). Your credited service for benefit accrual as of October 30, 2006, would be 17 and credited service for benefit accrual after October 30, 2006, would be eight.

Average Annual Benefit Amount

See Appendix 1.

A Look at the Benefit Calculations

Pension Plan Benefit Limit [Section 415(b)]

The annual Pension Plan benefit you can receive is limited, based on your age at retirement. These limits are scheduled to be indexed annually as directed by the Secretary of the Treasury.

Age at Retirement	2020 Maximum Benefits* Under Section 415(b)

62 and older	$230,000
61	$213,600
60	$198,700
59	$185,100
58	$172,700
57	$161,200
56	$150,700
55	$141,100

*rounded to the nearest thousand

Normal Retirement Benefit

Your normal retirement benefit under the Pension Plan and the Non-Qualified Plans is calculated under three formulas. You receive the benefit that is the greatest of the three. Following are descriptions of these formulas. The "Calculating a Normal Retirement Pension—Example" provides the assumptions and steps used in the calculation of a benefit under each of the three formulas. The following formulas apply to pilots who were employed by FedEx on or after October 30, 2006. Pilots who terminated or retired prior to October 30, 2006, should refer to the Pilot Benefit Book in effect on their termination or retirement date.

Formula 1

2% of Average Earnings times years of credited service for benefit accrual up to 25 years.

Formula 2

(See Appendix 2.)

Formula 2 applies if you are a Collectively Bargained Pilot and you were employed by FedEx on or after October 30, 2006.

The Formula 2 benefit is calculated as follows:

- Average Earnings times Age/Service Multiplier times years of credited service for benefit accrual as of June 1, 1999, **plus**
- 2% of Average Earnings times years of credited service for benefit accrual after June 1, 1999, **plus**
- Average Earnings times Additional Benefit Percentage times years of credited service for benefit accrual as of October 30, 2006.

Total credited service for benefit accrual is limited to 25 years.

Formula 3 ("Flat Dollar Formula")

For a detailed definition of terms used in this section see Appendix 1.

Formula 3 applies if you are a Collectively Bargained Pilot and you were employed by FedEx on or after October 30, 2006.

The Formula 3 benefit is calculated as follows:

> Average Annual Benefit Amount times the sum of (i) Age/Service Multiplier times years of credited service for benefit accrual as of June 1, 1999, plus (ii) 2% times years of credited service for benefit accrual after June 1, 1999, plus (iii) Additional Benefit Percentage times years of credited service for benefit accrual as of October 30, 2006; the combination of which is divided by 2%. Total credited service for benefit accrual is limited to 25 years.

These formulas show your annual benefit. To calculate your monthly benefit, you would divide by 12.

Calculating a Normal Retirement Pension—Example

Let's assume you are vested and retiring on your normal retirement date (age 62) of June 1, 2016. Your age as of June 1, 1999, was 45. Let's also assume you have 30 years of credited service—13 years as of June 1, 1999, and 17 years after June 1, 1999 (limited to 12 years in the formulas since total service is limited to 25 years). Using the chart in Appendix 2, your Age/Service Multiplier would be 2.08%. Your age as of October 30, 2006, was 52 and you had 20 years of credited service as of October 30, 2006. Using the chart in Appendix 3, your Additional Benefit Percentage would be 0.03%. Using the chart in Appendix 4, your Average Non-Qualified Plan Eligible Earnings based on the highest five years is $255,000. This amount is used in Formulas 1 and 2. Using the chart in Appendix 5, your Average Annual Benefit Amount is $4,978. This amount is used in Formula 3. These amounts are used to calculate your total benefit, as described below.

Calculation 1: Total Benefit From the Pension Plan and Non-Qualified Plans

Your total normal retirement benefit is calculated without regard to the compensation limit or the Section 415 Limit as shown below:

Formula 1:

1. .02 x 25 (credited service for benefit accrual) x $255,000 (Average Non-Qualified Plan Eligible Earnings) = $127,500.00 (total annual pension)
2. $127,500.00 (total annual pension) ÷ 12 (months) = $10,625.00 (total monthly pension)

Formula 2:

1. {[.0208 (Age/Service Multiplier) x 13 (credited service for benefit accrual as of June 1, 1999)] + [.02 x 12 (credited service for benefit accrual after June 1, 1999)] + [.0003 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October 30, 2006)]} x $255,000 (Average Non-Qualified Plan Eligible Earnings) = $131,682.00 (total annual pension)
2. $131,682.00 (total annual pension) ÷ 12 (months) = $10,973.50 (total monthly pension)

Formula 3:

1. $4,978 (Average Annual Benefit Amount) x {[.0208 (Age/Service Multiplier) x 13 (credited service for benefit accrual as of June 1, 1999)] + [.02 x 12 (credited service for benefit accrual after June 1, 1999)] + [.0003 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October 30, 2006)]} ÷ .02 = $128,531.96 (total annual pension)

2. $128,531.96 (total annual pension) ÷ 12 (months) = $10,711.00 (total monthly pension)

Because Formula 2 provides a larger benefit than Formula 1 or Formula 3, your total monthly benefit would be $10,973.50 a month, payable for your lifetime under the Straight Life Annuity payment option.

If you elect an option other than the Straight Life Annuity, your pension benefit would be adjusted to reflect your payment option.

Calculation 2: Benefit From the Pension Plan

In this example, because your Average Non-Qualified Plan Eligible Earnings exceeded your Average Pension Plan Eligible Earnings, a portion of your total pension of $10,973.50 would be paid from both the Pension Plan and the Compensation Limit Plan. When the Average Pension Plan Eligible Earnings of $244,000 (based on Pension Plan Eligible Earnings limited by the IRS compensation limit, see Appendix 4.) is used in the benefit calculation, the results are as follows:

Formula 1:

1. .02 x 25 (credited service for benefit accrual) x $244,000 (Average Pension Plan Eligible Earnings) = $122,000.00 (annual pension)
2. $122,000.00 (annual pension) ÷ 12 (months) = $10,166.67 (monthly pension)

Formula 2:

1. {[.0208 (Age/Service Multiplier) x 13 (credited service for benefit accrual as of June 1, 1999)] + [.02 x 12 (credited service for benefit accrual after June 1, 1999)] + [.0003 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October 30, 2006)]} x $244,000 (Average Pension Plan Eligible Earnings) = $126,001.60 (annual pension)
2. $126,001.60 (annual pension) ÷ 12 (months) = $10,500.13 (monthly pension)

Formula 3:

1. $4,978 (Average Annual Benefit Amount) x {[.0208 (Age/Service Multiplier) x 13 (credited service for benefit accrual as of June 1, 1999)] + [.02 x 12 (credited service for benefit accrual after June 1, 1999)] + [.0003 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October 30, 2006)]} ÷ .02 = $128,531.96 (total annual pension)
2. $128,531.96 (total annual pension) ÷ 12 (months) = $10,711.00 (total monthly pension)

Because Formula 3 provides a larger benefit than Formula 1 or Formula 2, your monthly benefit from the Pension Plan would be $10,711.00, payable for your lifetime under the Straight Life Annuity payment option.

If you elect an option other than the Straight Life Annuity, your pension benefit would be adjusted to reflect your payment option.

Calculation 3: Benefit From Compensation Limit Plan

The difference between your total pension benefit of $10,973.50 (from Calculation 1) and the benefit from the Pension Plan of $10,711.00 (from Calculation 2) is $262.50 ($10,973.50 - $10,711.00 = $262.50) and would be paid from the Compensation Limit Plan. In this example, the pension benefits are not limited by the Section 415 benefit limit. Had your benefit from the Pension Plan of $10,711.00 been reduced by the Section 415 limit, the amount of the reduction would be paid from the 415 Limit Plan.

Total Pension Benefit Sources

Your total pension benefit comes from the following sources:

Pension Plan monthly benefit	$10,711.00
415 Limit Plan monthly benefit	$ 0.00
Compensation Limit Plan monthly benefit	$ 262.50
Total monthly pension benefit	$10,973.50

NOTE: Your benefit from the Non-Qualified Plans accrued through December 31, 2004, will be paid in a monthly benefit in the same form and at the same time as elected under the Pension Plan. Your benefit from the Non-Qualified Plans accrued after December 31, 2004, will be paid as a lump sum on the later of the date at which you attain age 55 or 6 months following the date you terminate from all Controlled Group Members. (This piece of your Non-Qualified Plans benefit will be paid at this date even if you defer commencement of your Pension Plan benefit. The calculation of the lump sum of your benefit from the Non-Qualified Plans accrued after December 31, 2004, will be based on the monthly benefit payable as of the first of the month coincident with or following the date you terminate or the date you attain age 55, if later, with any applicable early retirement reduction applied.)

Early Retirement Benefit

Your early retirement benefit is calculated the same way as your normal retirement benefit. However, if you choose to commence payments before age 60, your normal retirement monthly benefit is reduced by .25% (.0025 or 1/12th of 3%) for each month your Benefit Commencement Date precedes age 60. This reduction is made because your payments start sooner than they would at age 60 and would therefore continue for a longer period of time. Note, if you commence payments after age 60, there is no reduction for early commencement.

Calculating an Early Retirement Pension—Example

Let's do another example with a different set of assumptions. Assume you are vested and retiring on your early retirement date, June 1, 2016, at age 55. Your age as of June 1, 1999, was 38. Let's also assume you have 30 years of credited service—13 years as of June 1, 1999, and 17 years after June 1, 1999 (limited to 12 years in the formulas since total service is limited to 25 years). Using the chart in Appendix 2, your Age/Service Multiplier would be 2.08%. Your age as of October 30, 2006, was 45 and you had 20 years of credited service for benefit accrual as of October 30, 2006. Using the chart in Appendix 3, your Additional Benefit Percentage would be 0.00%. Using the chart in Appendix 4, your Average Non-Qualified Plan Eligible Earnings based on the highest five years is $255,000. This amount is used in Formulas 1 and 2. Using the chart in Appendix 5, your Average Annual Benefit Amount is $4,978. This amount is used in Formula 3. These amounts are used to calculate your total benefit, as described below.

Calculation 4: Total Early Retirement Benefit From the Pension Plan and Non-Qualified Plans

Your total early retirement benefit is calculated without regard to the compensation limit or the Section 415 Limit as shown below.

Formula 1:

1. .02 x 25 (credited service for benefit accrual) x $255,000 (Average Non-Qualified Plan Eligible Earnings) = $127,500.00 (total annual pension)

2. $127,500.00 (total annual pension) ÷ 12 (months) = $10,625.00 (total monthly pension payable at normal retirement)

Formula 2:

1. {[.0208 (Age/Service Multiplier) x 13 (credited service for benefit accrual as of June 1, 1999)] + [.02 x 12 (credited service for benefit accrual after June 1, 1999)] + [.0000 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October 30, 2006)]} x $255,000 (Average Non-Qualified Plan Eligible Earnings) = $130,152.00 (total annual pension)
2. $130,152.00 (total annual pension) ÷ 12 (months) = $10,846.00 (total monthly pension payable at normal retirement)

Formula 3:

1. $4,978 (Average Annual Benefit Amount) x {[.0208 (Age/Service Multiplier) x 13 (credited service for benefit accrual as of June 1, 1999)] + [.02 x 12 (credited service for benefit accrual after June 1, 1999)] + [.0000 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October 30, 2006)]} ÷ .02 = $127,038.56 (total annual pension)
2. $127,038.56 (total annual pension) ÷ 12 (months) = $10,586.55 (total monthly pension payable at normal retirement)

Because Formula 2 provides a larger benefit than Formula 1 or Formula 3, your monthly normal retirement benefit would be $10,846.00, payable for your lifetime under the Straight Life Annuity payment option at normal retirement.

If you want to receive early retirement benefits at age 55, the calculation is:

1. 1 - [.0025 x 60 (number of months payments begin before age 60)] = 0.8500
2. 0.8500 x $10,846.00 (total monthly benefit payable at normal retirement) = $9,219.10 (reduced monthly pension payable as a Straight Life Annuity at early retirement age 55)

If you elect an option other than the Straight Life Annuity, your pension benefit would be adjusted to reflect your payment option.

Calculation 5: Early Retirement Benefit From the Pension Plan

In this example, because your Average Non-Qualified Plan Eligible Earnings exceeded your Average Pension Plan Eligible Earnings, a portion of your total pension of $9,219.10 would be paid from both the Pension Plan and the Compensation Limit Plan. When the Average Pension Plan Eligible Earnings of $244,000 (based on Pension Plan Eligible Earnings limited by the IRS compensation limit, see Appendix 4) is used in the benefit calculation, the results are as follows:

Formula 1:

1. 02 x 25 (credited service for benefit accrual) x $244,000 (Average Pension Plan Eligible Earnings) = $122,000.00 (annual pension)
2. $122,000.00 (annual pension) ÷ 12 (months) = $10,166.67 (monthly pension payable at normal retirement)

Formula 2:

1. {[.0208 (Age/Service Multiplier) x 13 (credited service for benefit accrual as of June 1, 1999)] + [.02 x 12 (credited service for benefit accrual after June 1, 1999)] + [.0000 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October

30, 2006)]} x $244,000 (Average Pension Plan Eligible Earnings) = $124,537.60 (annual pension)

2. $124,537.60 (annual pension) ÷ 12 (months) = $10,378.13 (monthly pension payable at normal retirement)

Formula 3:

1. $4,978 (Average Annual Benefit Amount) x {[.0208 (Age/Service Multiplier) x 13 (credited service for benefit accrual as of June 1, 1999)] + [.02 x 12 (credited service for benefit accrual after June 1, 1999)] + [.0000 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October 30, 2006)]} ÷ .02 = $127,038.56 (annual pension)
2. $127,038.56 (total annual pension) ÷ 12 (months) = $10,586.55 (total monthly pension payable at normal retirement)

Because Formula 3 provides a larger benefit than Formula 1 or Formula 2, your monthly normal retirement benefit under the Pension Plan would be $10,586.55 payable for your lifetime under the Straight Life Annuity payment option at normal retirement.

If you want to receive early retirement benefits at age 55, the calculation is:

1. 1 - [.0025 x 60 (number of months payments begin before age 60)] = 0.8500
2. 0.8500 x $10,586.55 (monthly benefit payable at normal retirement) = $8,998.57 (reduced monthly pension payable as a Straight Life Annuity at early retirement age 55)

If you elect an option other than the Straight Life Annuity, your pension benefit would be adjusted to reflect your payment option.

Calculation 6: Early Retirement Benefit From Compensation Limit Plan

The difference between your total early pension benefit of $9,219.10 (from Calculation 4) and the early benefit from the Pension Plan of $8,998.57 (from Calculation 5) is $220.53 ($9,219.10 - $8,998.57 = $220.53) and would be paid from the Compensation Limit Plan. In this example, the pension benefits are not limited by the Section 415 benefit limit. Had your benefit from the Pension Plan of $8,998.57 been reduced by the Section 415 limit, the amount of the reduction would be paid from the 415 Limit Plan.

Total Pension Benefit Sources

Your total pension benefit comes from the following sources:

Pension Plan monthly benefit	$ 8,998.57
415 Limit Plan monthly benefit	$ 0.00
Compensation Limit Plan monthly benefit	$ 220.53
Total monthly pension benefit	$ 9,219.10

NOTE: Your benefit from the Non-Qualified Plans accrued through December 31, 2004, will be paid in a monthly benefit in the same form and at the same time as elected under the Pension Plan. Your benefit from the Non-Qualified Plans accrued after December 31, 2004, will be paid as a lump sum on the later of the date at which you attain age 55 or 6 months following the date you terminate from all Controlled Group Members. (This piece of your Non-Qualified Plans benefit will be paid at this date even if you defer commencement of your Pension Plan benefit. The calculation of the lump sum of your benefit from the Non-Qualified Plans accrued after December 31, 2004, will be based on the monthly benefit payable as of the first of the month

coincident with or following the date you terminate or the date you attain age 55, if later, with any applicable early retirement reduction applied.)

Terminated Vested Benefit

If you are vested and terminate employment with a Participating Employer before age 55, you are eligible for a vested benefit beginning as early as age 55. The amount of this benefit is based on two items:

- The pension formula and definitions applicable at the time you terminate employment with a Participating Employer, including the benefit percentage, your Age/Service Multiplier, your years of credited service for benefit accrual, your Average Earnings and your average annual benefit amount
- Your age at the time you decide to commence your retirement benefits

For example, if you want benefits to begin age 60, your pension is calculated in the same manner as the normal retirement benefit. If you want benefits to commence between the ages of 55 and 60, your benefit is calculated the same as the early retirement benefit.

If the present value of your total benefit accrued under the Pension is less than $1,000, you will automatically receive a distribution of the lump-sum value. You may choose how to receive the payment either in a lump-sum payment or a rollover. If no choice is made, a lump-sum check for the value of your accrued pension benefit will be automatically mailed to your home address no later than 120 days following the date of your termination of employment.

If the present value of your total benefit accrued under the Pension Plan is between $1,000 and $5,000, you will automatically receive a distribution of the lump-sum value. You may choose how to receive the payment either in a lump-sum payment or a rollover. If no choice is made, your benefit will be automatically rolled over into an Individual Retirement Account (IRA) at Vanguard. Otherwise, you are eligible for a monthly benefit from the plan commencing as early as age 55.

NOTE: Your benefit from the Non-Qualified Plans accrued through December 31, 2004, will be paid in a monthly benefit in the same form and at the same time as elected under the Pension Plan. Your benefit from the Non-Qualified Plans accrued after December 31, 2004, will be paid as a lump sum on the later of the date at which you attain age 55 or 6 months following the date you terminate from all Controlled Group Members. (This piece of your Non-Qualified Plans benefit will be paid at this date even if you defer commencement of your Pension Plan benefit. The calculation of the lump sum of your benefit from the Non-Qualified Plans accrued after December 31, 2004, will be based on the monthly benefit payable as of the first of the month coincident with or following the date you terminate or the date you attain age 55, if later, with any applicable early retirement reduction applied.)

The FedEx Retirement Service Center will send you a calculation summary no later than 120 days after the close of the Plan Year (May 31) in which your termination date is entered in Workday. The Report of Benefits will show either:

- The amount of your monthly benefit payable at age 60 and the amount of your lump-sum benefit from the Non-Qualified Plans, if any, payable at the later of age 55 and 6 months after your date of termination, or
- The lump-sum present value of your pension benefit, if $1,000 or less.

To request a retirement kit, you must contact the FedEx Retirement Service Center at 1.855.604.6221 or online via the website at **retirement.fedex.com**, at least 30 days prior to your anticipated Benefit Commencement Date, but no earlier than 90 days.

Forms of Benefit Payment

You must carefully consider your form of payment selection. **Once you have elected a form of payment and benefits have commenced, you cannot change your form of payment.**

NOTE: Your benefit from the Non-Qualified Plans accrued through December 31, 2004, will be paid in a monthly benefit in the same form and at the same time as elected under the Pension Plan. Your benefit from the Non-Qualified Plans accrued after December 31, 2004, will be paid as a lump sum on the later of the date at which you attain age 55 or 6 months following the date you terminate from all Controlled Group Members. (This piece of your Non-Qualified Plans benefit will be paid at this date even if you defer commencement of your Pension Plan benefit. The calculation of the lump sum of your benefit from the Non-Qualified Plans accrued after December 31, 2004, will be based on the monthly benefit payable as of the first of the month coincident with or following the date you terminate or the date you attain age 55, if later, with any applicable early retirement reduction applied.)

Normal Form of Payment

If you are unmarried, the normal form of payment is a monthly benefit paid to you for your lifetime and following your death, no further payments are made. This is called a Straight Life Annuity. You may elect any of the optional forms of payment described below.

If you are married, the normal form of payment is a monthly benefit paid to you for your lifetime and following your death, 50% of that amount is payable to your spouse, if surviving, for his or her lifetime. This is called a 50% Joint and Survivor Annuity.

If you are married, you may not choose a form of payment other than the 50% Joint and Survivor Annuity, or 75% Joint and Survivor Annuity or 100% Joint and Survivor Annuity with your spouse as beneficiary, unless you waive your right to those payment forms and your spouse consents to your form of payment and your designated beneficiary. Your spouse's written consent must be witnessed by a notary public. The Confirmation of Pension Choices packet will include a Spousal Consent Waiver for Qualified Joint and Survivor Annuity and Consent to Non-Spouse Beneficiary, if applicable.

Spouse Definition

For Pension Plan purposes, all references to "spouse" shall mean a legally married spouse as recognized under the laws of the state or other jurisdiction in which the marriage is established. A former spouse shall be treated as the spouse to the extent provided under a Qualified Domestic Relations Order as described in Section 414(p) of the Code. The Plan Administrator may rely on the participant's written statement regarding such participant's marital status.

A common-law marriage will be valid where recognized in the applicable state jurisdiction provided you have submitted an acceptable affidavit of common-law marriage to the Retirement Service Center (RSC).

Optional Forms of Payment

You may want to receive benefits in some other way. If you do, you can select one of the following forms of payment:

- **Straight Life Annuity**—You receive a level monthly pension benefit for your lifetime. After your death, no further payments are made. This is the normal form of payment for unmarried participants. Unmarried participants may elect any form of payment.
- **Joint and Survivor Annuity**—You receive a reduced level monthly pension benefit and, upon your death, your beneficiary continues to receive a percentage of these payments

for his or her lifetime. You may choose the percentage your beneficiary receives: 50%, 75% or 100% of your benefit amount. A 50% Joint and Survivor Annuity is the normal form of payment for married participants. If you are married and wish to choose another form of payment or want to name a beneficiary other than your spouse, your spouse must provide a notarized consent in writing.

- **Joint and Survivor Pop-up Annuity**—You receive a reduced level monthly pension benefit for your lifetime. Upon your death, your beneficiary continues to receive a percentage (50%, 75% or 100%) of your payment for his or her lifetime. If your beneficiary pre-deceases you, your pension benefit increases to the amount of the Straight Life Annuity payment.
- **Life Annuity With Payments Guaranteed**—You receive a reduced level monthly pension benefit for life, with the guarantee that upon your death your beneficiary receives any payments you had not received within the selected guaranteed time period. You may choose a 5 year (60 months), 10 year (120 months) or 15 year (180 months) guaranteed period. If you survive the guaranteed period, no benefits are available for your spouse or beneficiary.
- **Social Security Leveling Option**—You may choose to receive an increased monthly pension benefit until age 62, age 65 or your normal Social Security retirement age (65, 66 or 67 depending on when you were born). After your chosen age, you receive a reduced monthly payment for life. These options will provide an approximately level retirement income when your reduced pension benefit is added to your primary Social Security benefit amount. This benefit is calculated using an estimated amount of primary Social Security in effect at the time of the calculation. No benefits are available to a beneficiary.
- **Cash Refund Option**—This option pays a reduced level monthly pension benefit to you for life and, upon your death, pays a lump sum to your designated beneficiary. If there is no surviving beneficiary, the lump sum is paid to your estate. The lump-sum amount is equal to the present value of the benefits you were expected to receive less the sum of all monthly pension benefits actually paid to you.

Important Information When Selecting a Joint and Survivor Form of Payment

If you select a Joint and Survivor Annuity, your election of both the form of payment and beneficiary are irrevocable. The survivor benefit is applicable only to the beneficiary designated at the time your monthly payments commence.

If, after the start of payments under a Joint and Survivor Annuity with your spouse as the survivor, you and your spouse divorce or your spouse dies, you may not select another person, including a new spouse, to receive the survivor benefits, and you may not select a different optional form of payment (*e.g.*, a Straight Life Annuity). In fact, in the event of divorce your former spouse will continue to have a right to the survivor benefits. Even a Qualified Domestic Relations Order (QDRO) will not transfer the survivor rights to another person, including a subsequent spouse, since the Pension Plan prohibits such a transfer.

If you select a Joint and Survivor Annuity form of payment, your benefit is reduced according to your survivor's age. If your designated beneficiary is not your spouse, the available Joint and Survivor Annuity options may be limited depending on the age of your beneficiary. In addition, an optional form of payment may not provide for a monthly payment to a joint annuitant or beneficiary that is greater than the monthly payment to you.

You must carefully consider your form of payment election. Once you have elected a form of payment and benefits have commenced, you cannot change your form of payment.

Joint and Survivor Benefit Calculations (based on $10,000 Straight Life Annuity)

The examples shown below are provided to give you a general idea of the adjustment made when you elect a Joint and Survivor Annuity. The adjustment is based on your age and your beneficiary's age on your benefit commencement date and the percentage of annuity elected (50%, 75% or 100%). The adjustment is applied to the Straight Life Annuity form of payment whether it is a normal or early retirement benefit.

Your monthly payments, based on your age and your survivor's age, are as follows:

Annuities	Your Age Is 60 Your Survivor's Age Is 60	Your Age Is 60 Your Survivor's Age Is 55	Your Age Is 60 Your Survivor's Age Is 50
50% Joint and Survivor			
Your monthly benefit	$9,080	$8,890	$8,720
Survivor's monthly benefit	$4,540	$4,445	$4,360
75% Joint and Survivor			
Your monthly benefit	$8,680	$8,430	$8,190
Survivor's monthly benefit	$6,510	$6,323	$6,143
100% Joint and Survivor			
Your monthly benefit	$8,320	$8,010	$7,730
Survivor's monthly benefit	$8,320	$8,010	$7,730

Your Pension Plan Forms of Payment May Be Limited

Under a provision of the Pension Protection Act of 2006, certain forms of payment may be restricted due to the specific funded status of the Pension Plan. If the Pension Plan becomes subject to benefit restrictions for any period of time, all participants will be notified within 30 days.

The Administrator may not know in advance whether the Pension Plan will be subject to benefit restrictions on a particular date. If you request a retirement packet and the Pension Plan is in a period of benefit restrictions or has the potential to become restricted prior to your benefit commencement date, you will receive appropriate information and required forms.

Also, lump-sum payments from certain death benefits may be limited during a period of benefit restrictions. Once the plan exits a period of benefit restrictions, if a lump sum had been limited, a one-time opportunity (a special second election) will be provided for the remainder of the restricted lump-sum payment in lieu of continuing a monthly annuity.

If you have any questions about benefit restrictions, call the FedEx Retirement Service Center at 1.855.604.6221. Customer service representatives are available Monday – Friday from 8 a.m. to 6 p.m. Central time.

Making Application for Benefits and When Payments Commence

NOTE: To request a retirement packet, you must contact the FedEx Retirement Service Center by phone at 1.855.604.6221, or online via the website at **retirement.fedex.com**, at least 30 days prior to your anticipated Benefit Commencement Date, but no earlier than 90 days.

Except in the case of an active employee who is age 72, if you reach age 70½ after December 31, 2019 (refer to "Active Employees age 70½ or Older"), you must have retired or terminated from all Controlled Group Members in order to commence a benefit from the Pension Plan. Monthly benefits commence on the first day of the month coincident with or next following the date you have met all Plan application requirements as described below.

Monthly benefits may commence as of the first day of the month coincident with or next following the date you have met all Plan application requirements as described below; additionally, your retirement effective date must be entered in your Human Resources Information System (HRIS) before your benefit payment can be made. If your retirement date is not entered timely, it could delay the start of your pension benefit payment.

As long as your completed application for benefits is received within 60 days following the date on your retirement kit, your initial benefit payment will be effective as of your elected Benefit Commencement Date. If your payment is delayed until after your elected Benefit Commencement Date, you will receive the payment on the earliest available payment date.

For example, if you requested a retirement kit on December 15, and you elected an annuity with a January 1 Benefit Commencement Date, and your completed application for benefits is returned on February 1 (within 60 days from the date on your retirement kit), you will receive your initial benefit payment March 1. Your initial benefit payment will include a retroactive payment for both January 1 and February 1. January 1 is considered your Benefit Commencement Date.

You have at least 30 days to make your benefit election. You can waive your right to the 30-day period if you submit your election form within 30 days of your elected Benefit Commencement Date. In any case, you have until the receipt of your first check or the date of your first direct deposit in which to request a different form of payment.

There are two ways in which you may choose to start your pension plan benefits.

- By Phone: Contact the Retirement Service Center (RSC) at 1.855.604.6221, Monday through Friday, 8 a.m. – 6 p.m. Central time. The RSC will send a retirement kit to your home address or secure mailbox on **retirement.fedex.com** if you have chosen an electronic delivery preference. Carefully review all the information in the retirement kit. Call the RSC if there are any errors or changes in the information.

  Next, you will need to call the RSC to make your pension payment choices, tax withholding elections and payment delivery method. After your elections are made, you will receive a Confirmation of Pension Choices and Pension Choices Authorization form in the mail. The Authorization form must be signed and returned to the RSC via upload, fax or postal mail by the specified deadline in order for payments to commence.
- Online: Visit **retirement.fedex.com**. From the Home page click the Retire Now tile and step through the online retirement process. You will be guided through the steps to make your pension benefit choices. Carefully review all your information. Call the RSC if there are any errors or changes in the information. Select your benefit commencement date, pension payment choices, tax withholding elections and payment delivery method. After your elections are made, you will receive a Confirmation of Pension Choices and

Pension Choices Authorization form through the website's secure mailbox or via the mail. The Authorization form must be signed and returned to the RSC via upload, fax or postal mail by the specified deadline in order for payments to commence.

Deciding When to Start Your Benefits

If upon termination of employment you choose to defer the commencement of your pension benefit, the size of each monthly annuity payment will be larger when your payments begin either because the reduction for early retirement will be less, or because you will receive an actuarial increase due to your deferred commencement of retirement benefits beyond normal retirement.

For participants who terminate prior to age 60 and live to the average life expectancy, the total value of benefits is greatest if payments start as soon as possible following termination of employment.

Taxes

Your benefit payment is subject to federal and, if applicable, state income tax. You will make your tax withholding election at the time you make your pension election(s) via phone or by accessing the website at **retirement.fedex.com**. If you do not make a choice for your federal tax withholding, the IRS requires automatic withholding as if you are married with three exemptions. If you do not make a choice for your state income tax withholding for your pension payment and you reside in a state that requires mandatory withholding from pension payments, state income tax will be withheld at a rate determined by the state in which you reside.

Important! Federal tax penalties can apply if you do not withhold enough money to cover your federal tax obligation for the year. Consult your personal tax advisor for assistance.

The lump-sum present value of your benefits payable from the Non-Qualified Pension Plans (if applicable) is subject to FICA tax at the end of the year in which your date of termination occurs, regardless of when you actually receive the distribution. The value is calculated based upon the benefit payable on the later of your date of termination or the date on which you turn age 55.

Designating a Beneficiary

In some cases, it might be necessary to designate a beneficiary to receive benefits after your death.

If you die before your Benefit Commencement Date and:

- You are unmarried, no benefits are payable to a beneficiary.*
- You are married, your spouse is automatically your beneficiary. A portion of your vested benefit will be paid to your spouse monthly. Refer to "Survivor Benefits," below.

If you die on or after your Benefit Commencement Date and:

- You are married or unmarried, the form of payment you chose at your Benefit Commencement Date will determine whether benefits are payable to a beneficiary (including a trust). Your retirement packet will include a beneficiary designation form to be completed, as applicable, based on your form of payment.
- Additionally, as a married participant, if you do not elect one of three Joint and Survivor Annuity options, your spouse must give notarized consent to your election of another form of payment and to your naming a non-spouse beneficiary.

*If you accrued a portion of your benefit as a non-pilot under the Portable Pension Account (PPA) formula, the full PPA portion of your benefit is payable to your designated beneficiary.

Survivor Benefits

In some cases, a beneficiary will receive benefits after your death.

If you die on or after your Benefit Commencement Date, benefits, if any, will be paid to your beneficiary based on the form of payment you selected when you retired.

If you die before your Benefit Commencement Date and:

- You are unmarried, no benefits are payable to a beneficiary.* However, your beneficiary(ies), while not entitled to survivor benefits from the Pension Plan, may be eligible to receive benefits under the FedEx life insurance plans and other retirement plans.
- You are married, a portion of your vested benefit will be paid to your spouse monthly. Your surviving spouse will receive a monthly pension based on the components of the benefit formulas on your date of death. The benefit will be calculated as if you had chosen the Joint and Survivor Annuity with 50% of your benefit continuing to your spouse.

Provided the survivor completes an application for benefits on or before the Benefit Commencement Date, the survivor's payment will commence on the first day of the month after:

- Your date of death, if you die on or after your early retirement age (age 55).
- Your early retirement age (age 55), if you die before you were eligible for early retirement.

If your surviving spouse elects to defer payment of survivor benefits until after your earliest possible retirement date, an Early Retirement reduction is applied and then the benefit is actuarially increased for a later commencement. If the first payment is made after the benefit commencement date, retroactive payments will be included for any missed months.

NOTE: If you retired and submitted a valid, unexpired election to commence your pension benefits within 90 days of your Benefit Commencement Date and you do not survive until your Benefit Commencement Date, you will be treated as if you survived until your elected Benefit Commencement Date and your benefits will be paid in the form elected by you. Depending on the form of payment elected, any survivor benefits will be paid to the beneficiary you selected. An election will be determined to have been submitted prior to your death if there is proof that the election confirmation was mailed, emailed, faxed, posted or received by the administrator prior to your death.

*If you accrued a portion of your benefit as a non-pilot under the Portable Pension Account (PPA) formula, the full PPA portion of your benefit is payable to your designated beneficiary.

Payments to an Alternate Payee

With the exception of a Qualified Domestic Relations Order (QDRO), your benefit from the Pension Plan cannot be assigned to anyone else. A court may issue a Domestic Relations Order (DRO) under state domestic relations law directing the plan administrator to pay all or a portion of your Pension Plan benefit to an alternate payee.

A QDRO is a judgment, decree or order made in accordance with domestic relations law and subject to provisions under federal law that require the plan administrator to pay all or a portion of your benefit to another person referred to as an "alternate payee". An alternate payee is a

spouse, former spouse or dependent child who is recognized under a QDRO as being entitled to receive all or part of your benefit.

The plan administrator ultimately is responsible for determining if a DRO is a QDRO. A third-party administrator has been hired to review DROs and to determine if they meet the requirements of a QDRO. All inquiries about QDROs should be directed to:

FedEx Retirement Service Center

Attn: QO Unit

P.O. Box 7144

Rantoul, IL 61866-7144

Overnight:

FedEx Retirement Service Center

Attn: QO Unit

S 1000 Perimeter Road

Rantoul, IL 61866

1.855.604.6221

Fax: 1.847.554.1969

Website: www.qocenter.com

You or your attorney may call 1.855.604.6221 to speak with a representative or request governing procedures and other documents, which are provided without charge.

Social Security—A Reminder

For information on Social Security benefits, either call your local Social Security office at 1.800.772.1213 or TTY: 1.800.325.0778 or visit their website at **www.ssa.gov** and complete a request for a Social Security statement.

Your Social Security benefits will not commence automatically. You must contact your local Social Security office to file an application for benefits. Also, you may be able to apply for benefits online at **www.ssa.gov/applytoretire**.

Requesting a Retirement Kit to Commence Your Pension Plan Benefit

You should start the process at least 30 days, but no more than 90 days, before your Benefit Commencement Date. There are two ways in which you may choose to start your pension plan benefits.

By Phone: Contact the Retirement Service Center (RSC) at 1.855.604.6221, Monday through Friday, 8 a.m. – 6 p.m. Central time. The RSC will send a retirement kit to your home address. Carefully review all the information in the retirement kit. Call the RSC if there are any errors or changes in the information.

Next, you will need to call the RSC to make your pension payment choices, tax withholding elections and payment delivery method. After your elections are made, you will receive a

Confirmation of Pension Choices and Pension Choices Authorization form in the mail. The Authorization form must be signed and returned to the RSC via upload, fax or postal mail by the specified deadline in order for payments to commence.

Online: Visit **retirement.fedex.com**. (May not be available for Pilots with an FTL Variable Plan or a Qualified Domestic Relations Order.) From the Home page click the Retire Now tile and step through the online retirement process. You will be guided through the steps to make your pension benefit choices. Carefully review all your information. Call the RSC if there are any errors or changes in the information.

Select your benefit commencement date, pension payment choices, tax withholding elections and payment delivery method. After your elections are made, you will receive a Confirmation of Pension Choices and Pension Choices Authorization form through the secure mailbox feature or via postal mail. The Authorization form must be signed and returned in the mail to the RSC via upload, fax or postal mail by the specified deadline in order for payments to commence.

Commencing a Terminated Vested Benefit

- Contact the RSC by phone at 1.855.604.6221 or online at **retirement.fedex.com** to change your home address.
- Contact the RSC at least 30 days, but no more than 90 days, before the desired Benefit Commencement Date. Representatives are available at the RSC Monday through Friday from 8 a.m. – 6 p.m., Central time. (**NOTE:** Benefits can commence no earlier than age 55.)
- Your benefit payment will commence on the first of the month coincident with or next following the date you have met all Plan application requirements and the RSC receives all required forms.

Commencing a Pre-Retirement Death Benefit for a Survivor or Beneficiary

If your spouse is eligible for a Pre-Retirement Death Benefit:

- The RSC will send your surviving spouse a calculation and instructions to commence the benefit, if applicable, within three weeks after your death is reported.
- If your spouse is eligible for an immediate benefit, he/she must complete and return the forms and required documentation to the RSC no later than 60 days following the elected Benefit Commencement Date. If your spouse is not eligible for an immediate benefit, he/she should contact the RSC at least 30 days, but not more than 90 days, before the desired Benefit Commencement Date and complete and return the forms and required documentation to the RSC on or before that date.

Claims and Appeals

Information for filing a claim for benefits, reconsidering a claim, appealing a denial and legal action is explained in “Claims and Appeals.”

Appendix 1

Following are definitions of terms used in computing the Flat Dollar Formula (Formula 3):

Annual Benefit Amount

The Annual Benefit Amount is computed for use in the Flat Dollar Formula (Formula 3). Your Annual Benefit Amount under the Pension Plan is based on your Craft, Seat, Year Group, hours flown and Bid Periods for which a bid period override is received for each calendar year.

The Annual Benefit Amount is determined by adding the following data:

- Hourly Benefit Multiplier times Total Flight Hours, plus
- Seat Multiplier times International Hours, plus
- Override Amount times Bid Periods, plus
- Additional Annual Amount

Following are definitions of the terms used above:

Hourly Benefit Multiplier

This multiplier is based on your Craft, Seat and Year Group as of January 1 of each calendar year. See tables following for schedules of Hourly Benefit Multipliers.

Craft

Craft is the specific aircraft type: narrow body or wide body.

Seat

Seat means Captain, First Officer or Second Officer.

Year Group

A pilot's full years of longevity plus one, as defined in the Agreement.

Total Flight Hours

Total Flight Hours are equal to your credit hours for which you received your normal pay rate plus 150% of credit hours for which you received 150% or more of your pay rate. All hours for the period June 1, 1999, to December 31, 1999, have been multiplied by a factor of 1.1667 to reflect the change in the credit hours from seven to six.

Seat Multiplier

For the appropriate Seat, the Seat Multiplier is equal to:

Before January 1, 2007		January 1, 2007 through December 31, 2015		On and After January 1, 2016	
CAP	$.13	CAP	$.18	CAP	$.20
F/O	$.09	F/O	$.14	F/O	$.16
S/O	$.07	S/O	$.12	S/O	N/A

International Hours

Credit hours for which you are paid an international override amount in addition to your pay rate.

If you have credit hours past age 60 in a lower seat, the Annual Benefit Amount for the calendar year in which you reach age 60 will be determined based upon Craft, Seat and Year Group determined as of the first day of the year for credit hours prior to attaining age 60 and the Craft, Seat and Year Group after the seat change for credit hours after attaining age 60.

Override Amount

The Override Amount shall be equal to the following for the appropriate seat and consecutive years of service in such seat:

Override Amount Before October 30, 2006

Service	CAP or F/O	S/O
1	$16.00	$12.00

2	$18.00	$14.00
3	$20.00	$16.00
4	$22.00	$18.00

Override Amount on and After October 30, 2006 Through November 1, 2015

Service	SCA CAP	FPS/TAA/ LCA CAP	F/O or Flex/PCA CAP	SCA S/O	Other S/O
1	$36.00	$26.00	$16.00	$17.00	$12.00
2	$38.00	$28.00	$18.00	$19.00	$14.00
3	$40.00	$30.00	$20.00	$21.00	$16.00
4 or more	$42.00	$32.00	$22.00	$21.00	$16.00

Override Amount on and After November 2, 2015

Service	SCA CAP	FPS/TAA/LCA CAP	F/O or Flex/PCA CAP
1	$42.00	$30.00	$20.00
2	$44.00	$32.00	$22.00
3	$46.00	$34.00	$24.00
4 or more	$50.00	$38.00	$26.00

Bid Periods

Bid Periods are the number of months for which a bid period override is received for Line Check Airmen, Flex Flight Standards Check Airmen, Flex Instructors/Proficiency Check Airmen, Flight Project Specialists or Technical Advisors/Aircraft.

Additional Annual Amount

If you were employed by FedEx and were in an active pay status (or on military leave of absence) throughout the period June 1, 2004, to October 30, 2006, the Additional Annual Amount is the amount shown for each calendar year in the following tables based on Seat and Craft as of November 1, 2006. For pilots retiring between November 1, 2006, and December 31, 2006, the amount shown for calendar years 2006 and 2007 was combined and included as their 2006 Additional Annual Amount.

	For 2006 Calendar Year		
	Narrow Body		Wide Body
CAP	$250.00		$280.00
F/O	$150.00		$168.00
S/O	$ 70.00		$ 80.00

	For 2007 Calendar Year		
	Narrow Body		Wide Body
CAP	$280.00		$320.00
F/O	$166.00		$186.00
S/O	$ 78.00		$ 90.00

If you were not in an active pay status (or on military leave of absence) throughout the Amendable Period, the above amounts will be prorated based on the number of months you were in an active status during the Amendable Period (capped at 29) divided by 29.

If you were employed as a pilot on January 28, 2011, your Additional Annual Amount for calendar year 2011 (limited to $52.00) is 1% of your 2010 Annual Benefit Amount.

If you were employed by FedEx and were in an active pay status (or on military leave of absence) throughout the period February 25, 2013, to August 19, 2015, the Additional Annual Amount is the amount shown for each calendar year in the following tables based on the highest Seat and Craft during this period assuming you still are actively employed in the specified calendar year.

	For 2015 Calendar Year		
	Narrow Body		**Wide Body**
CAP	$363.00		$429.00
F/O	$242.00		$286.00

	For 2016 Calendar Year		
	Narrow Body		**Wide Body**
CAP	$264.00		$312.00
F/O	$176.00		$208.00

Additional Benefit Percentage

Your Additional Benefit Percentage is based on your age and years of credited service for vesting as of October 30, 2006, as determined from Appendix 3. For former Flying Tiger Line, Inc. (FTL) pilots, your FTL years of credited service for vesting count in determining your Additional Benefit Percentage, but FTL years of service do NOT count toward your credited service for benefit accrual.

Average Annual Benefit Amount

Average Annual Benefit Amount (an example is shown in Appendix 5) is the average of your five highest Annual Benefit Amounts (need not be consecutive). This average is limited to $5,200.

Use these charts to determine your Hourly Benefit Multiplier:

Schedule of Hourly Benefit Multiplier			
Effective January 1, 1988 through December 31, 1989			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	12 or more	2.66
Wide Body	CAP	11	2.65
Wide Body	CAP	10 to 9	2.63
Wide Body	CAP	5 to 8	2.58
Wide Body	CAP	2 to 4	2.55
Narrow Body Wide Body	CAP CAP	12 or more 1	2.26
Narrow Body	CAP	11	2.25
Narrow Body	CAP	8 to 10	2.21
Narrow Body	CAP	5 to 7	2.17

Schedule of Hourly Benefit Multiplier			
Effective January 1, 1988 through December 31, 1989			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body Wide Body Narrow Body	F/O F/O CAP	12 or more 11 1 to 4	1.88
Wide Body Narrow Body Narrow Body Wide Body Wide Body	F/O F/O F/O S/O S/O	2 to 10 12 or more 6 to 11 12 or more 6 to 11	1.42
Narrow Body Narrow Body Narrow Body Wide Body	F/O S/O S/O S/O	2 to 5 12 or more 3 to 11 2 to 5	1.00
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.67

Schedule of Hourly Benefit Multiplier			
Effective January 1, 1990 through December 31, 1990			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	12 or more	2.76
Wide Body	CAP	11	2.74
Wide Body	CAP	10 to 9	2.72
Wide Body	CAP	5 to 8	2.68
Wide Body	CAP	2 to 4	2.64
Narrow Body Wide Body	CAP CAP	12 or more 1	2.35
Narrow Body	CAP	11	2.34
Narrow Body	CAP	8 to 10	2.30
Narrow Body	CAP	5 to 7	2.25
Wide Body Wide Body Narrow Body	F/O F/O CAP	12 or more 11 1 to 4	1.95
Wide Body Narrow Body Narrow Body Wide Body Wide Body	F/O F/O F/O S/O S/O	2 to 10 12 or more 6 to 11 12 or more 6 to 11	1.47
Narrow Body Narrow Body	F/O S/O	2 to 5 12 or more	1.04

Schedule of Hourly Benefit Multiplier			
Effective January 1, 1990 through December 31, 1990			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Narrow Body Wide Body	S/O S/O	3 to 11 2 to 5	
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.70

Schedule of Hourly Benefit Multiplier			
Effective January 1, 1991 through December 31, 1992			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	12 or more	2.80
Wide Body	CAP	11	2.79
Wide Body	CAP	10 to 9	2.76
Wide Body	CAP	5 to 8	2.72
Wide Body	CAP	2 to 4	2.68
Narrow Body Wide Body	CAP CAP	12 or more 1	2.39
Narrow Body	CAP	1	2.38
Narrow Body	CAP	8 to 10	2.34
Narrow Body	CAP	5 to 7	2.29
Wide Body Wide Body Narrow Body	F/O F/O CAP	12 or more 11 1 to 4	1.98
Wide Body Narrow Body Narrow Body Wide Body Wide Body	F/O F/O F/O S/O S/O	2 to 10 12 or more 6 to 11 12 or more 6 to 11	1.50
Narrow Body Narrow Body Narrow Body Wide Body	F/O S/O S/O S/O	2 to 5 12 or more 3 to 11 2 to 5	1.06
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.71

Schedule of Hourly Benefit Multiplier			
Effective January 1, 1993 through December 31, 1995			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	12 or more	2.86
Wide Body	CAP	11	2.80
Wide Body	CAP	10 to 9	2.76
Wide Body	CAP	5 to 8	2.72
Wide Body	CAP	2 to 4	2.68
Narrow Body	CAP	12 or more	2.44
Narrow Body Wide Body	CAP CAP	11 1	2.39
Narrow Body	CAP	8 to 10	2.34
Narrow Body	CAP	5 to 7	2.29
Wide Body Wide Body Narrow Body	F/O F/O CAP	12 or more 11 1 to 4	1.99
Wide Body Narrow Body Narrow Body Wide Body Wide Body Narrow Body	F/O F/O F/O S/O S/O S/O	2 to 10 12 or more 6 to 11 12 or more 6 to 11 12 or more	1.50
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 5 3 to 11 2 to 5	1.06
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.71

Schedule of Hourly Benefit Multiplier			
Effective January 1, 1996 through December 31, 1999			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15 or more	3.00
Wide Body	CAP	14	2.97
Wide Body	CAP	12 to 13	2.92
Wide Body	CAP	10 to 11	2.86
Wide Body	CAP	6 to 9	2.79
Wide Body	CAP	2 to 5	2.75
Narrow Body	CAP	15 or more	2.59
Narrow Body	CAP	13 to 14	2.53
Narrow Body Wide Body	CAP CAP	10 to 12 1	2.45
Narrow Body	CAP	6 to 9	2.38
Narrow Body	CAP	2 to 5	2.33
Wide Body Wide Body Narrow Body	F/O F/O CAP	15 or more 11 to 14 1	2.03
Wide Body Narrow Body Narrow Body Wide Body Wide Body Narrow Body Narrow Body	F/O F/O F/O S/O S/O S/O S/O	2 to 10 15 or more 5 to 14 15 or more 5 to 14 15 or more 11 to 14	1.50
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 4 3 to 10 2 to 4	1.10
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.72

Schedule of Hourly Benefit Multiplier			
Effective January 1, 2000 through December 31, 2000			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15 or more	3.66
Wide Body	CAP	14	3.63
Wide Body	CAP	12 to 13	3.56
Wide Body	CAP	10 to 11	3.48
Wide Body	CAP	6 to 9	3.40
Wide Body	CAP	2 to 5	3.36
Narrow Body	CAP	15 or more	3.16
Narrow Body	CAP	13 to 14	3.09
Narrow Body Wide Body	CAP CAP	10 to 12 1	2.99
Narrow Body	CAP	6 to 9	2.91
Narrow Body	CAP	2 to 5	2.84
Wide Body Wide Body Narrow Body	F/O F/O CAP	15 or more 11 to 14 1	2.48
Wide Body Narrow Body Narrow Body Wide Body Wide Body Narrow Body Narrow Body	F/O F/O F/O S/O S/O S/O S/O	2 to 10 15 or more 5 to 14 15 or more 5 to 14 15 or more 11 to 14	1.83
Narrow Body Narrow Body Narrow Body	F/O S/O S/O	2 to 4 3 to 10 2 to 4	1.34
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.88

Schedule of Hourly Benefit Multiplier			
Effective January 1, 2001 through December 31, 2002			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15 or more	3.77
Wide Body	CAP	14	3.74
Wide Body	CAP	12 to 13	3.67
Wide Body	CAP	10 to 11	3.59
Wide Body	CAP	6 to 9	3.50
Wide Body	CAP	2 to 5	3.46
Narrow Body	CAP	15 or more	3.25
Narrow Body	CAP	13 to 14	3.18
Narrow Body Wide Body	CAP CAP	10 to 12 1	3.08
Narrow Body	CAP	6 to 9	2.99
Narrow Body	CAP	2 to 5	2.93
Wide Body Wide Body Narrow Body	F/O F/O CAP	15 or more 11 to 14 1	2.56
Wide Body Narrow Body Narrow Body Wide Body Wide Body Narrow Body Narrow Body	F/O F/O F/O S/O S/O S/O S/O	2 to 10 15 or more 5 to 14 15 or more 5 to 14 15 or more 11 to 14	1.89
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 4 3 to 10 2 to 4	1.38
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.91

Schedule of Hourly Benefit Multiplier			
Effective January 1, 2003 through December 31, 2003			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15 or more	3.92
Wide Body	CAP	14	3.89
Wide Body	CAP	12 to 13	3.82
Wide Body	CAP	10 to 11	3.73
Wide Body	CAP	6 to 9	3.65
Wide Body	CAP	2 to 5	3.59
Narrow Body	CAP	15 or more	3.38
Narrow Body	CAP	13 to 14	3.31
Narrow Body Wide Body	CAP CAP	10 to 12 1	3.20
Narrow Body	CAP	6 to 9	3.11
Narrow Body	CAP	2 to 5	3.05
Wide Body Wide Body Narrow Body	F/O F/O CAP	15 or more 11 to 14 1	2.66
Wide Body Narrow Body Narrow Body Wide Body Wide Body Narrow Body Narrow Body	F/O F/O F/O S/O S/O S/O S/O	2 to 10 15 or more 5 to 14 15 or more 5 to 14 15 or more 11 to 14	1.96
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 4 3 to 10 2 to 4	1.43
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.95

Schedule of Hourly Benefit Multiplier			
Effective January 1, 2004 through December 31, 2006			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15 or more	4.12
Wide Body	CAP	14	4.08
Wide Body	CAP	12 to 13	4.01
Wide Body	CAP	10 to 11	3.92
Wide Body	CAP	6 to 9	3.83
Wide Body	CAP	2 to 5	3.77
Narrow Body	CAP	15 or more	3.55
Narrow Body	CAP	13 to 14	3.47
Narrow Body Wide Body	CAP CAP	10 to 12 1	3.36
Narrow Body	CAP	6 to 9	3.27
Narrow Body	CAP	2 to 5	3.20
Wide Body Wide Body Narrow Body	F/O F/O CAP	15 or more 11 to 14 1	2.79
Wide Body Narrow Body Narrow Body Wide Body Wide Body Narrow Body Narrow Body	F/O F/O F/O S/O S/O S/O S/O	2 to 10 15 or more 5 to 14 15 or more 5 to 14 15 or more 11 to 14	2.06
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 4 3 to 10 2 to 4	1.50
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 1 1 to 2	0.99

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2007 through December 31, 2007			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	4.49
Wide Body	CAP	14	4.45
Wide Body	CAP	12 to 13	4.37
Wide Body	CAP	10 to 11	4.27
Wide Body	CAP	6 to 9	4.17
Wide Body	CAP	2 to 5	4.11
Narrow Body	CAP	15	3.87
Narrow Body	CAP	14	3.82
Narrow Body	CAP	12 to 13	3.75
Narrow Body Wide Body	CAP CAP	10 to 11 1	3.66
Narrow Body	CAP	6 to 9	3.56
Narrow Body	CAP	2 to 5	3.49
Wide Body Narrow Body	F/O CAP	12 to 15 1	3.13
Wide Body Narrow Body Wide Body	F/O F/O S/O	2 to 11 10 to 15 10 to 15	2.55
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 9 6 to 15 3 to 9	1.94
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 to 2 1 1 to 5	1.08

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2008 through December 31, 2008			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	4.63
Wide Body	CAP	14	4.58
Wide Body	CAP	12 to 13	4.50
Wide Body	CAP	10 to 11	4.40
Wide Body	CAP	6 to 9	4.30
Wide Body	CAP	2 to 5	4.24
Narrow Body	CAP	15	3.99
Narrow Body	CAP	14	3.94
Narrow Body	CAP	12 to 13	3.86
Narrow Body Wide Body	CAP CAP	10 to 11 1	3.77
Narrow Body	CAP	6 to 9	3.67
Narrow Body	CAP	2 to 5	3.45
Wide Body Narrow Body	F/O CAP	12 to 15 1	3.22
Wide Body Narrow Body Wide Body	F/O F/O S/O	2 to 11 10 to 15 10 to 15	2.63
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 9 6 to 15 3 to 9	1.99
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 to 2 1 1 to 5	1.11

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2009 through December 31, 2009			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	4.76
Wide Body	CAP	14	4.72
Wide Body	CAP	12 to 13	4.64
Wide Body	CAP	10 to 11	4.53
Wide Body	CAP	6 to 9	4.43
Wide Body	CAP	2 to 5	4.36
Narrow Body	CAP	15	4.11
Narrow Body	CAP	14	4.06
Narrow Body	CAP	12 to 13	3.98
Narrow Body Wide Body	CAP CAP	10 to 11 1	3.89
Narrow Body	CAP	6 to 9	3.78
Narrow Body	CAP	2 to 5	3.71
Wide Body Narrow Body	F/O CAP	12 to 15 1	3.32
Wide Body Narrow Body Wide Body	F/O F/O S/O	2 to 11 10 to 15 10 to 15	2.71
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 9 6 to 15 3 to 9	2.05
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 to 2 1 1 to 5	1.15

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2010 through December 31, 2011			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	4.91
Wide Body	CAP	14	4.86
Wide Body	CAP	12 to 13	4.78
Wide Body	CAP	10 to 11	4.67
Wide Body	CAP	6 to 9	4.56
Wide Body	CAP	2 to 5	4.50
Narrow Body	CAP	15	4.23
Narrow Body	CAP	14	4.18
Narrow Body	CAP	12 to 13	4.10
Narrow Body Wide Body	CAP CAP	10 to 11 1	4.00
Narrow Body	CAP	6 to 9	3.89
Narrow Body	CAP	2 to 5	3.82
Wide Body Narrow Body	F/O CAP	12 to 15 1	3.42
Wide Body Narrow Body Wide Body	F/O F/O S/O	2 to 11 10 to 15 10 to 15	2.79
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 9 6 to 15 3 to 9	2.12
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 to 2 1 1 to 5	1.18

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2012 through December 31, 2012			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	5.06
Wide Body	CAP	14	5.01
Wide Body	CAP	12 to 13	4.92
Wide Body	CAP	10 to 11	4.81
Wide Body	CAP	6 to 9	4.70
Wide Body	CAP	2 to 5	4.63
Narrow Body	CAP	15	4.36
Narrow Body	CAP	14	4.31
Narrow Body	CAP	12 to 13	4.22
Narrow Body Wide Body	CAP CAP	10 to 11 1	4.12
Narrow Body	CAP	6 to 9	4.01
Narrow Body	CAP	2 to 5	3.93
Wide Body Narrow Body	F/O CAP	12 to 15 1	3.52
Wide Body Narrow Body Wide Body	F/O F/O S/O	2 to 11 10 to 15 10 to 15	2.87
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 9 6 to 15 3 to 9	2.18
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 to 2 1 1 to 5	1.22

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2013 through December 31, 2015			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	5.21
Wide Body	CAP	14	5.16
Wide Body	CAP	12 to 13	5.07
Wide Body	CAP	10 to 11	4.95
Wide Body	CAP	6 to 9	4.84
Wide Body	CAP	2 to 5	4.77
Narrow Body	CAP	15	4.49
Narrow Body	CAP	14	4.43
Narrow Body	CAP	12 to 13	4.35
Narrow Body Wide Body	CAP CAP	10 to 11 1	4.24
Narrow Body	CAP	6 to 9	4.13
Narrow Body	CAP	2 to 5	4.05
Wide Body Narrow Body	F/O CAP	12 to 15 1	3.63
Wide Body Narrow Body Wide Body	F/O F/O S/O	2 to 11 10 to 15 10 to 15	2.96
Narrow Body Narrow Body Wide Body	F/O S/O S/O	2 to 9 6 to 15 3 to 9	2.25
Wide Body Wide Body Narrow Body Narrow Body	F/O S/O F/O S/O	1 1 to 2 1 1 to 5	1.26

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2016 through December 31, 2016			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	5.73
Wide Body	CAP	14	5.67
Wide Body	CAP	12 to 13	5.57
Wide Body	CAP	10 to 11	5.45
Wide Body	CAP	6 to 9	5.32
Wide Body	CAP	2 to 5	5.25
Narrow Body	CAP	15	4.94
Narrow Body	CAP	14	4.88
Narrow Body	CAP	12 to 13	4.78
Narrow Body Wide Body	CAP CAP	10 to 11 1	4.67
Narrow Body	CAP	6 to 9	4.55
Narrow Body	CAP	2 to 5	4.45
Wide Body Narrow Body	F/O CAP	12 to 15 1	3.99
Wide Body Narrow Body	F/O F/O	2 to 11 10 to 15	3.26
Narrow Body	F/O	2 to 9	2.67
Wide Body Narrow Body	F/O F/O	1 1	1.38

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2017 through December 31, 2017			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	5.90
Wide Body	CAP	14	5.84
Wide Body	CAP	12 to 13	5.74
Wide Body	CAP	10 to 11	5.61
Wide Body	CAP	6 to 9	5.48
Wide Body	CAP	2 to 5	5.40
Narrow Body	CAP	15	5.09
Narrow Body	CAP	14	5.03
Narrow Body	CAP	12 to 13	4.93
Narrow Body Wide Body	CAP CAP	10 to 11 1	4.81
Narrow Body	CAP	6 to 9	4.68
Narrow Body	CAP	2 to 5	4.59
Wide Body Narrow Body	F/O CAP	12 to 15 1	4.11
Wide Body Narrow Body	F/O F/O	2 to 11 10 to 15	3.35
Narrow Body	F/O	2 to 9	2.75
Wide Body Narrow Body	F/O F/O	1 1	1.42

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2018 through December 31, 2018			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	6.08
Wide Body	CAP	14	6.02
Wide Body	CAP	12 to 13	5.91
Wide Body	CAP	10 to 11	5.78
Wide Body	CAP	6 to 9	5.65
Wide Body	CAP	2 to 5	5.57
Narrow Body	CAP	15	5.24
Narrow Body	CAP	14	5.18
Narrow Body	CAP	12 to 13	5.07
Narrow Body Wide Body	CAP CAP	10 to 11 1	4.96
Narrow Body	CAP	6 to 9	4.82
Narrow Body	CAP	2 to 5	4.72
Wide Body Narrow Body	F/O CAP	12 to 15 1	4.23
Wide Body Narrow Body	F/O F/O	2 to 11 10 to 15	3.45
Narrow Body	F/O	2 to 9	2.83
Wide Body Narrow Body	F/O F/O	1 1	1.47

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2019 through December 31, 2019			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	6.26
Wide Body	CAP	14	6.20
Wide Body	CAP	12 to 13	6.09
Wide Body	CAP	10 to 11	5.95
Wide Body	CAP	6 to 9	5.82
Wide Body	CAP	2 to 5	5.73
Narrow Body	CAP	15	5.40
Narrow Body	CAP	14	5.33
Narrow Body	CAP	12 to 13	5.23
Narrow Body Wide Body	CAP CAP	10 to 11 1	5.11
Narrow Body	CAP	6 to 9	4.97
Narrow Body	CAP	2 to 5	4.86
Wide Body Narrow Body	F/O CAP	12 to 15 1	4.36
Wide Body Narrow Body	F/O F/O	2 to 11 10 to 15	3.56
Narrow Body	F/O	2 to 9	2.91
Wide Body Narrow Body	F/O F/O	1 1	1.51

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2020 through December 31, 2020			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	6.51
Wide Body	CAP	14	6.45
Wide Body	CAP	12 to 13	6.34
Wide Body	CAP	10 to 11	6.19
Wide Body	CAP	6 to 9	6.05
Wide Body	CAP	2 to 5	5.96
Narrow Body	CAP	15	5.61
Narrow Body	CAP	14	5.54
Narrow Body	CAP	12 to 13	5.44
Narrow Body Wide Body	CAP CAP	10 to 11 1	5.31
Narrow Body	CAP	6 to 9	5.17
Narrow Body	CAP	2 to 5	5.06
Wide Body Narrow Body	F/O CAP	12 to 15 1	4.53
Wide Body Narrow Body	F/O F/O	2 to 11 10 to 15	3.70
Narrow Body	F/O	2 to 9	3.03
Wide Body Narrow Body	F/O F/O	1 1	1.57

Schedule for Hourly Benefit Multiplier			
Effective January 1, 2021			
Craft	**Seat**	**Year Group**	**Hourly Benefit Multiplier**
Wide Body	CAP	15	6.71
Wide Body	CAP	14	6.64
Wide Body	CAP	12 to 13	6.53
Wide Body	CAP	10 to 11	6.38
Wide Body	CAP	6 to 9	6.23
Wide Body	CAP	2 to 5	6.14
Narrow Body	CAP	15	5.78
Narrow Body	CAP	14	5.71
Narrow Body	CAP	12 to 13	5.60
Narrow Body Wide Body	CAP CAP	10 to 11 1	5.47
Narrow Body	CAP	6 to 9	5.32
Narrow Body	CAP	2 to 5	5.21
Wide Body Narrow Body	F/O CAP	12 to 15 1	4.67
Wide Body Narrow Body	F/O F/O	2 to 11 10 to 15	3.81
Narrow Body	F/O	2 to 9	3.12
Wide Body Narrow Body	F/O F/O	1 1	1.62

Appendix 2

Use this chart to calculate your retirement benefit under Formulas 2 and 3:

Your Age/Service Multiplier											
Your Years of Credited Service for Vesting as of June 1, 1999	Your Age as of June 1, 1999										
	Less than 50	50	51	52	53	54	55	56	57	58	59 or older
Less than 10	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
10	2.05%	2.05%	2.05%	2.05%	2.05%	2.05%	2.05%	2.05%	2.05%	2.05%	2.05%
11	2.06%	2.06%	2.06%	2.06%	2.06%	2.06%	2.06%	2.06%	2.06%	2.06%	2.06%
12	2.07%	2.07%	2.07%	2.07%	2.07%	2.07%	2.07%	2.07%	2.07%	2.07%	2.07%
13	2.08%	2.08%	2.08%	2.08%	2.08%	2.08%	2.08%	2.08%	2.08%	2.08%	2.08%
14	2.09%	2.09%	2.09%	2.09%	2.09%	2.09%	2.09%	2.09%	2.09%	2.09%	2.09%
15	2.10%	2.12%	2.14%	2.15%	2.16%	2.17%	2.18%	2.19%	2.20%	2.21%	2.22%
16	2.11%	2.13%	2.15%	2.16%	2.17%	2.18%	2.19%	2.20%	2.21%	2.22%	2.23%
17	2.12%	2.14%	2.16%	2.17%	2.18%	2.19%	2.20%	2.21%	2.22%	2.23%	2.24%
18	2.13%	2.15%	2.17%	2.18%	2.19%	2.20%	2.21%	2.22%	2.23%	2.24%	2.25%
19	2.14%	2.16%	2.18%	2.19%	2.20%	2.21%	2.22%	2.23%	2.24%	2.25%	2.26%
20	2.15%	2.17%	2.19%	2.20%	2.21%	2.22%	2.23%	2.24%	2.25%	2.26%	2.27%
21	2.16%	2.18%	2.20%	2.21%	2.22%	2.23%	2.24%	2.25%	2.26%	2.27%	2.28%
22	2.17%	2.19%	2.21%	2.22%	2.23%	2.24%	2.25%	2.26%	2.27%	2.28%	2.29%
23	2.18%	2.20%	2.22%	2.23%	2.24%	2.25%	2.26%	2.27%	2.28%	2.29%	2.30%
24	2.19%	2.21%	2.23%	2.24%	2.25%	2.26%	2.27%	2.28%	2.29%	2.30%	2.31%
25 or more	2.20%	2.22%	2.24%	2.25%	2.26%	2.27%	2.28%	2.29%	2.30%	2.31%	2.32%

Appendix 3

Use this chart to calculate your retirement benefit under Formulas 2 and 3:

Additional Benefit Percentage Based on Age/Service										
Years of Credited Service for Vesting as of October 30, 2006	Your Age as of October 30, 2006									
	50	51	52	53	54	55	56	57	58	59 or older
Less than 10	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
10	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
11	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
12	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
13	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
14	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
15	0.02%	0.02%	0.02%	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%	0.03%
16	0.02%	0.02%	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%
17	0.02%	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%	0.04%
18	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%	0.04%	0.04%
19	0.02%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%	0.04%	0.04%	0.04%
20	0.02%	0.03%	0.03%	0.03%	0.03%	0.03%	0.04%	0.04%	0.04%	0.04%
21	0.03%	0.03%	0.03%	0.03%	0.03%	0.04%	0.04%	0.04%	0.04%	0.04%
22	0.03%	0.03%	0.03%	0.03%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
23	0.03%	0.03%	0.03%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.05%
24	0.03%	0.03%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.05%	0.05%
25 or more	0.03%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.05%	0.05%	0.05%

Appendix 4

This chart shows how the Average Earnings were determined for the examples.

Determining Average Non-Qualified Plan Eligible Earnings and Average Pension Plan Eligible Earnings		
The examples show a Pilot making above the compensation limit. The Pension Plan Average Earnings are based on the limited Eligible Earnings.		
Year	**Non-Qualified Plan Eligible Earnings**	**Pension Plan Eligible Earnings (Limited to Compensation Limit)**
2015	$295,000	$265,000
2014	$275,000	$260,000
2013	$265,000	$255,000
2012	$230,000*	$230,000
2011	$210,000*	$210,000
Total	$1,275,000	$1,220,000
Average	$1,275,000 ÷ 5 = $255,000	$1,220,000 ÷ 5 = $244,000

*Note: the Pilot did not exceed the compensation limit for these years.

Appendix 5

This chart shows how the average annual benefit amount was determined for the examples.

Year	As of January 1		Hourly Benefit Multiplier	Regular Hours	Overtime Hours	Total Flight Hours	International Hours	Seat Multiplier*	Override Amount	Bid Periods	Additional Annual Amount	Annual Benefit Amount
	Craft	Seat	Year Group									
2015	Wide Body	Captain	29	5.21	986	26	1,025	0	0.18	22	0	429	5,769
2014	Wide Body	Captain	28	5.21	998	12	1,016	0	0.18	22	0	0	5,293
2013	Wide Body	Captain	27	5.21	963	22	996	50	0.18	22	0	0	5,198
2012	Narrow Body	Captain	26	4.36	1,005	0	1,005	16	0.14	22	0	0	4,384
2011	Narrow Body	Captain	25	4.23	980	16	1,004	0	0.14	22	0	0	4,247

In this example, the Average Annual Benefit Amount is $4,978. (The Average Annual Benefit Amount is the total of the highest five Annual Benefit Amounts divided by 5.)

Annual Benefit Amount equals:

- Hourly Benefit Multiplier times Total Flight Hours, plus
- Seat Multiplier times International Hours, plus
- Override Amount times Bid Periods, plus
- Additional Annual Amount .

PILOTS' RETIREMENT SAVINGS PLAN (PRSP)

Assets were transferred from the Federal Express Corporation Profit Sharing Plan to the Federal Express Corporation Pilots' Retirement Savings Plan (the Plan or PRSP) effective June 1, 2002. On January 1, 2017, the Pilots' Money Purchase Pension Plan (PMPPP) was merged into the PRSP.

The PRSP is a defined contribution plan and is designed to provide you a convenient way of accumulating additional savings for your retirement. The PRSP allows you to make Pre-tax/401(k) contributions, Roth contributions, After-tax contributions and, if eligible, catch-up contributions and Roth catch-up contributions through convenient payroll deductions. In addition, FedEx Express will make Employer Matching contributions, Employer Nonelective contributions and Sick Bank contributions for eligible participants. Fidelity Investments, Inc. serves as the recordkeeper.

You are eligible for the PRSP if your employment is covered by a collective bargaining agreement that provides for your participation in the PRSP.

If you are a resident of Puerto Rico, different tax rules may apply.

Plan Year

The Plan Year for the PRSP is from January 1 through December 31. The initial Plan Year was June 1, 2002, through December 31, 2002.

Eligibility for Plan Participation

If you are employed by FedEx Express, as a pilot, you can begin making Pre-tax/401(k), Roth, After-tax, and if eligible, Catch-up, Roth catch-up, Rollover and Roth Rollover contributions on your Plan Entry Date. Your Entry Date is the first day of the month coincident with or next following:

- Your completion of one month of employment with FedEx Express or another Controlled Group Member.

If You Are Reemployed

If you terminate employment and are later reemployed as a pilot, the following rules apply to your eligibility for making Pre-tax/401(k), Roth, After-tax, Catch-up, Roth Catch-up, Rollover and Roth Rollover contributions:

- If you were a participant prior to your termination date, you are eligible on your reemployment date.
- If you had satisfied all conditions for eligibility prior to your termination date but had not yet entered the PRSP, you will enter the PRSP the first day of the month coincident with or next following your reemployment date.
- If you had not satisfied all conditions for eligibility prior to your termination date and are reemployed, the following rules will apply:
  - If your period of severance is less than 12 months after your last termination date, the period beginning on your severance date and ending on the date you first perform one hour of service is counted toward the one-month service requirement.
  - If your period of severance is 12 months or more after your last termination date, the period beginning on your severance date and ending on the date you first perform one hour of service is not counted toward the one-month service requirement.

Therefore, you will enter the PRSP on the first of the month coincident with or next following your reemployment date.

Enrollment

Automatic Enrollment

Before you become eligible to participate in the PRSP, you will receive eligibility notification from Fidelity that explains the automatic enrollment program.

Automatic Enrollment includes three features: enrollment, investment selection and annual savings rate increases. You have the option to change or cancel any of these features if you wish, as instructed below.

- **Automatic enrollment.** With automatic enrollment, eligible pilots are automatically enrolled at a pre-tax contribution rate of 3% of eligible earnings. You will see your first paycheck deduction on the first check following your eligibility date.
- **Automatic annual increases.** If you are automatically enrolled in the PRSP, your payroll deduction rate will increase automatically on the anniversary of your eligibility date by 3% after the first year, 3% in the following year and 1% in the third year until it reaches 10% of your eligible earnings or the Internal Revenue Service (IRS) limit.
- **Default investment selection.** If you are automatically enrolled in the PRSP, your contributions will be invested automatically in a date-specific Vanguard® Target Retirement Trust Select based on your age and an anticipated retirement age of 65, if you have no investment election on file. You may change your investments at any time. See “Investment Options” in this section for details.

If you are automatically enrolled in the PRSP and subsequently are on any type of unpaid leave of absence, including long-term disability, your contributions will resume with your next paycheck unless you opt out or change your contribution election.

If you do not wish to participate in the PRSP, you must contact Fidelity as soon as possible after receiving your eligibility notification or log on to netbenefits.com to make a change.

Investments in Target Retirement Trusts are subject to the risks of their underlying investments. The year in the investment name refers to the approximate year (the target date) when an investor would retire and leave the workforce. The trust will gradually shift its emphasis from more aggressive investments to more conservative ones based on its target date. An investment in a Target Retirement Trust is not guaranteed at any time, including on or after the target date.

It is important to note that you can increase or decrease your contribution rate and/or change your investment options at any time. You also may change your annual automatic increase rate—to 1%, 2% or 3%—and have the increase occur in any other month you designate. You may automatically increase your Pre-tax contributions up to 50% of your eligible earnings.

New hires have the option to withdraw all payroll deferrals (adjusted for gains or losses) within 90 days of the first automatic withdrawal. This “permissible withdrawal” is not subject to any early withdrawal penalty and is included in your gross income for the year in which the withdrawal occurs. To request a permissible withdrawal, you must contact Fidelity at 1.833.383.3339.

If you opt out of automatic enrollment, you can enroll on your own at any time online at netbenefits.com or by calling Fidelity at 1.833.383.3339.

Your Cost

FedEx pays the administrative cost for the PRSP. Refer to the annual participant disclosure notice for any fees that you may incur. The annual participant disclosure notice may be found on netbenefits.com.

Designating a Beneficiary

It is important that you name the person or persons you wish to receive benefits upon your death. You can name your beneficiary(ies) online at netbenefits.com. You cannot designate a beneficiary in any FedEx system.

If you choose to name a person(s) under the age of majority (*i.e.*, a minor) as primary or secondary beneficiary(ies), as applicable, any death benefit payment will be made only to the legal guardian of the minor. In the event of your death, Fidelity must receive acceptable legal documentation that establishes the guardianship of the minor(s).

If you are married at the time of your death, your spouse is automatically the beneficiary unless your spouse consents to the designation of another person as your beneficiary on the beneficiary form. Your spouse's written consent must be witnessed by a notary public. The completed, signed beneficiary designation must be on file with Fidelity prior to the date of your death. It is important that you periodically review your beneficiary designation because the most recent valid beneficiary form on file determines who receives any death benefits.

If your beneficiary dies before your PRSP balance is distributed, your account is paid to the named contingent beneficiary. If you are not married, and no beneficiary is named, your account is paid to one or more surviving relatives in the following order:

- First, to child or children (adoptive and biological), in equal shares;
- Second, to parents, in equal shares;
- Third, to siblings (adoptive and biological), in equal shares; and
- Fourth, to your estate in full.

Your joint and survivor beneficiary for the Money Purchase Plan Account and Military Leave Money Purchase Plan Contribution Account is your spouse. Please note that if you are married and eligible to receive a distribution of part or all of your Money Purchase Plan Account balance, the joint and survivor annuity is your normal form of payment for Money Purchase Plan Account balances—plus current and future earnings—with your spouse as the primary beneficiary.

Definition of a Spouse

For PRSP purposes, all references to "spouse" shall include a legally married spouse as recognized under the laws of the state or other jurisdiction in which the marriage took place.

A common-law marriage will be valid where recognized in the applicable state jurisdiction.

PRSP Contributions

The following types of contributions can be made to the PRSP:

- Pre-tax/401(k) contributions
- Roth contributions
- After-tax contributions
- Catch-up contributions

- Roth Catch-up contributions
- Rollover contributions
- Roth Rollover contributions
- Employer Matching contributions
- Employer Sick Bank contributions
- Employer Nonelective contributions

All PRSP contributions are held in a trust fund. The PRSP's cash assets are managed and invested by the trustee, as directed by you.

Eligible Earnings

Eligible earnings include, but are not limited to the following:

- All credit hours, including but not limited to:
  - Draft
  - Volunteer
  - Trip make-up for which you receive pay
  - International Override
  - Passover Pay (POP)
- Premiums for:
  - Flex Instructors/Proficiency Check Airmen (PCA)
  - Line Check Airmen (LCA)
  - Flex Flight Standards Check Airmen (SCA)
  - Flight Project Specialist (FPS)
  - Technical Advisor/Aircraft (TAA)
  - Passover Retro Pay (POR)
  - FAA Designee (FAA)
- Sick leave hours drawn from your sick banks (except non-taxable hours drawn from your Occupational Illness/Injury Sick Bank (OII) on or after January 1, 2007, as a result of a worker's compensation illness or injury)
- Amounts distributed from the Pilots' Retirement Savings Plan's unused Sick Bank Account because of the limits imposed by Section 415 of the IRC
- Past Profit Sharing paid in cash*
- Vacation pay
- Signing bonuses paid in 2006, 2007, 2015, 2016 and 2017
- Lump sum paid in 2011
- Vacation buybacks

Eligible earnings include pay prior to deductions, *e.g.*, pre-tax health care, dependent care and your Pre-tax/401(k) contributions.

*Effective June 1, 1999, Profit Sharing contributions were discontinued.

Exclusions from eligible earnings include, but are not limited to:

- Domestic and International Per Diem Pay
- Long Term Disability payments
- Excess Life Premiums

- Reimbursed expenses
- Non-taxable amounts paid from a Pilot's Occupational Illness/Injury Sick Bank (OII) on or after January 1, 2007, as a result of a worker's compensation illness or injury
- End of Career Sick Leave/Advance Notice of Planned Retirement Bonus

Contributions

You can change the amount you contribute to the PRSP at any time. Contact Fidelity at netbenefits.com or 1.833.383.3339. Your contribution change will begin within the next two pay periods, depending on the timing of the change and the date of the next payroll run.

See "Important Limits on Contributions" for more information.

With the exception of sick bank contributions and employer contributions due to military leave of absence, all contributions are generally deposited within five business days after each regular payroll.

Pre-tax/401(k) Contributions

You can contribute from 1% to 50% per paycheck of your eligible earnings in 1% increments, on a pre-tax basis through payroll deductions. Your Pre-tax/401(k) contributions grow tax deferred. Since your contributions are deducted from your pay before taxes are calculated and withheld, your taxable income for the year is reduced and you pay less in income taxes.

NOTE: the 1% to 50% limit applies to your combined Pre-tax/401(k) and Roth contributions.

Roth Contributions

You can contribute from 1% to 50% per paycheck of your eligible earnings in 1% increments, on an after-tax basis through payroll deductions. Earnings on Roth contributions are not taxed when distributed as long as the first Roth contribution to the account was made at least five years earlier and the withdrawal meets one of the following conditions:

- It is made after the account holder turns age 59½.
- It is a result of total and permanent disability or death.

Note: the 1% to 50% limit applies to your combined Pre-tax/401(k) and Roth contributions.

Employer Matching Contributions

FedEx contributes $.50 on the dollar for the first combined $1,000 Pre-tax/401(k) and Roth contributions that you save each plan year. This means FedEx will contribute up to an additional $500 for the first $1,000 you contribute during a plan year. For example:

- If you save $500 during the plan year, FedEx matches $250.
- If you save $1,000 or more, FedEx matches $500.

FedEx's matching contribution and any earnings also grow tax deferred.

Employer Nonelective contributions

FedEx contributes 9% of eligible earnings up to the IRS limits for each paycheck. FedEx's Employer Nonelective contribution and any earnings also grow tax deferred.

Sick Bank Contributions

FedEx Express also will make an annual deposit to your Sick Bank Account based on unused sick leave accumulated during the previous calendar year (January 1 through December 31), as follows:

- First, FedEx will determine the unused hours of sick leave during the plan year that would cause your disability sick leave account to exceed 686 hours.
- Then, that portion of your sick leave account will be "cashed out" and deposited into your Sick Bank Account (up to any applicable limitations) in the first bid period following the close of the plan year. Any portion of your excess sick leave contribution not eligible to be deposited into your Sick Bank Account will be paid to you in cash by Payroll. This cash payment maybe considered as Eligible Earnings in the year that you receive the payment. Note, if you are age 50 or older and have not reached the applicable catch-up limit in the PRSP, pre-tax contributions for that year may be reclassified as catch-up in order to allow additional sick bank contributions.

After-tax Contributions

You can contribute from 1% to 20% of your eligible earnings in 1% increments on an after-tax basis through payroll deductions. Earnings on your contributions are tax-deferred (*i.e.*, they are taxed when distributed).

Catch-Up Contributions and Roth Catch-up Contributions

Eligible participants may elect to make additional pre-tax Catch-up and Roth Catch-up contributions. To be eligible, you must be age 50 or older, or attain age 50 by the end of the calendar year in which contributions are made. You are eligible to contribute up to the limit if:

- You have contributed up to the Pre-tax/401(k) contribution limit of 50% of your eligible earnings; or
- You reach the IRS 402(g) limit (described in the section entitled *Important Limits on Contributions*) during the plan year.

If you do not reach either of these limits, any Catch-up contributions you make may be reclassified after the end of the calendar plan year as Pre-tax/401(k), and Roth Catch-up contributions may be reclassified after the end of the calendar plan year as Roth contributions.

To make Catch-up or Roth Catch-up contributions, you must elect a separate pre-tax Catch-up and/or Roth Catch-up payroll deduction by designating a percentage from 1% to 30% of your eligible earnings to be deducted per paycheck.

NOTE: The 1% to 30% limit applies to a combined total of Catch-up and Roth Catch-up.

Earnings on Roth Catch-up contributions are not taxed when distributed if certain conditions are met (refer to *Earnings on Roth* above).

Rollover Contributions

If you were a participant in a tax-qualified plan of a former employer, you can transfer (roll over) your former account balance to the PRSP. However, you may not roll any other FedEx plan into the PRSP.

You may also rollover a Roth IRA or a prior employer-designated Roth balance to the PRSP. You must be eligible to participate before you can roll over contributions. Employee After-tax

contributions are not accepted into the Rollover Account. However, earnings from After-tax contributions are eligible for the Rollover Account. If you want to make a rollover, call Fidelity at 1.833.383.3339. You also will need to contact the financial institution where you have your account for instructions on how to roll over your eligible balance to the PRSP.

Important Limits on Contributions

Nondiscrimination Test

Effective January 1, 2018, the PRSP is structured as a Qualified Automatic Contribution Arrangement (QACA). That means the IRS safe harbor designation applies and the PRSP is not subject to Average Deferral Percentage (ADP) testing for pre-tax contributions to make sure the PRSP does not favor Highly Compensated Employees (HCEs). As defined by the IRS, you are considered an HCE in 2021 if you earned more than $130,000 during 2020. The IRS periodically changes the amount of earnings used to determine who is an HCE.

Combined Contribution Limit Section 415(c) of the Internal Revenue Code (IRC)

The amount that can be contributed annually to the Pilots' Retirement Savings Plan (PRSP) is limited. This limit applies to all contributions made to your PRSP accounts through Pre-tax/401(k), Roth, After-tax, Employer Matching, Sick Bank and Employer Nonelective contributions. Catch-up and Roth Catch-up contributions are excluded from this limit.

For the 2021 Plan Year, the limit is the lesser of:

- 100% of your eligible earnings; or
- $58,000

This limit is scheduled to be indexed by the Secretary of the Treasury based on increases in the cost of living.

Employee contributions are calculated prior to any Employer Nonelective contributions in each paycheck. Once you reach the 415(c) limit, all contributions will cease, including any Employer contributions. Your contributions will automatically restart in January of the following year at the previously elected percentage(s). It is important to closely monitor your After-tax contributions so that you do not miss out on Employer contributions.

If contributions during the Plan Year happen to exceed the Section 415(c) limit, the excess contributions (plus earnings) will be returned to you in the following order:

- PRSP Sick Bank contributions
- PRSP After-tax contributions
- PRSP Pre-tax/401(k) contributions
- PRSP Roth contributions
- PRSP Employer Matching contributions
- PRSP Employer Nonelective contributions

Employee Contribution Limit—Section 402(g) of the Internal Revenue Code (IRC)

The calendar year limit on combined Pre-tax/401(k) and Roth contributions is as follows:

Year	Limit
2016	$18,000
2017	$18,000
2018	$18,500
2019	$19,000
2020	$19,500
2021	$19,500

Once you reach the limit, your contributions will automatically cease and restart in January of the following year at the previously elected percentage(s). If your contributions happen to exceed the 402(g) limit, your account will be reduced by any excess contributions (plus earnings) and will be refunded to you.

Maximum Compensation Limit—Section 401(a)(17) of the Internal Revenue Code (IRC)

The IRS also limits the maximum compensation that can be used to determine your benefits under the retirement plans. The limit is indexed by the Secretary of the Treasury based on increases in the cost of living.

The calendar year compensation limit is as follows:

Year	Limit
2015	$265,000
2016	$265,000
2017	$270,000
2018	$275,000
2019	$280,000
2020	$285,000
2021	$290,000

Benefits Upon Return From a Military Leave of Absence (MLOA)

If you return to employment after a period of qualified military leave of absence, generally up to 5 years, and have satisfied the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA), Plan eligibility will include the time you were in the military. You must present proof of your activation date and release from active duty date to your Manager.

You may make up any missed Pre-tax/401(k), Roth, After-tax and, if applicable, Catch-up and Roth Catch-up contributions. Make-up contributions may be made over a period that is three times the period of your military service, not to exceed 5 years. Make-up contributions are calculated using your imputed earnings determined in accordance with USERRA. Any missed Employer Matching contributions and Employer Nonelective contributions will be credited for your period of qualified MLOA. In order to receive Employer Matching contributions, you must make up missed Pre-tax/401(k) and/or Roth contributions. To initiate any make up contributions, call Fidelity at 1.833.383.3339.

Contributions may not exceed the applicable limits for the year in which they would have been contributed. Your loan payments will be suspended while you are on MLOA.

PRSP Accounts

References to account in this summary plan description generally refer to all your various accounts taken together. However, a series of separate recordkeeping accounts will be established and maintained under the PRSP to record and track contributions made by you and by your Participating Employer on your behalf, as well as earnings and losses on such amounts and withdrawals and distributions.

The following accounts are the current active savings accounts:

- **After-tax Contributions Account**—This account is for your After-tax contributions to the PRSP.
- **Catch-up Contribution Account**—This account is for Catch-up contributions to the PRSP made by eligible participants.
- **Employer Match Contribution Account**—This account is for Employer Matching contributions on your Pre-tax/401(k) and Roth contributions.
- **Employer Nonelective Contribution Account**—This account is for Employer Nonelective contributions effective January 1, 2017, and later.
- **Military Leave Money Purchase Plan Contribution Account**—This account is for Employer contributions made to the Pilots' Money Purchase Pension Plan account for periods of qualifying military service occurring prior to the merge of the PMPPP into the PRSP effective January 1, 2017.
- **Military Leave Employer Nonelective Contribution Account** – This is for Employer Nonelective contributions effective January 1, 2017, and later due to qualifying periods of military leave.
- **Money Purchase Plan Account**—This account is for Employer contributions made to the Pilots' Money Purchase Pension Plan account prior to the merge of the PMPPP into the PRSP effective January 1, 2017.
- **Money Purchase Plan Rollover Contribution Account**—This account is for your rollover contributions from a prior employer's tax-qualified retirement plan into the Federal Express Corporation Pilots' Money Purchase Pension Plan prior to January 1, 2017. The PMPPP was merged into the PRSP effective January 1, 2017.
- **Pre-tax/401(k) Contribution Account**—This account is for your pre-tax contributions to the PRSP.
- **Qualified Nonelective Contribution Account**—This account is for amounts attributable to qualified nonelective contributions.
- **Rollover Account**—This account is for your rollover contributions from a prior employer's tax-qualified retirement plan.

- **Roth Catch-up Contribution Account**—This account is for Roth Catch-up contributions to the PRSP made by eligible participants.
- **Roth Contribution Account**—This account is for your Roth contributions to the PRSP.
- **Roth Conversion Contribution Account**—These accounts are for amounts irrevocably converted to Roth Contributions.
- **Roth Rollover Account**—This account is for your Roth rollover contributions from a prior employer's tax-qualified retirement plan.
- **Sick Bank Account**—This account is for your contributions attributable to your unused sick leave in excess of 686 hours.

The following accounts are no longer funded by FedEx Express:

- **Profit Sharing Contributions Account**—This account combines the following sources:
  - Employer Stock Account—This account is for your share, if any, of FedEx's Profit Sharing stock contributions to the PRSP.
  - Regular Employer Account—This account is for your share, if any, of FedEx's Profit Sharing cash contributions to the PRSP.
- **Company Stock Distribution Account (also known as the Investment Credit Stock Account)**—This account is for contributions made by FedEx to the PRSP before 1987. The value of this account is not available for loans or in-service withdrawals, including hardship withdrawals. Your stock in this account cannot be withdrawn until retirement, termination, total disability or death.
- **ESOP Account**—The Employee Stock Ownership Plan was designed to allocate Federal Express Common Stock to employees over a five-year period from fiscal year 1986 through fiscal year 1990. The last stock allocation was made in 1990. Until its merger into the former Federal Express Corporation Profit Sharing Plan, of which the PRSP was a spin-off, the ESOP was maintained by FedEx as a separate retirement plan. The value of your ESOP shares is not available for loans or in-service withdrawals, including hardship withdrawals. Your stock in this account cannot be withdrawn until retirement, termination, total disability or death.

Vesting

Vesting refers to your right to receive a benefit when you terminate employment, subject to the distribution rules. You are always 100% vested in all your accounts in the PRSP.

Account Statements

Account statements for the PRSP are available online at **netbenefits.com** and will not automatically be mailed to your home unless you have opted out of electronic delivery. To change your delivery preferences, call Fidelity at 1.833.383.3339 or log on to NetBenefits at **netbenefits.com** and click *Profile*, then *Preferences*.

Investment Options

No investment is without risk. Since your choices could have a substantial impact on the amount you ultimately receive from the PRSP, you should consider your investments carefully.

If you do not choose an investment option, all contributions are automatically invested in the Target Retirement Trust Select closest to the year in which you will turn age 65. In addition, if you have chosen an investment option for your Employer Matching contributions but have never chosen an investment option for your Employer Sick Bank contributions, your Employer Sick

Bank contributions will be invested in accordance with the investment election pertaining to the congruent grouping that applies to employer contributions.

The investment options in the PRSP are organized into the following tiers:

- Vanguard Target Retirement Trust Select Funds
- Vanguard LifeStrategy® Funds
- Core funds
- Other

Advice Services

Fidelity offers a managed account service. It's a way to help you get, and stay, on course toward your retirement goals. With Fidelity Personalized Planning & Advice, you get active retirement account management. This means that Fidelity's team of investment professionals invest, monitor and rebalance your account as needed to adjust to changes in the market, or changes to your situation. When developing your personalized investment strategy, the service also can consider monies you have saved outside of the PRSP. There is a fee for Fidelity Personalized Planning & Advice which is based on a declining scale. Please contact a Fidelity Representative at 1.866.630.9722 for more information about the managed account service.

NOTE: If you are enrolled in Fidelity Personalized Planning & Advice, the Automatic Rebalancing Service is not available to you.

The Automatic Rebalance Service allows participants to maintain a consistent investment allocation over time by rebalancing the account to a desired investment allocation either annually, semi-annually or quarterly. Based on the elected frequency, the account will be rebalanced to the target investment allocation established.

Fidelity BrokerageLink® Option

Fidelity BrokerageLink Option. Provided you sign the enrollment form, you are able to open an account with Fidelity BrokerageLink® and invest all or a portion of your PRSP balance in investments that are not included in the investment options offered in the PRSP. You cannot purchase shares of FedEx Corporation stock.

An annual fee is associated with this option. Keep in mind that the risks can be substantially different with this strategy—and you have the responsibility of paying commissions and other costs.

You may grant Third Party Access on the Fidelity BrokerageLink account to an advisor who has access to your PRSP account. The Collective Bargaining Agreement states a Hold Harmless and Indemnification Agreement form must be on file at Fidelity to allow your advisor continued access to trade on your behalf. The Hold Harmless and Indemnification Agreement form is available on netbenefits.com. **NOTE:** Participants who have an allocation directed to Fidelity BrokerageLink are not able to use the Automatic Rebalancing Service.

Vanguard Target Retirement Trusts

Vanguard Target Retirement Trusts provide a professionally maintained, diversified mix of investments that shifts emphasis to more conservative investments as you move closer to retirement.

With one investment selection, you can create a diversified portfolio that aligns your investments with your goals. Depending on your needs, investing in a single Target Retirement Trust could

provide diversification and is designed to keep your assets invested appropriately for someone in your stage of life, up to and including your retirement years.

Investments in Target Retirement Trusts are subject to the risks of their underlying investments. The year in the investment name refers to the approximate year (the target date) when an investor would retire and leave the workforce. The trust will gradually shift its emphasis from more aggressive investments (stocks) to more conservative ones (bonds and short-term reserves) based on its target date. An investment in a Target Retirement Trust is not guaranteed at any time, including on or after the target date.

Consider choosing the investment with the date that's closest to the year when you expect to retire.

		Investment mix*
Vanguard Target Retirement 2070 Trust Select**	2068 or later	90% stocks, 10% bonds
Vanguard Target Retirement 2065 Trust Select**	2063 or later	90% stocks, 10% bonds
Vanguard Target Retirement 2060 Trust Select**	2058 to 2062	90% stocks, 10% bonds
Vanguard Target Retirement 2055 Trust Select**	2053 to 2057	90% stocks, 10% bonds
Vanguard Target Retirement 2050 Trust Select**	2048 to 2052	90% stocks, 10% bonds
Vanguard Target Retirement 2045 Trust Select**	2043 to 2047	90% stocks, 10% bonds
Vanguard Target Retirement 2040 Trust Select**	2038 to 2042	90% stocks, 10% bonds
Vanguard Target Retirement 2035 Trust Select	2033 to 2037	84% stocks, 16% bonds
Vanguard Target Retirement 2030 Trust Select	2028 to 2032	76% stocks, 24% bonds
Vanguard Target Retirement 2025 Trust Select	2023 to 2027	69% stocks, 31% bonds
Vanguard Target Retirement 2020 Trust Select	2018 to 2022	61% stocks, 39% bonds
Vanguard Target Retirement Income Trust Select***	2007 or earlier	30% stocks, 70% bonds

**Target asset allocations for the investments. Allocations for the date-specific investments will shift (from stocks to bonds and short-term reserves) over time based on an assumed retirement age of 65.*

***The target allocations of the investments dated 2040 through 2070 are currently identical; however, as time passes, each investment will gradually shift toward a more conservative allocation depending on the maturity date of the trust.*

****The Income Trust is designed for retirees.*

Please note that while the Target Retirement Trust Select funds shift to more conservative asset allocations as participants' ages increase, the investment continues to have exposure to stocks. For example, the Target Retirement Income Trust Select is for retirees who may need to draw income. If you invest in this Trust, at age 65 your investments will have an allocation of 30% stocks and 70% bonds. On average, individuals who retire at age 65 may expect to enjoy 17 to 20 years in retirement, and many will enjoy even longer lives. The investment allocation for each Target Retirement Trust Select fund factors in average life expectancy after the target date is reached and, as a result, continues to have exposure to stocks during the retirement years, to recognize the still-lengthy investment horizon and to fend off inflationary pressure. Participants/investors who need to access their account balances more rapidly in their retirement years might need to consider shifting their asset allocations to even more conservative investment options as they near retirement.

All investing is subject to risk. Each Target Retirement Trust Select fund invests in several broadly diversified Vanguard investments—primarily low-cost Vanguard index funds.

As previously explained, Target Retirement Trust Select funds are one-fund options that automatically shift their emphasis to more conservative investments over time. However, it is important to know that the investment manager can make changes to the investment mix—even if those changes will create more risk. Therefore, it is still a good idea to periodically check your assets so that you can assess whether the Target Retirement Trust Select fund you chose still meets your needs. Diversification does not ensure a profit or protect against a loss in a declining market. Investments in bond funds are subject to interest rate, credit and inflation risk.

Fund Name	Fund Type	Objective	Risk Level
Vanguard Target Retirement 2070 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive
Vanguard Target Retirement 2065 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive
Vanguard Target Retirement 2060 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive
Vanguard Target Retirement 2055 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive
Vanguard Target Retirement 2050 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive

Fund Name	Fund Type	Objective	Risk Level
Vanguard Target Retirement 2045 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive
Vanguard Target Retirement 2040 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive
Vanguard Target Retirement 2035 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive
Vanguard Target Retirement 2030 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate to aggressive
Vanguard Target Retirement 2025 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate
Vanguard Target Retirement 2020 Trust Select	Balanced (stocks and bonds)	Seeks to provide capital appreciation and current income (consistent with its current asset allocation).	Moderate
Vanguard Target Retirement Income Trust Select	Balanced (stocks and bonds)	Seeks to provide current income and some capital appreciation.	Conservative to moderate

Vanguard LifeStrategy Funds

LifeStrategy Funds are balanced funds. That means they each invest in a diversified mix of Vanguard stock funds and bond funds to provide both income and growth. This “fund of funds” approach makes it easy to invest in a broad mix of investments at a risk level that is comfortable for you.

LifeStrategy Funds may be right for you if you want a predetermined investment mix and the flexibility to change that mix when your time horizon, risk tolerance, or investment goals change.

Keep in mind that although LifeStrategy Funds can simplify investing, all investing is subject to risk. Each LifeStrategy Fund invests in several broadly diversified Vanguard funds and is subject to the risks associated with these underlying funds.

Fund Name/ Ticker Symbol	Fund Type	Objective	Risk Level
Vanguard LifeStrategy Conservative Growth Fund **(VSCGX)**	Balanced (stocks and bonds)	Seeks to provide current income and low-to-moderate capital appreciation.	Moderate
Vanguard LifeStrategy Moderate Growth Fund **(VSMGX)**	Balanced (stocks and bonds)	Seeks to provide capital appreciation and a low-to-moderate level of current income.	Moderate

Core Options: Index-based and Money Market Funds, Plus a Stable Value Investment

The tier is composed mostly of index-based investments, also known as passively managed funds.

These funds replicate as closely as possible a particular index (for example, the S&P 500). Why would anyone invest in an index fund and earn just what the market earns? Because index funds generally cost less to run than actively managed funds, whose managers try to outperform the market. That means they can provide low-cost access to broad segments of the stock and bond markets.

You may create your own portfolio mix by choosing from this tier alone or in combination with investments in other options.

Fund Name/ Ticker Symbol	Fund Type	Objective	Risk Level
Vanguard Prime Money Market Fund Admiral Shares **(VMRXX)**	Money market	Seeks to provide current income while maintaining liquidity and a stable share price of $1.	Conservative
Vanguard Retirement Savings Trust II **(No ticker symbol)**	Stable value	Seeks to provide current and stable income while maintaining a stable share value of $1.	Conservative
Vanguard U.S. Bond Index Fund **(No ticker symbol)**	Bond	Seeks to track the performance of a broad, market-weighted bond index.	Conservative to moderate
Vanguard U.S. Large Cap Equity Index Fund **(No ticker symbol)**	Domestic stock	Seeks to track the performance of a benchmark index that measures the investment	Moderate to aggressive

Fund Name/ Ticker Symbol	Fund Type	Objective	Risk Level
		return of large-capitalization stocks.	
Vanguard U.S. Small and Mid-Cap Equity Index Fund **(No ticker symbol)**	Domestic stock	Seeks to track the performance of a benchmark index that measures the investment return of small- and mid-capitalization stocks.	Aggressive
Vanguard International Equity Index Fund **(No ticker symbol)**	International stock	Seeks to track the performance of a benchmark index that measures the investment return of stocks issued by companies located in developed and emerging markets, excluding the United States.	Aggressive

Supplemental Options: Actively Managed Funds

The funds in this tier are typically actively managed.

In actively managed funds, investment managers select specific investments with the goal of outperforming an investment benchmark (for example, the S&P 500). Because more work goes into researching and choosing specific investments, an actively managed fund can cost more to run than a passively managed fund. But these funds can be useful if you want to invest in a specific segment of the stock or bond markets.

Keep in mind that it's difficult to identify which market segments are likely to outperform others and funds that concentrate on a relatively narrow market sector face the risk of higher share-price volatility. For these reasons, you may want to consider using this tier as a supplement to the broader investments of the core options.

In the event a proxy decision needs to be made regarding shares of a Vanguard mutual fund, the Vanguard fund shares will be voted in accordance with the investment guides for the PRSP.

Fund Name/ Ticker Symbol	Fund Type	Objective	Risk Level
Vanguard Inflation-Protected Securities Fund Institutional Shares **(VIPIX)**	Bond	Seeks to provide investors inflation protection and income consistent with investment in inflation-indexed securities.	Conservative to moderate
Janus Henderson Core Plus Fixed Income Collective Fund: Class - II **(No ticker symbol)**	Bond	Seeks to maximize current income and some capital appreciation, consistent with preservation of capital.	Moderate

Fund Name/ Ticker Symbol	Fund Type	Objective	Risk Level
Vanguard Wellington™ Fund Admiral Shares **(VWENX)**	Balanced (stocks and bonds)	Seeks to provide long-term capital appreciation and reasonable current income.	Moderate
Vanguard Windsor™ Fund Admiral Shares **(VWNEX)**	Domestic stock	Seeks to provide long-term capital appreciation.	Moderate to aggressive
Vanguard PRIMECAP Fund Admiral Shares **(VPMAX)**	Domestic stock	Seeks to provide long-term capital appreciation.	Aggressive
Vanguard International Growth Fund Admiral Shares **(VWILX)**	International stock	Seeks to provide long-term capital appreciation.	Aggressive
Vanguard International Value Fund Investor Shares **(VTRIX)**	International stock	Seeks to provide long-term capital appreciation.	Aggressive

A note about risk

All investing is subject to risk. Diversification does not ensure a profit or protect against a loss in a declining market. Investments in bond funds are subject to interest rate, credit, and inflation risk. U.S. government backing of Treasury or agency securities applies only to the underlying securities and does not prevent share-price fluctuations. Investments in Target Retirement Trust Select funds are subject to the risks of their underlying funds. The year in the Trust name refers to the approximate year (the target date) when an investor in the fund would retire and leave the workforce. The fund will gradually shift its emphasis from more aggressive investments to more conservative ones based on its target date. An investment in a Target Retirement Trust Select fund is not guaranteed at any time, including on or after the target date. LifeStrategy Funds are subject to the risks associated with their underlying funds. Prices of mid- and small-cap stocks often fluctuate more than those of large-company stocks. Foreign investing involves additional risks including currency fluctuations and political uncertainty. Stocks of companies in emerging markets are generally more risky than stocks of companies in developed countries.

The Vanguard Retirement Savings Trust II is not a mutual fund. It is a collective trust available only to tax-qualified plans and their eligible participants. The collective trust mandates are managed by Vanguard Fiduciary Trust Company, a subsidiary of The Vanguard Group, Inc.

FedEx Corporation Stock Fund

This unregistered custom separate account is composed of shares of FedEx Corporation common stock (Company stock), that arose as a result of contributions to the Profit Sharing Contributions Account, Company Stock Distribution Account (also known as the Investment Credit Stock Account) and ESOP Account. In addition, the Federal Express Corporation Stock Fund consists of money market securities for liquidity purposes. This fund is closed to new contributions or investments. You may exchange out of the FedEx Corporation Stock Fund into

other funds in your account at any time. If you do elect to exchange out of the FedEx Corporation Stock Fund, it is important for you to be aware of certain consequences once your shares are exchanged and the proceeds reinvested in other investment funds:

- Because FedEx Corporation stock is not an investment option in the PRSP, you cannot exchange assets back into the FedEx Corporation Stock Fund; this exchange is one-way.
- Currently shares in the FedEx Corporation Stock Fund can be distributed in-kind, which means you can receive a distribution at retirement or termination in the form of stock.
- Special federal income tax treatment is afforded to employer securities that have increased in value relative to their cost basis and are distributed as part of a lump-sum distribution from a qualified retirement plan. If you elect to diversify out of the FedEx Corporation Stock Fund, you will lose any potential benefit from this tax treatment. You should contact a tax advisor for more information.

When trading in connection with a FedEx Corporation stock fund, you will not be directly charged for the sale of the underlying stock. Your commission costs for a particular business day's overall trading will be incorporated into the Participant Transaction Price for that business day. Fidelity's commission on FedEx Corporation stock sold in the PRSP is typically 1 cent to 3 cents per share. For a fund transfer to be executed on the same business day as the exchange is requested, it must be completed by 12 p.m., Central time, for trades regarding the FedEx Corporation Stock Fund.

Confidentiality of FedEx Corporation Stock Fund holdings:

- Retirement Services limits access to information about individual participant and beneficiary FedEx Corporation Stock Fund holdings (information relating to the purchase, holding, and sale of securities, and the exercise of voting, tender and similar rights) to Retirement Services employees that need such information to administer the PRSP.

- Retirement Services is responsible for maintaining the confidentiality of individually identifiable FedEx Corporation Stock Fund holdings information, and for monitoring trustee and recordkeeper compliance with their privacy obligations.

- The instructions a participant or beneficiary provides as to selling, voting, tendering, or exercising similar rights with respect to FedEx Corporation Stock Fund units will be submitted to the applicable trustee and held in confidence. This information will not be disclosed to FedEx Corporation or any of its affiliates except as necessary to comply with Federal laws or state laws not preempted by ERISA.

Annually, every participant with one or more units to his/her credit in the FedEx Corporation Stock Fund receives proxy solicitation materials and instructions on voting Company stock. All voting instructions will be submitted to Fidelity Management Trust Company (the "Trustee"). The Trustee will hold voting records in confidence. In the event a proxy decision needs to be made regarding shares of a Vanguard mutual fund, the Vanguard fund shares will be voted by the fiduciary for the PRSP in accordance with the investment guidelines for the PRSP.

Because it concentrates on a single stock, the FedEx Corporation Stock Fund is considered riskier than a stock mutual fund, which is diversified.

Policies That Affect Your Investment Direction

While the PRSP allows a great deal of flexibility for you to choose your investments, Fidelity has established policies to discourage short-term trading and to help eliminate the negative impact of market-timing or other strategies that may raise transaction costs of the investment funds for all fund shareholders.

A summary of each policy is provided below. Please refer to the prospectus of each investment fund for a more detailed summary, as well as any changes to these policies.

Competing funds policy

Under the competing funds policy, you are agreeing to certain limitations imposed by issuers of investment contracts when you invest in Vanguard Retirement Savings Trust II. Shifts from the trust into short-term bond funds and money market funds are not generally permitted because these funds have similar investment objectives and are designated as competing funds. In the PRSP, Vanguard Prime Money Market Fund Admiral Shares, Vanguard Treasury Money Market Fund Investor Shares and Fidelity BrokerageLink® are designated as competing funds.

Before exchanging from Vanguard Retirement Savings Trust II into the competing fund(s), you must first exchange to a non-competing fund for 90 days. These requirements are typically imposed by issuers such as insurance companies, banks, or other approved financial institutions as a condition for issuing investment contracts to retirement plans.

Please refer to the prospectus of each applicable investment fund for a more detailed summary, as well as any changes to these policies. **NOTE:** The Janus Henderson Core Plus Fixed Income Collective Fund is a commingled investment trust (CIT), not a mutual fund. No prospectus is available because CITs are not included in the definition of a registered security and regulated investment company under various securities laws. Other CITs within the 401(k) are the Vanguard Retirement Savings Trust II and the Vanguard Target Retirement Select Trusts.

Frequent-trading policy

A frequent-trading policy applies to all funds in the PRSP, with the exception of Vanguard Retirement Savings Trust II and Vanguard Prime Money Market Fund Admiral Shares. Under this policy, if you exchange money out of a fund, you will not be able to exchange money back into the same fund within 30 calendar days. The term “exchange” refers to a transaction in which proceeds from a redemption of fund shares in the PRSP are used to purchase another investment offered within the PRSP.

Please note that the 30-day restriction only applies to exchanges into a fund and does not apply to transactions such as contributions, distributions and loans. You may always exchange money out of any fund at any time. In addition, the 30-day restriction described above will not apply to any change that you make to the investment of future contributions. Excessive trading will result in the limitation or prohibition of additional purchases (other than contributions and loan repayments) for 85 calendar days; additional excessive trading will result in a limitation of one exchange day per calendar quarter for a 12-month period. The participant disclosure notice gives a more detailed description of restrictions on fund exchanges, including any changes made to this policy. You can request a copy of the prospectus by calling Fidelity at 1.833.383.3339 or online at netbenefits.com.

This policy will not apply to the following:

- Vanguard Retirement Savings Trust II and Vanguard Prime Money Market Fund Admiral Shares.

- Purchases of shares with participant payroll or employer contributions or loan repayments.
- Purchases of shares with dividends or capital gains distributions.
- Distributions, loans, and in-service withdrawals from the PRSP.
- Redemptions of shares as part of a plan termination or at the direction of the plan administrator.
- Redemptions of shares to pay fund or account fees.
- Share or asset transfers or rollovers.
- Re-registration of shares.
- Conversions of shares from one share class to another in the same fund.

ERISA Section 404(c)

The PRSP is intended to satisfy the requirements of Section 404(c) of the Employee Retirement Income Security Act (ERISA). In general, this means that investment losses caused by your investment decisions will not give you a right against any plan fiduciary, including FedEx, the trustee or any named fiduciary. Therefore, FedEx Corporation, the PRSP's Participating Employers, the trustee or any named fiduciary will not be liable for those losses. Since you alone will be responsible for the losses or gains that result from your investment decisions, it is very important that you carefully consider the investment options available to you and periodically re-evaluate your options.

You should note that in the event a proxy voting decision needs to be made regarding shares of a Vanguard mutual fund, the Vanguard fund shares will be voted in accordance with the investment guidelines for the PRSP.

How to Select or Change Your Investment Options

Your Choices—Consider choosing a single Vanguard Target Retirement or LifeStrategy Fund or create your own mix from the remaining funds as long as the total equals 100%, such as:

- 100% in one fund;
- 45% in one fund, 55% in another fund;
- 50% in each of two different funds;
- 50% in one fund, 15% in one fund and 35% in one fund; or
- 10% in each of six different funds and 40% in one fund.

NOTE: Selections may be made in 1% increments.

There are two ways you can change your investment choices:

- You can transfer part or all of your existing balance among your investment fund options.
- You also can change your investment choices for future contributions at any time.

Each investment change is independent of the other. To change both existing balance and future contributions, you must make two independent changes. Changes may be made any day, 24 hours a day, subject to limitations as set forth in each fund's prospectus. However, you can only change your investment choices for your existing balances once during any business day. Once you have made a change in your investment choices for your existing balances, you must wait until the following business day to make another change.

How to Request a Change—Fidelity provides convenient online and phone services that allow you to select or change your investment options. Changes can be made any day, 24 hours a day online at netbenefits.com or by calling Fidelity at 1.833.383.3339.

If you make elections/changes before the stock market closes (normally 3 p.m., Central time), your elections/changes are based on that day's closing price. If you make elections/changes after the stock market closes, your elections/changes will be based on the next business day's closing price.

When the stock market closes before 3 p.m., Central time, any elections/changes made before closing are based on that day's closing price. Elections/changes made after closing are based on the next business day's closing price.

Fidelity will send a written confirmation of your elections or changes to your home address unless you choose to receive confirmations electronically at your email address.

For more information about any fund, including investment objectives, risks, charges and expenses, call Fidelity at 1.833.383.3339 to obtain a prospectus or fund fact sheet. The prospectus or fund fact sheet contains this and other important information about the fund. Read and consider the prospectus or fund fact sheet information carefully before you invest. You also can download fund prospectuses or fund fact sheet at netbenefits.com.

An investment in a money market fund is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. Although a money market fund seeks to preserve the value of your investment at $1 per share, it is possible to lose money by investing in such a fund. An investment in a stable value trust is neither insured nor guaranteed by the U.S. government. There is no assurance that the trust will be able to maintain a stable net asset value, and it is possible to lose money by investing in the trust.

Vanguard Retirement Savings Trust II is not a mutual fund. It is a collective trust available only to tax-qualified plans and their eligible participants. The collective trust mandates are managed by Vanguard Fiduciary Trust Company, a subsidiary of The Vanguard Group, Inc.

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Vanguard Marketing Corporation, Distributor of the Vanguard Funds.

Benefit Availability

The PRSP has provisions for withdrawals, loans and distributions as described in the following sections.

Withdrawals

Eligibility for Withdrawals

There are two types of withdrawals available from the PRSP: In-service withdrawals and hardship withdrawals. Your ability to make a withdrawal depends on a number of different factors:

- Your age,

- The circumstances for the withdrawal, and
- Your years of service.

In-Service Withdrawal

If you meet the eligibility requirements, you can make in-service withdrawals for any reason.

If you are under age 59½, you are allowed in-service withdrawals each plan year as follows:

- One in-service withdrawal from your combined vested balances in the Profit Sharing Contributions Account if you have 5 or more years of participation in the Plan. Minimum withdrawal is $1,000.
- Two in-service withdrawals from your After-tax Contributions Account. The minimum withdrawal is $500 or your entire account balance, whichever is less.
- One in-service withdrawal from your Sick Bank Account, if you have 5 or more years of participation in the Plan. Minimum withdrawal is $1,000.

There are no limits to in-service withdrawals on or after age 59½ and the 10% excise tax will not apply. In addition, you are eligible to take a withdrawal from the Money Purchase Plan Account upon reaching age 62 or older. Please note that withdrawals from the Money Purchase Plan Account require spousal consent if you are married.

Once you attain age 59½, no 10% excise tax will apply to benefit payments.

Steps to Take to Request an In-Service Withdrawal

To request an In-Service withdrawal, call Fidelity at 1.833.383.3339 or go to netbenefits.com. An application will be mailed the next business day.

Hardship Withdrawal

Withdrawals are made for hardship reasons from the following accounts in the order that they are listed. The hardship will be made from your accounts in the following order of redemption:

- After-tax Contributions Account
- Profit Sharing Contributions Account
- Sick Bank Account
- Rollover Account
- Roth Rollover Account
- Pre-tax/401(k) Contribution Account
- Roth Contributions Account
- Roth In Plan Conversion Account
- Roth In Plan Conversion – EE Restricted Account
- Catch-up Contribution Account
- Roth Catch-Up Contribution Account

Hardship withdrawals, in the amount of $500 or more, may be made at any time. Any such withdrawal must be for an immediate and heavy financial need of the Participant or primary beneficiary. To be considered a hardship, there must be a bona fide need for funds for one of the following reasons:

- Medical expenses incurred, or to be incurred, by you or your dependents that are not covered by health insurance.* You may be required to provide a statement from the insurance company that payment is being denied.

- Closing cost and down payment necessary to purchase your primary residence (but not for mortgage payments).
- Tuition payment, educational fees, and room and board expenses for the next semester, quarter or 12-month period of post-secondary education for you or your dependents. Any FedEx employer-paid tuition reimbursement for which you are eligible will be considered before paying a hardship withdrawal.
- Prevention of your eviction from your primary residence or the foreclosure of your mortgage on primary residence.
- Expenses incurred for the funeral or burial of a deceased parent, spouse, child or dependent.
- Hardships caused by natural disasters to principal residence or place of employment that is a location identified as a covered disaster area as described by IRS Announcements.*

***NOTE:** This hardship provision allows for a withdrawal from the plan to cover the amount not covered by insurance benefits.

Hardship withdrawal forms will require your certification of need under penalties of perjury.

Approximately one week from the application receipt date must be allowed for Fidelity to process the withdrawal.

Government regulations for retirement and savings plans change frequently. Changes to the withdrawal provisions may be necessary to comply with future legislation. The PRSP adopted the IRS rules governing hardship distributions. Under these provisions, you can continue making contributions to the plan after the receipt of a hardship distribution.

Steps to Take to Request a Hardship Withdrawal

To request a hardship withdrawal, call Fidelity at 1.833.383.3339 or go online to netbenefits.com. You will be responsible for providing supporting documentation of your hardship.

CARES Act Distribution

The Coronavirus Aid, Relief and Economic Security (CARES) Act permits qualified participants to request penalty-free distributions of up to $100,000 for qualifying coronavirus-related reasons if the distribution is made before December 31, 2020. This provision was added to the PRSP effective April 10, 2020. Qualified reasons for the distribution include adverse financial consequences due to being quarantined, furloughed, laid off or having work hours reduced; being unable to work due to a lack of childcare; or closing or reducing hours of a business owned or operated by the individual. CARES Act Distributions are more favorable than hardship withdrawals—including those for Federal Emergency Management Agency (FEMA)-declared disasters—because:

- Tax on the income from the withdrawal may be paid over a three-year period;
- Participants may repay the amount withdrawn to an eligible retirement plan within three years;
- Repayments will not be subject to the retirement plan contribution limits; and
- All contribution sources (other than money purchase plan sources) will be available.

Withdrawal Tax Considerations

Distributions for in-service and hardship withdrawals (except for your actual After-tax contributions that were already taxed) are subject to federal, state and local taxes. There is an additional 10% tax unless one of the following exceptions applies:

- You are at least age 59½
- You terminate employment during or after the year you reach age 55
- You have retired
- You die
- You become disabled (as described in this section)
- You incur medical expenses that do not exceed the medical deduction limits allowed by the IRS for personal income tax purposes
- Payments are made because of a Qualified Domestic Relations Order
- Payments are made to the IRS due to a tax levy

As required by the IRS, 20% of your taxable in-service withdrawal, except hardship withdrawals, is automatically withheld for federal income tax purposes unless the withdrawal is directly transferred (rolled over) from the Plan to an eligible retirement plan or individual retirement account (IRA).

Hardship withdrawals are not eligible to be rolled over.

Withdrawal of After-tax contributions made before January 1, 1987, does not have to include earnings; however, withdrawal of After-tax contributions made after December 31, 1986, must include earnings on the principal amount withdrawn.

In-Plan Roth Conversions

In addition to the option of making Roth contributions, you also can convert some or all of your vested plan savings to a Roth contribution.

The advantage of a conversion is that you will not pay taxes on your earnings if you meet certain distribution requirements. You must, however, weigh that benefit against the cost of a conversion as you would owe ordinary income taxes on any pre-tax money (including earnings on After-tax contributions) for the tax year in which you convert to Roth.

The tax on a conversion could be significant. You or your tax advisor would need to determine whether the amount you convert to Roth would raise your taxable income enough to push you into a higher income tax bracket or result in other adverse tax consequences.

You also would need to consider how you would pay the taxes on the conversion. Fidelity will report the in-plan Roth conversion as taxable income to the Internal Revenue Service for the tax year in which the conversion is made. Your total income for the year will determine the tax liability at the time your individual tax return is filed. You cannot elect to have taxes withheld from the conversion amount.

It is also important to note that a Roth in-plan conversion cannot be undone (recharacterized) once it is converted.

Favorable tax treatment applicable to certain distributions of FedEx stock does not apply to Roth conversions. If you convert FedEx stock, the taxable amount of the conversion includes any net unrealized appreciation (NUA).

Money converted to Roth contributions will not be eligible for after-tax withdrawals, and outstanding loan balances may not be converted.

Roth assets, including earnings on those contributions, can be withdrawn tax free, so long as the distribution is made at least five years after the first Roth contribution, and you have attained the age of 59½. The five-year period begins with January 1 of the year of the conversion and applies separately to each conversion. For example, if you make an in-plan Roth conversion in 2017, the five-year period begins on January 1, 2017.

If you withdraw Roth assets within five years of conversion, you may owe an additional 10% federal excise tax on the portion of the withdrawal attributable to the conversion unless you have attained age 59½.

Please note that state income taxes may vary from state to state. For more information, consult your tax advisor.

Completing an In-Plan Conversion

Contact Fidelity at 1.833.383.3339. Associates are available Monday through Friday from 8:30 a.m. to 9 p.m., Eastern time.

Loans

Funds Available for Loans

You may only make loans against your accounts if you are actively at work. You repay the loan through payroll deductions while employed by FedEx Express. The loan will be made from your accounts in the following order below:

- After-tax Contributions Account Profit Sharing Contributions Account (any stock included in a loan will be paid in the form of cash instead of a stock certificate)
- Sick Bank Account
- Employer Match Contribution Account
- Employer Nonelective Contribution Account
- Military Leave Nonelective Contribution Account
- Rollover Account
- Roth Rollover Account
- Pre-tax/401(k) Contributions Account (employee contributions)
- Roth Contribution Account
- Roth In Plan Conversion Account
- Roth In Plan Conversion – EE Restricted Account
- Roth In Plan Conversion – ER Restricted Account
- Catch-up Contribution Account
- Roth Catch-up Contribution Account

Loan repayments will be reinvested proportionately into the source(s) from which the loan was redeemed and into fund(s) based on current investment elections.

Loan Rules

The most you can borrow is half of your account balance as of the date your loan is issued, up to a total of $50,000. If your account decreases due to market fluctuation, your loan will be based on the amount available.

The Coronavirus Aid, Relief and Economic Security (CARES) Act permitted the increase of the maximum loan limit for qualified individuals to 100% of their vested account balance up to $100,000. This provision was implemented effective April 24, 2020, for loans requested by September 2020.

NOTE: To minimize your available loan amount decreasing due to fluctuating market conditions, on the day of your loan request, consider investing your PRSP Accounts in the more stable Vanguard Prime Money Market Fund Admiral Shares until your loan has been issued.

The minimum amount you can borrow is $1,000. Loan repayments are amortized on two payments per month. A $50 nonrefundable loan processing fee is required for each loan initiated. The amount of your loan request must cover the loan fee, which will be deducted from your loan amount when your loan is processed. The current fee of $50 is reviewed periodically.

You may only have one loan outstanding at a time. You are not eligible for another loan for one year after the final payment on your previous loan has been posted to your account. (Effective April 21, 2020, the loan wait period was reduced to 30 days for the remainder of the 2020 plan year. The one year wait period was reinstated effective January 1, 2021.) Outstanding loan balances may be paid off early. Additional partial payments toward principal are also allowed.

The loan repayment period is a minimum of 12 months and a maximum of 60 months for all new loans (other than principal residence loans). If your loan is for the down payment and closing costs to purchase your principal residence, it may be extended to 10 years. A fixed interest rate applies over the term of the loan. The rate charged is set monthly and is equal to the prevailing prime rate charged by a major national bank. Note: The Coronavirus Aid, Relief and Economic Security (CARES) Act permits qualified participants to delay loan repayments that were due between March 27, 2020 (the date of the CARES Act enactment) and December 31, 2020. You must contact Fidelity by phone between March 27, 2020, and December 31, 2020, to request a delay of loan repayments. All loans deferred will restart in January 2021 using a reamortized amount.

For additional information about the loan process, contact Fidelity.

If you terminate or retire from a Controlled Group Member, die, become disabled (as defined in this section) or choose to receive all account balances, the loan balance becomes due. If your loan was in good standing and you do not make a full repayment, your loan balance will be treated as a distribution at the end of the calendar quarter following the calendar quarter in which you terminate or retire. If your loan had deemed/defaulted prior to your termination, it will not be offset until you choose to take distribution of your account.

To Apply for a Loan:

> Contact Fidelity at 1.833.383.3339 or online at netbenefits.com to request a loan. You will be required to provide documentation for a Principal Residence loan.

Loan Default and Suspension Rules

Default on a loan will occur when you fail to make required repayment within the grace period allowed in the Plan. The grace period ends on the last day of the calendar quarter following the calendar quarter in which your last scheduled payment was due or made, whichever is first, not to exceed the required IRS five-year limit for a general purpose loan plus the grace period (allow five days prior to the due date for processing). The grace period is different for an approved non-military unpaid leave of absence and a military leave of absence.

While on an approved non-military unpaid leave of absence, you may suspend your loan payment for a maximum of 12 months or your loan end date, whichever is first. Upon your return to work, your loan balance will be reamortized and payment deductions should resume. Your repayment amount may change upon reamortization of the loan balance. If your loan payment does not resume upon your return to work, it is your responsibility to call Fidelity at 1.833.383.3339. Your loan end date will be extended by the period of non-military leave of absence, but not beyond the 12-month statutory limit per occurrence or the 5-year limit for a general-purpose loan. If you do not return from such unpaid leave of absence within one year and if the loan remains unpaid by the end of the calendar quarter following the calendar quarter in which the repayment due was not made, the entire amount of the outstanding loan balance, as of the last day of the second calendar quarter, shall be deemed to have been distributed to you as of that date and will be reported on Form 1099-R tax statement for the plan year.

While on a military leave of absence, your loan payment will be suspended for the duration of your military leave, subject to USERRA Regulations. Upon your return to work, your loan balance will be reamortized and payment deductions should resume. Your repayment amount may change upon reamortization of the loan balance. If your loan payment does not resume, it is your responsibility to call Fidelity, 1.833.383.3339. Your loan end date will be extended by the period of the military leave of absence.

The Coronavirus Aid, Relief and Economic Security (CARES) Act permits qualified participants to delay loan repayments that were due between March 27, 2020 (the date of the CARES Act enactment) and December 31, 2020. You must contact Fidelity by phone between March 27, 2020, and December 31, 2020, to request a delay of loan repayments. All loans deferred will restart in January 2021 using a reamortized amount.

If you default on the payment of principal and interest due, the account in which you have been given a security interest will be permanently reduced by the amount of the outstanding loan at the time you process a distribution. Even if assets in your accounts cannot be distributed and the loan is defaulted, a distribution will be deemed to have occurred with the resulting tax consequences and issuance of a Form 1099-R tax statement. Any taxable portion may be subject to a 10% excise tax in addition to federal, state, and local income tax. Although the loan will be taxable to you, it will remain outstanding under the Plan and will not be offset until your account is distributed. You will be unable to take a new loan from the PRSP until you repay the full amount of your deemed/defaulted distribution plus applicable accrued interest. The deemed/defaulted distribution will count as an outstanding loan amount against the maximum number of loans available. Once you repay your deemed/defaulted distribution balance with accrued interest, you may then be eligible to receive a new loan subject to the PRSP's restrictions. The one-year wait between loans will restart on the date your deemed/defaulted distribution is repaid.

Call Fidelity at 1.833.383.3339 to request information on paying off your defaulted loan.

You are responsible for updating any change of address in Workday. If you are no longer employed by FedEx, call Fidelity, 1.833.383.3339, to change your address.

Distributions (When Payment(s) Can Be Made)

Retirement or Termination of Employment—If you are no longer employed by any Controlled Group Member, you may receive a distribution of your account under one of the forms of benefit payment described in this section.

Fidelity will send information to apply for your benefits as soon as possible following your termination or retirement date as reflected in Workday. If your balance is greater than $1,000, you may choose to defer payment of your account balance in the PRSP until age 70½ (age 72

for those reaching age 70½ after December 31, 2019), at which time Required Minimum Distributions (RMDs) will begin. If your account balance is $1,000 or less, your account balance is distributed as soon as administratively possible. (See “Total Distribution Forms of Payment.”)

You are required to start taking distributions no later than April 1 of the calendar year following the later of the calendar year that you attain age 70½ (age 72 for those reaching age 70½ after December 31, 2019) or the calendar year that you terminate employment with FedEx. RMDs are not eligible for a direct rollover. While your money remains in the PRSP, you can continue to direct your investments. **Note:** The Coronavirus Aid, Relief and Economic Security (CARES) Act permitted eligible participants to defer RMDs due to be paid in 2020. If you terminate employment with a Participating Employer and become employed by another Controlled Group Member, you will not be eligible to receive a distribution or to roll over your PRSP balance to a retirement plan sponsored by a non-participating Controlled Group Member. This applies if you are an active employee with any FedEx Corporation Controlled Group Member. However, you will be able to change your investment options and to apply for a withdrawal from your PRSP accounts. Additionally, you will be permitted to request a new loan or continue loan payments on a monthly basis by completing an application to have your loan repayments automatically deducted from your personal checking or savings account. Call Fidelity at 1.833.383.3339 to request the ACH Loan application.

Death—If you die, your beneficiary will be eligible to receive a distribution of your account under one of the applicable forms of benefit payment. Your beneficiary will be required to submit proof of your death to Fidelity.

If your beneficiary is your spouse, and your account balance is $1,000 or less, your balance will be paid out as soon as administratively possible.

If your balance is greater than $1,000 and your spouse is your beneficiary, your spouse can elect one of the applicable forms of payment.

If your beneficiary is not your spouse and your account balance is $1,000 or less, your account balance will be paid as soon as administratively possible. If your balance is greater than $1,000, your beneficiary can elect one of the applicable forms of payment.

If you do not designate a beneficiary and you had not reached your required beginning date before you die, your account balance must be distributed by the end of the fifth year following the year of your death. If you died after reaching your required beginning date, distributions may be stretched over your life expectancy based on the single life mortality table.

If you die after December 31, 2019, your entire balance generally must be distributed within ten years of your death. Exceptions to this ten-year rule apply if your designated beneficiary is your spouse, a child who has not reached the age of majority by the time of your death, a disabled or chronically ill individual, or a beneficiary who is no more than ten years younger than you.

Steps to Take to File an Application for Benefits

Death

1. Your beneficiary must notify Fidelity at 1.833.383.3339 of your death and submit necessary information to Fidelity.
2. Fidelity will verify the beneficiary and coordinate the distribution process.

Disability

If you become disabled, regardless of age, you may be eligible to receive a one-time distribution of your entire account balance. You also may request any of the withdrawal options provided for in the Plan subject to your eligibility.

For this purpose, disability means a participant's inability, because of a medically determinable physical or mental impairment, to engage in any substantially gainful activity for which that individual is reasonably qualified (or could reasonably become qualified) on the basis of education, training or experience.

The earliest date on which you can receive a distribution due to your disability is:

- 24 months after the date on which you are determined, in the discretion of the Administrator, to be totally disabled,
- The date on which you become eligible for Social Security disability benefits, or
- The date on which you submit satisfactory medical evidence of terminal illness.

Forms of Benefit Payment

You may choose to have your accounts distributed in one of the methods described below. **You should carefully choose the payment option that you believe best serves your needs, since you will not be able to change it once payment(s) commence or an annuity has been purchased for you. However, if you elect an annuity option, you may change to any of the other available annuity forms of payment any time prior to your Benefit Commencement Date.**

- **Lump Sum**—Provides a one-time payment of your entire account balance. The IRS requires an automatic withholding of 20% of your taxable distribution on payments made directly to you. To avoid the 20% withholding, you may request a direct rollover distribution be made to a qualified rollover IRA or another qualified retirement plan, as described below. If you receive a distribution prior to age 55 and do not roll it over, any taxable portion of your distribution may be subject to a 10% federal excise tax in addition to federal, state and local income tax. Please note that any balance that you have in the Investment Credit Stock Account and/or ESOP Account must be distributed in one Lump Sum payment.
- **Partial Payment Distribution or Periodic Distribution**—Provides payment(s) in an amount and frequency specified by you. These options allow you to take your savings periodically for unexpected events or nonrecurring expenses and can be taken as a rollover or in cash.
- **Direct Rollover**—Provides a payment of your Plan balance to a qualified rollover IRA or another qualified plan. You are permitted to roll over to more than one institution. By selecting this payment option, you can avoid income and excise taxes.
- **Installment Option**—Provides payments over a certain period in substantially equal monthly, quarterly, semiannual or annual payments. The trustee will first segregate the total amount to be paid out into the Vanguard Prime Money Market Fund Admiral Shares. The period over which such payments are made can be for any duration period that you choose, but it must not extend beyond your life expectancy or the life expectancy of you and your beneficiary (only available for account balances greater than $1,000).
- **Annuity Option**—Provides for periodic payments under an annuity contract purchased from an insurance company (only available for account balances greater than $5,000). If

you choose the annuity option, you will be responsible for payment of any fees involved with the purchase.

Important Information When Selecting a Joint and Survivor Annuity Form of Payment

Balances in the Money Purchase Plan Account—If you are married, you may not choose a form of payment other than the Joint and Survivor Annuity with 50%, 75%, or 100% continued to your spouse, unless your spouse consents to your payment choice and beneficiary. Your spouse's written consent must be witnessed by a notary public and received at Fidelity before an applicable distribution can be processed.

In the case of either the Single Life Annuity or the 50%, 75%, or 100% Joint and Survivor Annuity, the amount of your benefit will be determined by the purchase of an appropriate annuity contract.

If you select a Joint and Survivor Annuity, your election of both the form of payment and the beneficiary are irrevocable. The survivor benefit is applicable only to the designated beneficiary at the time your monthly payment commences.

If, after the start of payments under a Joint and Survivor Annuity with your spouse as the survivor, you and your spouse divorce or your spouse dies, you may not select another person, including a new spouse, to receive the survivor benefits, and you may not select a different optional form of payment (*e.g.*, a Single Life Annuity). In the event of divorce your former spouse will continue to have a right to the survivor benefits. Even a QDRO will not transfer the survivor rights to another person, including a subsequent spouse, since the PRSP prohibits such a transfer.

If you select a Joint and Survivor Annuity form of payment, your benefit is reduced according to your age and your beneficiary's age on your benefit commencement date. If your designated beneficiary is not your spouse, the law restricts the amount your benefit can be reduced in order to provide a benefit to a beneficiary. In addition, an optional form of payment may not provide for a monthly payment to a joint annuitant or beneficiary that is greater than the monthly payment to you and the expected value of benefits payable to you may not be reduced more than 50%.

Payments to an Alternate Payee

With the exception of a Qualified Domestic Relations Order (QDRO), your benefit from the PRSP cannot be assigned to anyone else.

A court may issue a Domestic Relations Order (DRO) under state domestic relations law directing the plan administrator to pay all or a portion of your PRSP benefit to an alternate payee. A QDRO is a judgment, decree or order made in accordance with domestic relations law and subject to provisions under federal law that requires the plan administrator to pay all or a portion of your benefit to another person referred to as an "alternate payee." An alternate payee is a spouse, former spouse or dependent child who is recognized under the QDRO as being entitled to receive all or part of your benefit.

The plan administrator ultimately is responsible for determining if a DRO is a QDRO. A third-party administrator has been hired to review DROs and to determine if they meet the requirements of a QDRO. All inquiries about QDROs should be directed to:

Mailing Address:

FedEx Retirement Service Center
Attn: QO Unit
P.O. Box 7144
Rantoul, IL 61866-7144

Overnight:

S 1000 Perimeter Road
Rantoul, IL 61866

Fax:

1.847.554.1969

Website:

www.qocenter.com

Retirement Service Center:

1.855.604.6221

You or your attorney may call 1.855.604.6221 to speak with a representative or request governing procedures and other documents, which are provided without charge.

Claims and Appeals

Information about filing a claim for benefits, reconsidering a claim, appealing a denial and legal action is provided in “Claims and Appeals.”

How to Access Your Account by Telephone

Call Fidelity at 1.833.383.3339 from a touch-tone phone.

Retiree Health Coverage—A Reminder

It is important that you consider the cost of retiree health coverage when you are saving and planning for retirement. The cost of retiree health coverage is significantly higher than the cost of active health coverage.

COMPANY JUMPSEAT

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General

To the extent permitted by law or regulation, pilots shall be given access to Company jumpseats on terms no less favorable than those provided in the Company's Jumpseat Policy, effective January 25, 1998, and as included in this Pilot Benefit Book (PBB). As detailed in Section 26.J.2. of the November 2, 2015, Agreement, a pilot may use a Company staging jumpseat to position him/herself to his base for the start of his scheduled trip ("No Harm, No Foul"), provided he/she meets the requirements of that section and the Company's Jumpseat Policy.

Violations of the Company's Jumpseat Policy could lead to discipline up to and including termination, subject to the provisions of Sections 19 and 21 of the collective bargaining agreement. Day of operations denials of jumpseat travel privileges (e.g., due to dress code violations), and jumpseat travel suspensions issued as part of the standard application of the Company's Jumpseat Policy (e.g., for no-shows), are not considered discipline subject to Sections 19 and 21.

For additional information on the Company's Jumpseat Policy, please see People Manual 7-47 (Jumpseat). Pilots should submit an *Insite* report on any jumpseat issues or questions.

Eligibility

1. Must be a pilot listed on the Master Seniority list.
2. Pilots are not required to complete the jumpseat certification test or maintain currency of the same.
3. Pilots on suspension, or leave of absence, sick leave, or Workers' Compensation time off are not eligible to use the jumpseat. In extenuating circumstances, an exception may be granted to a pilot who is medically able to jumpseat. This may be done by written approval (email is sufficient) from the Duty Officer (for day of operations situations) or the pilot's Fleet Captain/Fleet Manager (for situations involving more lead time) sent to Jumpseat Administration. The Duty Officer or the pilot's Fleet Captain/Fleet Manager may consult with the Company's aeromedical advisor on the pilot's medical situation prior to approving any jumpseat travel.
4. Pilots performing duty in the uniformed services of less than 31 days are not on leave of absence for purposes of applying this section. Pilots on extended military leaves of absence are allowed to jumpseat via a separate process and should reference the Pilot Military Handbook available from the Pilot home page / Resources / General Info.
5. Pilots who have a temporary impairment that would prevent them from safely using the jumpseat will be denied jumpseat travel (i.e., cast on limbs or body).

Carriage of Persons on Cargo Aircraft

Certain persons may be carried on cargo flights without complying with certain passenger requirements. (See FAR 121.547 and FAR 121.583.) Carriage of such persons and allocation of available jumpseats shall be in accordance with the Flight Operations Manual (the current applicable sections of which are FOM 2.93 Carriage of Persons on Cargo Aircraft and FOM 13.13 Charter Security).

Booking Priorities

Federal Aviation Regulations (FARs) specify who may occupy a jumpseat. Company compliance with these regulations is the responsibility of the Senior Vice President of Flight Operations. Assignment of observer or additional seats is coordinated through Jumpseat

General

To the extent permitted by law or regulation, pilots shall be given access to Company jumpseats on terms no less favorable than those provided in the Company's Jumpseat Policy, effective January 25, 1998, and as included in this Pilot Benefit Book (PBB). As detailed in Section 26.J.2. of the November 2, 2015, Agreement, a pilot may use a Company staging jumpseat to position him/herself to his base for the start of his scheduled trip ("No Harm, No Foul"), provided he/she meets the requirements of that section and the Company's Jumpseat Policy.

Violations of the Company's Jumpseat Policy could lead to discipline up to and including termination, subject to the provisions of Sections 19 and 21 of the collective bargaining agreement. Day of operations denials of jumpseat travel privileges (e.g., due to dress code violations), and jumpseat travel suspensions issued as part of the standard application of the Company's Jumpseat Policy (e.g., for no-shows), are not considered discipline subject to Sections 19 and 21.

For additional information on the Company's Jumpseat Policy, please see People Manual 7-47 (Jumpseat). Pilots should submit an *Insite* report on any jumpseat issues or questions.

Eligibility

1. Must be a pilot listed on the Master Seniority list.
2. Pilots are not required to complete the jumpseat certification test or maintain currency of the same.
3. Pilots on suspension, or leave of absence, sick leave, or Workers' Compensation time off are not eligible to use the jumpseat. In extenuating circumstances, an exception may be granted to a pilot who is medically able to jumpseat. This may be done by written approval (email is sufficient) from the Duty Officer (for day of operations situations) or the pilot's Fleet Captain/Fleet Manager (for situations involving more lead time) sent to Jumpseat Administration. The Duty Officer or the pilot's Fleet Captain/Fleet Manager may consult with the Company's aeromedical advisor on the pilot's medical situation prior to approving any jumpseat travel.
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Booking Priorities

Federal Aviation Regulations (FARs) specify who may occupy a jumpseat. Company compliance with these regulations is the responsibility of the Senior Vice President of Flight Operations. Assignment of observer or additional seats is coordinated through Jumpseat

Administration and the Flight Services Department. Persons authorized to occupy such seats and their booking and bumping priority are as determined by FARs and the Senior Vice President of Flight Operations based on the following list of Booking Priorities (BPs). The BP descriptions include criteria regarding booking and bumping priorities and timeframes for making reservations.

From highest priority to lowest priority, the BPs are as follows:

Booking Priority	Description
BP1	● **FAA/NTSB inspectors and United States Secret Service Agents.** Available in Cockpit or Cabin jumpseats. ● **Aircraft Maintenance Technician when traveling to or from repairing a Company aircraft grounded in the field (when an operational emergency is declared by MOCC).** Available in Cockpit jumpseats when Cabin jumpseats not available. ● May bump jumpseat reservations in all lower Booking Priority categories until scheduled departure time.
BP2	● **Person(s) necessary for: safety of flight; safe handling of animals; safe handling of hazardous or radioactive materials; security of confidential or valuable cargo; preservation of fragile or perishable cargo; experimenting/testing of cargo containers/handling devices; and cargo loading/offloading of outsized cargo.** All require FAA and Company approval. Available in Cockpit jumpseats when Cabin jumpseats not available. ● **State Department couriers, military couriers/loadmasters, U.S. Honor Guard/escorts.** Available in Cockpit jumpseats when Cabin jumpseats not available. ● **Pilots assigned by the Company to travel by jumpseat as part of a trip scheduled in accordance with the pilots' collective bargaining agreement.** Available in Cockpit jumpseats when Cabin jumpseats not available. ● **Flight Management (Managing Directors and above) traveling for the purpose of conducting systems observation and validation.** Available in Cockpit jumpseats only. ● May bump jumpseat reservations in all lower Booking Priority categories until scheduled departure time.
BP3	● **Operational Emergency (declared by MOCC).** Available for a ground support mechanic traveling to repair critical ground sort/loading equipment in the field. Available in Cabin jumpseats only. ● **Business Emergency (approved by Vice President of Flight Operations).** Company travel for jumpseat eligible employee(s) when no other means of transportation is available. Available in Cockpit jumpseats when Cabin jumpseats not available. ● **Personal Emergency (not booked more than 24 hours prior to scheduled departure time and immediate manager notified).** Travel due to the death or life-threatening illness or life-threatening injury of an immediate family member (as defined in the People Manual). Any change after reservation made results in downgrade of Booking Priority to BP8. ● May bump jumpseat reservations in all lower Booking Priority categories until scheduled departure time.
BP4	● **Company Travel for Executive Officers.** Company travel for Chief Executive Officer, Executive Vice President(s), Senior Vice President(s), Vice President of

Booking Priority	Description
	Flight Operations, Vice President of Aircraft Base Maintenance, Vice President of Aircraft Line Maintenance, and Vice President of Flight Training. Available in Cabin jumpseats only, unless jumpseater is eligible for Cockpit jumpseats. ● **Company Travel in Lieu of Company Purchased Ticket (including Qualifying Deviation Air Travel Authorized by the Pilots' Collective Bargaining Agreement).** Available for travel within 3 days (72 hours) of a scheduled Company business event/activity identified on the crew calendar. ● **Jumpseat Travel pursuant to Section 5.H.2. of the Pilots' Collective Bargaining Agreement.** ● Does not bump reservations in Booking Priority 5. May bump jumpseat reservations in all lower Booking Priority categories until 3 business days before scheduled departure time. May bump jumpseat reservations in the "OFF" Booking Priority category up until 1 hour before showtime.
BP5	● **Training observations required by regulation.** May bump jumpseat reservations in all lower Booking Priority categories until 3 business days (not including weekends or holidays) before scheduled departure time. Available in Cockpit jumpseats only.
BP6	● **Non-Essential Travel—Decade.** May bump jumpseat reservations in all lower Booking Priority categories until 3 business days before scheduled departure time. Any change after reservation made results in downgrade of Booking Priority to BP8. ● **Travel by Technical Representatives of equipment manufacturer and travelers authorized by FAA Form 8430-6.** May bump jumpseat reservations in all lower Booking Priority categories until 3 business days before scheduled departure time.
BP7	● **Staging (Jumpseat Staging eligible AOD and GOC employees only).** Staging eligible employee traveling to/from base/work location and permanent residence. May bump jumpseat reservations in all lower priority categories until 72 hours before scheduled departure time.
BP8	● **Non-Essential Travel (jumpseat eligible employees only).** May bump jumpseat reservations in all lower priority categories until 1 hour before showtime.
OFF	● **Offline/Cockpit Access Security System (CASS) listings and reservations.** Available in Cabin jumpseats when no Cockpit jumpseats are available. Offline jumpseaters/CASS Participants may make jumpseat reservations no earlier than 24 hours prior to scheduled departure time and no later than 1 hour before showtime.

Notes:

1. The term **Cockpit Jumpseat** refers to a jumpseat located on the flight deck (i.e., "in front of" the cockpit bulkhead) on aircraft equipped with an Intrusion Resistant Cockpit Door (IRCD). On aircraft without an IRCD (or on aircraft with a deferred or non-functional IRCD), all jumpseats, even those located behind the cockpit bulkhead, are considered Cockpit Jumpseats. Access to Cockpit Jumpseats is subject to FAR 121.547 and applicable interpretative guidance.

   FedEx Express B777 and B767 aircraft are not equipped with an IRCD. Although equipped with an IRCD, FedEx Express MD11 aircraft in the "crew rest" configuration do not have any jumpseats located aft of the cockpit bulkhead and all jumpseats on these aircraft are located on the flight deck.

2. The term **Cabin Jumpseat** refers to a jumpseat located aft of the cockpit bulkhead on an aircraft equipped with an IRCD. Access to Cabin Jumpseats is subject to FAR 121.583 and applicable interpretative guidance.

   FedEx Express MD11/10, Airbus, and B757 aircraft are equipped with an IRCD. Although equipped with an IRCD, FedEx Express MD11 aircraft in the "crew rest" configuration do not have any jumpseats located aft of the cockpit bulkhead and all jumpseats on these aircraft are located on the flight deck.
3. When Cockpit Jumpseats are fully booked, Cockpit Jumpseat reservations may "flow back" into Cabin Jumpseats (in the same Booking Priority), if Cabin Jumpseats are available at the time of the reservation. Cockpit jumpseaters may be asked to occupy empty Cabin Jumpseats at the discretion of the Pilot-in-Command of the flight.
4. Cockpit eligible jumpseaters shall not bump reservations of cabin jumpseat-only eligible jumpseaters in a lower Booking Priority category if a Cockpit Jumpseat is available.

Company Travel in Lieu of Company Purchased Ticket (BP4) ("Company Travel") refers to travel which would otherwise be paid for by FedEx Express, includes qualifying deviation air travel authorized by the November 2, 2015, Agreement.

Non-Essential Travel—Decade (BP6) reservations are available to all FedEx Express pilots who have completed at least 10 years of continuous service. This privilege allows pilots with 10 years of continuous service to make one roundtrip reservation per fiscal year in BP6. Employees with 20 years of continuous service are permitted to make two roundtrip reservations per fiscal year in BP6. Decade travel should be booked as a confirmed seat. Standby reservations are not allowed. Any time a pilot changes a Non-Essential Travel—Decade reservation, the pilot loses one Non-Essential Travel—Decade reservation allowed that fiscal year.

Staging (BP7) reservations are available to all FedEx Express pilots who commute by air to/from their base. Pilots must name one FedEx Express 3-letter ramp identifier located within 150 miles of their permanent, primary residence identified in Workday along with their FedEx Express base. A pilot's permanent, primary residence for Staging purposes may not change more frequently than 90 days unless it is at the direction of the Company. Any such changes must correspond to the pilot's actual permanent residence address identified in Workday. Pilots may access the Jumpseat Staging Request Form from the PFC home page by choosing VIPS > VIPS Site Index > Jumpseats and Authorizations to complete and submit electronically. Request are sent to the Fleet Captain or Manager for review and processing.

(JS system enhancement scheduled 08/2022) Staging authorization will be automatically added to the Jumpseat Reservation system upon hire for pilots commuting from permanent residence declared in Workday and Base assignment in VIPS.

Note: Pilots should only use BP7 Staging status when traveling outside of the 72-hour window prior to or following a scheduled business event on the pilot's crew calendar.

Note: Pilots should use BP4 Company Business status when travel will occur within 72 hours pre/post scheduled business event on pilot's crew calendar.

Note: Dependent on flight availability and routing between base and residence, Jumpseat Administration may add an additional MSL (Major Sort Location) to provide the necessary connectivity to optimize availability to use Staging.

Note: Pilots that choose to live outside of the designated range must request an exception to the nearest RAMP location, which will not be unreasonably denied, or commute with a commercial airline that FDX has an established reciprocal jumpseat agreement.

Non-Essential Travel (BP8) reservations are available to all FedEx Express pilots. Reservations for Non-Essential Travel are accepted on a first-come, first-served basis, within the guidelines of the Company's Jumpseat Policy.

All pilots traveling by Company jumpseat, regardless of BP status, are responsible for canceling reservations in accordance with the "Cancellation" section (below), as well as adhering to the "Check-In and Required Showtime" parameters (below). Failure to comply with these rules may result in loss of jumpseat privileges in accordance with the "No Shows/Suspensions" section (below).

Operational Bumping

When necessary for operational reasons, jumpseaters will be bumped from a flight in the following order: OFF, BP8, BP7, BP6, BP5, BP4, BP3, BP2, and BP1. Operational bumping within the same Booking Priority category shall be based on the timestamp of the reservations (with the most recent reservation being bumped first) and FOM 2.93.

Reservations

Under current procedures, jumpseat reservations may be made 24 hours a day, 365 days a year through the Company's online "Freebird" system, via telephone, or in person at Jumpseat Administration in the Memphis AOC. At any given time, one or more of these systems shall be available for this purpose, subject to the Company's continued authorization to provide this benefit. Reservations may be made within 3 weeks (21 days) of the current date. The new reservation day starts at 12:00 a.m. in the departing city time zone. Walk-up jumpseating is not permitted except as outlined in the FOM.

> **Example: Monday, October 6, for a flight Monday, October 27.**
>
> ***You may make reservations for any flight on Monday, October 27 as early as 12 a.m. Central Time, October 6.***

If you are unable to book a reservation, you may list yourself as a standby for the flight. You are responsible for checking your status. Status may be checked within the Freebird online system or by calling a jumpseat reservationist. Only Business travel standbys are contacted when flights become available, time permitting. An email notification, time permitting, may be sent to the first standby when a set becomes available. The open seat(s) are held available for standby jumpseater(s) until 6 hours prior to departure. At that time, the standby list is discarded and open seat(s) may be reserved on a first-come, first-served basis.

Reservation Bumping

Jumpseaters making reservations with a higher BP status may bump jumpseaters with lower BP reservations as outlined in the "Booking Priorities" section (above).

Jumpseaters may also be bumped at any time as outlined in the "Operational Bumping" section (above).

1. Bumping (preempting) another person from a jumpseat for BP4, BP5, or BP6 status travel must occur at least 3 business days (weekdays) prior to the day of the flight (i.e., there must be at least 2 full weekdays between the day of the request and the day of the flight). Weekends and holidays are not counted for the purpose of bumping.

Wednesday	Thursday	Friday	Saturday	Sunday	Monday
Bumping Day	Business	Business	Flight Day	Flight Day	Flight Day

	Day 1	Day 2			

In this example, on Wednesday a pilot (up to 23:59 Central Time), can bump flights for Saturday, Sunday, and/or Monday or later, since the two full business day requirement is satisfied by Thursday and Friday.

Thursday	Friday	Saturday	Sunday	Monday	Tuesday
Bumping Day	Business Day 1			Business Day 2	Flight Day

In this example, on Thursday a pilot (up to 23:59 Central Time), can bump flights for Tuesday or later, since the two full business day requirement is satisfied by Friday and Monday.

Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday
Bumping Day	Business Day 1			Holiday	Business Day 2	Flight Day

In this example, on Thursday a pilot (up to 23:59 Central Time), can bump flights for Wednesday or later, since the two full business day requirement is satisfied by Friday and Tuesday. The following holidays apply: New Year's Eve, New Year's Day, Christmas Eve, Christmas Day, and Thanksgiving.

2. If an administration error is found in the booking of a flight that is 3 business days away or less, the passenger who is currently booked on the flight remains on the flight. Jumpseat Administration will make every effort to accommodate the passenger affected by the error on another flight.

   Note: The Company is not responsible for any travel expenses incurred by pilots when jumpseat travel becomes unavailable.

3. Pilots may be bumped up until flight time by a jumpseat traveler with a BP1, BP2, or BP3 status. Pilots deadheading on a BP2 status may bump specific flights when multiple flights exist. The decision as to which flight(s) will be bumped is made by Flight Management or Duty Officer.
4. If two flights are scheduled through the same city with all jumpseats booked and one of the flights is rerouted or canceled, the jumpseaters on the flight that is not rerouted or canceled retain their seats.
5. A jumpseating pilot traveling on a BP4, BP7, or BP6 status on a rerouted/cancelled flight, or a flight where an Emergency has been declared (i.e., a flight with a jumpseat traveler on BP3 status), cannot bump another jumpseater even if he/she holds a higher priority status.

   Note: Pilots traveling on BP4, BP7, and BP6 status may not bump a passenger out of a city that has multiple flights. The bumping pilot will be booked on the flight having the lowest priority jumpseat.

6. Offline/CASS reservations on FDX jumpseat are subject to be bumped by travel status B0-B8 up to 1 hour prior to scheduled departure.

Cancellation

1. If the pilot has a reservation for more than one flight (e.g., Flt XXX MEM/OAK and Flt. YYY OAK/MEM) and is bumped from only one of them (e.g., Flt YYY OAK/MEM), the pilot is still confirmed on the un-bumped reservation. It is the pilot's responsibility to decide whether to cancel or keep the confirmed reservation on the other flight.

2. If the pilot is unable to use a jumpseat reservation(s), the pilot must cancel the reservation(s) as soon as possible. A cancellation must be made no less than 6 hours before the scheduled departure time for BP8, BP7, or BP6 reservations, and no less than 2 hours before the scheduled departure for BP4 reservations. Failure to comply may result in a "no-show."
3. If the pilot has a reservation on more than one flight (e.g., on Flt. XXX into Memphis and on Flt. YYY out of Memphis), the pilot must cancel them as two separate flight reservations. Jumpseat Administration does not assume that the Flt. XXX reservation is not valid because the pilot canceled the reservation on Flt. YYY.
4. To cancel a reservation, do one of the following:
   a. Use Freebird;
   b. Call Jumpseat Administration and cancel with a jumpseat reservationist.

Note: Speaking with ramp personnel does not affect a cancellation. If the pilot does not cancel a reservation through one of the approved methods, the pilot is considered a no-show for the flight and is subject to the "No-Shows/Suspension" section (below). The pilot is ultimately responsible for ensuring that jumpseat reservations are cancelled.

No-Shows/Suspensions

A pilot who fails to report for a scheduled jumpseat or who does not arrive by the scheduled showtime is considered a "no-show" and may receive a "no-show" notice. If the pilot arrives after the scheduled showtime, Jumpseat Administration in Memphis/Ramp Operations elsewhere, will determine the impact on the operation and may allow boarding of the flight, with the concurrence of the Captain and GOC Dispatcher assigned to the flight. If the pilot does not accompany the operating flight crew to the aircraft, the pilot must be on board the aircraft 30 minutes prior to scheduled departure.

Receipt of a "no-show" notice for a jumpseat reservation in Booking Priority Category 6, 7, or 8 shall result in suspension of jumpseat privileges for 1 day for the first offense, 15 days for the second offense, 60 days for the third offense, and 1 year for the fourth offense within a 365-day period from the first offense. Jumpseat Administration shall also notify the pilot's Fleet Captain/Fleet Manager, who may take other appropriate action in response to the employee's no-show(s).

Receipt of a "no-show" notice for a jumpseat reservation in Booking Priority Category 5 or higher may also result in suspension of jumpseat privileges. Jumpseat Administration shall notify the pilot's Fleet Captain/Fleet Manager, who may take other appropriate action in response to the employee's no-show(s).

Notes:

1. No-shows caused by operational disruptions or adjustments shall not result in a "no-show" notice, suspension of jumpseat privileges or notification of the pilot's Fleet Captain/Fleet Manager.
2. If extenuating circumstances led to a no-show, upon request, Jumpseat Administration and the pilot's Fleet Captain/Fleet Manager will review the situation, as soon as practicable after the pilot's request (the target response time will be within 5 business days), to decide whether the no-show penalty should be reversed.

Requirements for Jumpseating

1. Before checking in for a flight, the pilot should confirm that the following requirements are satisfied:
   a. The pilot's bag(s) must be screened prior to checking in for the jumpseat flight. After the pilot's bag(s) are screened, the pilot must check in for the reserved flight with Jumpseat or designated Ramp employees with screened baggage. The pilot is required to go through screening only once, provided the pilot's bag(s) remains within the secure area. The pilot must comply with all TSA and Company requirements.
   b. FAA regulations require that the pilot pack and know the contents of the pilot's bag(s). Dangerous goods are prohibited. (See "Dangerous Goods" on page "Company Jumpseat-11," and FOM 10.17.) TSA regularly updates the list of restricted and prohibited items. A current list can be found on pilot.fedex.com under the security tab. (See also FOM 13.12.) The pilot's bag(s) must be always in the pilot's control, and the pilot must not carry items from unknown persons. The pilot's bag(s) should be limited to only what the pilot can carry up the boarding steps. Oversized articles are prohibited.

      Note: If you require any oversize articles at your destination, plan to ship them through the FedEx employee discount-shipping program.
   c. Animals/pets are not allowed to accompany the pilot when jumpseating.
   d. Good personal hygiene is expected.
   e. Personal electronic devices must be turned off during the flight unless approved by the Captain.
   f. [Reserved].
   g. The consumption of alcoholic beverages within 8 hours of departure is strictly prohibited.
   h. Smoking (including the use of e-cigarettes) is prohibited on the aircraft or on any airport ramp, except in designated locations.
   i. It is the pilot's responsibility to ensure that the emergency contact information in Workday is current and accurate.
2. International Travel
   a. In addition to the requirements of section 1 above, the pilot jumpseating internationally is responsible for the following:
      1) Confirming with each ramp their check-in procedures. Certain international ramps may require advance check-in (i.e., 8- to 24-hour notice) to comply with flight paperwork and customs/immigration policies.
      2) Pilots are responsible for complying with entry requirements. These requirements may be different depending on travel status (i.e., deadheading crew versus non-essential (BP8) travel).
      3) If the pilot is not a United States passport holder, his/her passport must meet current entry/transit requirements to enter the United States. Non-compliance may subject the pilot to government fines.
      4) If you have any questions on entry or visa requirements, call Jumpseat Administration.

         Note: Failure to comply with the requirements above could result in loss of Company jumpseat privileges and costly immigration fines.

3. The following employee classifications are charged with determining that the above requirements are met and have the authority to deny travel for noncompliance:
   a. Ramp Agent or equivalent Ramp/Hub Check-In personnel;
   b. Jumpseat Administration MEM /Flight Coordination IND;
   c. Captain of the flight.

Dress Code

1. Casual attire is approved as proper dress while traveling on jumpseats.
2. In all cases, you must present a neat and clean appearance.
3. The following are examples of inappropriate attire:
   a. any clothing that would prevent an individual's safe and timely exit in an emergency situation;
   b. any other clothing that would detract from the business image of Federal Express;
   c. clothing with offensive terminology or graphics;
   d. clothing with holes/ragged edges;
   e. T-shirts (i.e., shirts without a collar), including those with FedEx Logo;
   f. dirty/worn-out jeans;
   g. fatigues;
   h. leggings (without or in place of slacks/regular skirt);
   i. micro-mini skirts;
   j. bare midriff;
   k. tight, sheer/see-through clothing;
   l. shorts, cutoffs, tank tops;
   m. beach clothing;
   n. hair curlers;
   o. jogging/exercise suits, workout clothing;
   p. sandals, mules, beach footwear;
   q. hiking or military style boots; and/or
   r. high-heeled shoes.

      NOTE: High-heeled shoes/sandals/mules or spiked-heeled shoes are considered unsafe footwear due to the grated areas and steps used for boarding/disembarking the aircraft.

4. This dress code also includes any other clothing that would detract from the business image of FedEx Express and/or the prevention of proper use of emergency equipment to include restrictive or flowing clothing, hairdos, and jewelry. Mustaches should be trimmed to the corner of the mouth (beards, goatees, and other facial hair are prohibited), as well as any other items deemed unsafe. Failure to comply will result in denial of jumpseat travel by removal from the flight.
5. The following people are charged with determining the above jumpseat requirements are met and have the authority to deny travel for noncompliance. You must adhere to their requests to alter/change clothing, shave, or deboard due to inappropriate and/or unsafe attire. Each one of the following has the authority to deny jumpseat passage for non-compliance.
   (1) Ramp agent/Ramp Manager
   (2) Jumpseat Administration
   (3) Captain

Check-In and Required Showtime

1. Pilots are responsible for checking in by published showtime. Check-in is at least 1 hour prior to scheduled departure. Some flights have extended showtimes due to possible early departures (refer to flight information in Freebird or ask Jumpseat Administration). Arriving earlier than your showtime when possible is encouraged.
2. Normal check-in point is the ramp office, Flight Coordination in the hubs, or in Memphis, Jumpseat Administration. The pilot is responsible to confirm physical check-in location, which can be obtained from the Freebird system. Ramp office phone numbers are also available in Freebird. Arriving at locations other than the ramp office (e.g., a city station or cargo building where the ramp office is not jointly located) does not meet the required check-in time rule. You must check in on time at the ramp office (or Jumpseat Administration in Memphis) or you will be considered a no-show. You may be dropped from the flight at the Captain's discretion (delay should not occur because a jumpseater is late).
3. Under FAA regulations, your FedEx ID card must always be visible. Present your ID to the ramp agent or Jumpseat Administration representative in Memphis when checking in. Pilots are also required to present a current FedEx ID to the Captain when introducing themselves.
4. Jumpseating pilots should discuss access to the ramp and aircraft with the ramp agent. In most cases, you are required to be escorted by a Federal Express ramp employee or an operating pilot. If you have any doubts about local procedure, wait to be escorted.
5. Domestically, jumpseating pilots are responsible for moving their baggage to and from the aircraft. At some international stations, provisions may exist for the handling of jumpseater baggage.
6. Normal jumpseat courtesy dictates checking in and introducing yourself to the Captain and crew and requesting permission to jumpseat.

Duties and Taxes

Jumpseaters must not utilize jumpseating to avoid the declaration requirements associated with duties and taxes (U.S. Customs and related regulations).

Dangerous Goods

You are prohibited from carrying Dangerous Goods on board the aircraft in your carry-on baggage. Pilots with specific questions can refer to the Dangerous Goods Manual or contact Dangerous Goods Administration at 1.901.434.9544, 8 a.m.-5 p.m. – CT, Monday – Friday. — See FOM 10.17.

Restricted/Prohibited Items

TSA regularly updates the list of restricted and prohibited items. A current list can be found on pilot.fedex.com under the security tab. See FOM 13.12.

Carriage of Weapons

1. Please review carefully FOM section 13.17 regarding the carriage of unauthorized firearms or weapons on FedEx property.
2. For FFDOs, see in addition FOM 13.19.

3. No firearms or weapons are permitted on Company property, in Corporate aircraft, in Company vehicles, or in Corporate buildings unless authorized by Corporate Security. Where federal, state, or local laws impose different or additional requirements, the Company will abide by governing law. Possessing or carrying unauthorized firearms or weapons on Company property may result in discipline, up to and including termination, subject to Sections 19 and 21 of the collective bargaining agreement.

In-Flight Catering

See Section 5.E. of the collective bargaining agreement.

The Flight

1. The Captain has the ultimate responsibility for safe operation of the aircraft and for maintaining the schedule. The Captain is in complete command of the aircraft, which means he/she has complete authority over the crew and the jumpseating passengers on the flight from the time the jumpseaters report for the flight until the flight is terminated. The Captain's orders shall receive prompt compliance. The Captain's command authority means complete discretion in the assignment or reassignment of seats for all personnel other than assigned pilots, and he/she may exclude, deboard, or relocate anyone who presents potential danger to the safety of the flight.
2. Below 10,000 MSL, jumpseaters must maintain sterile cockpit procedures.
3. Jumpseaters must store bag(s) as directed by the operating crew.
4. All pilots are expected to be familiar with the operation of the emergency equipment on the aircraft on which they are jumpseating. If any questions arise, request a safety briefing from the operating crew.
5. All personal portable radio signal transmitting devices except hearing aids and heart pacemakers shall not be operated during all phases of operation except cruise flight. During cruise, jumpseaters may use some devices with the Captain's permission. Certain electronic devices are not permitted to be operated from block-out to block-in. Specifics are detailed in the FOM.

Post-Flight

1. Before exiting the aircraft, ensure all safety equipment is in its proper position.
2. A "Thank you" to the operating crew is always appropriate.

Safety

Never take action to operate any emergency equipment unless directed by an operating pilot. Exceptions to this rule are:

1. When acting as an additional crewmember performing duties as directed or briefed by the Captain.
2. When a pilot is unavailable, and the situation dictates immediate action on your part.
3. During a loss of aircraft pressurization, which requires that you put on your oxygen mask without delay.
4. Any use of the cockpit doorbell code by a jumpseater is considered an emergency access request in accordance with the pilot.fedex.com website unless briefed otherwise by the crew.

Reporting of Jumpseat Abuses

1. Pilots encountering problems or involved in alleged abuses while jumpseating on Federal Express aircraft should utilize the ALPA DART system to communicate the event to your ALPA jumpseat representative. The DART system is available on the FDX ALPA website.
2. The ALPA Jumpseat Committee and FedEx Flight Management will investigate the alleged abuses and provide feedback utilizing the provisions of Section 26.J.1. of the November 2, 2015, Agreement.

Reciprocal Jumpseat Agreements

1. FedEx management, in conjunction with the ALPA Jumpseat Committee, will enter reciprocal jumpseat agreements with other FAR part 121, part 135, and foreign carriers on behalf of FedEx flight pilots. ALPA Jumpseat Committee shall have the opportunity to recommend additions, deletions, or changes to the reciprocal agreements. The Company shall consult with ALPA before approving or terminating any reciprocal jumpseat agreements with other carriers. Reciprocal access to cockpit jumpseats is available only through CASS, which is described more fully in FOM 13.20.
2. Both the ALPA and the Company shall make available to the crew force the list of air carriers that have reciprocal jumpseat agreements with FedEx.
3. FedEx pilots jumpseating on other carriers are expected to always conduct themselves in a courteous and professional manner. Pilots are expected to know and follow the procedures established by the individual carriers. Information on the requirements of specific carriers can be found on the Jumpseat page of the ALPA website: www.alpa.org/fdx/jumpseat, and on the pilot.fedex.com website under the tab for “Reciprocal CASS Airlines.”
4. Pilots encountering problems or involved in alleged abuses while jumpseating on a reciprocal airline may use the ALPA DART system to communicate the event to your ALPA jumpseat representative. The DART system is available on the FDX ALPA website.

OTHER BENEFITS AND SERVICES

In addition to the major benefit programs for health, disability, life insurance, and retirement, Federal Express provides a variety of other benefits and services to complete your total benefits package.

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OTHER BENEFITS AND SERVICES

In addition to the benefit plans, programs, and services described in this section, FedEx Express also has compensation policies that are often seen as benefits. These policies may include vacations, holidays, and jury duty, military, and personal and bereavement absences, as described in the Collective Bargaining Agreement.

Note, the programs described in this section are available to pilots on the same terms and conditions as available to other employees of the Company.

Accident Insurance

Accident insurance helps you stay ahead of the medical and out-of-pocket expenses that add up so quickly after an accident injury—not just for emergency treatment, hospital stays, and medical exams, but for other expenses you may face such as transportation and lodging needs.

For additional information about this plan, visit http://metlife.com/fedex or www.metlife.com/mybenefits or call 1.844.463.8339.

Adoption Assistance

FedEx offers an Adoption Assistance benefit for active, and permanent full-time and part-time U.S. employees who have completed at least one year of continuous service with FedEx.

LifeCare®, our WorkLife Balance vendor, administers the Adoption Assistance benefit. This benefit will reimburse eligible employees* up to $5,000 for one child per calendar year (up to $15,000 lifetime maximum) for approved adoption expenses. Once an adoption is finalized, an eligible employee may submit a written claim to LifeCare.

IMPORTANT! A claim must be submitted within 90 days following the date that the adoption is finalized.** You are required to submit as much supporting documentation as possible at this time. **All claims submitted after the 90-day deadline will be denied for late filing.** If you have any concerns about meeting the requirements within 90 days (such as procuring a birth certificate or signed adoption order), please call LifeCare at 1.877.543.3339 to speak with a specialist BEFORE the 90-day deadline.

For more information about the benefit, including eligible and ineligible expenses, log on to https://worklifebalance.lifecare.com. New users can click on the New Users Sign-Up link and enter “fedex” as the registration code, then enter a FedEx employee ID adding leading zeroes to equal 10 digits.

* If you and your spouse both work at FedEx, only one of you can use the benefit.

** A fraudulent misstatement or omission of fact may be used to deny claims for benefits. If the eligible employee resides in a jurisdiction that requires court approval of adoptions, the Plan will not consider an adoption finalized until the date the court issues a final adoption order, decree, or judgment. If an eligible employee adopts an eligible child from another country in an international adoption, the Plan will not recognize the adoption as finalized until the local legal adoption requirements of the jurisdiction in which the eligible employee resides have been met.

LifeCare can also assist employees with navigating the adoption process by providing information and resources. Contact a LifeCare Adoption Specialist at 1.877.543.3339 for additional information on the adoption benefits.

Allstate Identity Protection

Your identity is made up of more than your Social Security number and credit score. That's why Allstate Identity Protection does more than monitor your credit reports. They help you look after your online activity, from financial transactions to what you share on social media. And if fraud occurs, their $1 million identity theft insurance policy and remediation experts have you covered.

For more information on Allstate Identity Protection, contact Allstate at 1.800.789.2720 or visit www.myaip.com/fedex.

Catalog Store

The Company Store Online—FedEx Collection (formerly Catalog Store)

The FedEx Company Catalog Store offers a variety of merchandise for personal and business use. Each of our stores carries the full line of products available through The FedEx Collection catalogs, as well as additional merchandise specific to their local markets. The selection of merchandise includes apparel, gifts, and awards, as well as a full line of business and travel accessories. Pilots receive a 10% discount on all purchases with a valid FedEx ID. Shop online at www.bdasites.com/fedexcollection.

Credit Association

You and your immediate family (spouse, children, parents, siblings, and grandparents) may join the FedEx Employees Credit Association. You are eligible to join as soon as FedEx issues you an employee number. For the most current information on products and services available through the FedEx Employees Credit Association, you should contact the Credit Association directly at 1.800.228.8513, or 1.901.344.2500 in the Memphis area, or visit the website at https://fecca.com/.

Critical Illness

Provides a lump-sum payment if you or a covered family member is diagnosed with a covered medical condition. Payments will be made directly to you, not to the doctors, hospitals, or other health care providers. You will receive a check mailed directly to your home to spend as you see fit.

For additional information about this plan, visit metlife.com/fedex or www.metlife.com/mybenefits or call 1.800.GET.MET8 (1.800.438.6388).

Employee Reduced-Rate Shipping

FedEx Express offers Express employees and eligible retirees reduced rates for personal shipping. For more information, contact FedEx Express Revenue Services at 1.800.622.1147 or via email at EmployeeDiscountShipping@corp.ds.fedex.com.

Hospital Indemnity

Provides you with a lump-sum payment when you or your family member is admitted to the hospital. A flat amount is usually paid for a hospital admission and a per-day amount for your entire hospital stay. The payment is made directly to you and is in addition to any other insurance you may have.

For additional information about this plan, visit metlife.com/fedex or www.metlife.com/mybenefits or call 1.844.463.8339.

MetLife Legal Plans

Pilots and retirees may purchase the MetLife Legal Plans. With MetLife Legal Plans, you get access to experts who can assist you with a broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft, or caring for aging parents. For additional information about this plan, visit metlife.com/fedex or www.metlife.com/mybenefits, or call 1.844.463.8339.

LifeCare WorkLife Balance and Discount Program

Need help managing work and life? LifeCare is the WorkLife Balance program administrator that provides guidance, personalized resources, and discounts to get you help when you need it. LifeCare is available to all employees and their dependents on the first day of active employment, regardless of coverage. FedEx provides this benefit at no cost to you.
Whatever life throws at you, LifeCare can help—24 hours a day. The LifeCare website provides interactive tools, information, and resources on the following:

- Child Care & Parenting
- Senior Care & Aging
- Adoption Assistance
- Education
- Financial Concerns
- Health & Wellness
- Daily Needs (relocation, pet care, financial, home improvement, travel, etc.)
- Personal guidance and educational materials to help you understand your options

For more information, log on to https://worklifebalance.lifecare.com. New users can click on the New Users Sign-Up link and enter "fedex" as the registration code, then enter a FedEx employee ID adding leading zeroes to equal 10 digits.

LifeCare also includes LifeMart, an online discount center with access to discounts on a selection of products and services, as well as FedEx exclusive discounts. To access LifeMart, log in to the LifeCare website and then click on the LifeMart link in the top left corner.
To contact LifeCare, 24 hours a day, call 1.877.543.3339, or go to the LifeCare website.

Group Long-Term Care Insurance (LTCI)

(As of January 1, 2013, this program is closed to new enrollees.)

Long-term care insurance helps pay for services provided by a nursing home or a professional home care agency when you or your covered family members are no longer able to care for yourselves independently.

For the most current information, call MetLife at 1.844.463.8339.

Auto & Home Group Insurance Program (Voluntary Personal Property Insurance)

Gives you access to special savings on auto, home, and renter insurance. You can elect coverage anytime throughout the year and do not have to wait for your current policies to renew to switch. Two vendor options allow for choice and best pricing.

For the most accurate comparison, please have your current policies with you when you call. Farmers: Call 1.844.463.8339 or visit http://www.metlife.com/fedex.

Travelers: Call 1.866.903.5054 or visit www.travelers.com/fedex.

Pet Insurance

Coverage for major medical expenses, vaccinations, spay/neuter, flea/tick, dental cleanings, etc. You can elect coverage anytime throughout the year.

For more information call 1.877.738.7874, or visit www.petinsurance.com/fedex.

Tuition Assistance Program

The Tuition Assistance Program encourages you to get additional education and training to enhance your career development at FedEx.

Please see the Tuition Assistance website on the FedEx intranet (https://home.fedex.com/corporate, keyword: tuition) for more information about the program.

WHAT TO DO WHEN – KEY POINTS

Various life events affect your continuing coverage under the benefit plans described in this book.

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Please see the 'Who to Call" Section in this Pilot Benefit Book for specific phone numbers, addresses, and websites for benefit programs listed.

Continuing Coverage After Employment Termination if Not Retiree Health Eligible

If you terminate employment and do not meet the age and service requirements for Retiree Health Coverage, your coverage under most plans end. The provisions are described under each plan. See key points below.

Plan or Program	Coverage
Medical Benefit, includes mental health/substance abuse and prescription drugs	Coverage ends and payroll deductions stop. You can elect medical coverage for yourself and eligible dependents under the Federal Express Corporation Group Health Plan for Pilots through COBRA.
Dental Benefit	Same as medical benefit.
Vision Benefit and Advantage Eye Care Program	Same as medical benefit.
Long-Term Disability (LTD), includes Supplementary Disability Benefit	Coverage ends.
Basic Life Insurance	Coverage ends. Conversion available. 31-day election grace period.
Pilot Optional Life Insurance Spouse Optional Life Insurance Child Optional Life Insurance	Coverage ends. Portability and conversion options may be available. 31-day election grace period.
Basic Accidental Death and Dismemberment (AD&D)	Coverage ends. Conversion to an individual policy available. 31-day election grace period.
Optional Accidental Death and Dismemberment (AD&D)	Coverage ends. Conversion to an individual policy available. 31-day election grace period.
Business Travel Accident	Coverage ends.
Pension Plan	If vested, may receive monthly benefits as early as age 55 (reduction for early benefit commencement).
Pilots' Retirement Savings Plan (PRSP)	Distributions available or generally can be deferred until age 72.
Health Savings Account (HSA)	Company contributions stop. The HSA will be converted to a non-sponsored account.
Health Reimbursement Account (HRA)	Company credits stop. The HRA will be converted to a Spend Down HRA.
Dependent Care Flexible Spending Account (FSA)	Payroll deductions stop. Reimbursement for eligible expenses incurred prior to termination must be filed with HealthEquity by March 31 of the following year.
Health Care Flexible Spending Account (FSA): Full Purpose and Limited Purpose	Payroll deductions stop. Reimbursement for eligible expenses incurred prior to termination must be filed with HealthEquity by March 31 of the following year or you can elect to continue participation for the remainder of the calendar year through COBRA using after-tax dollars. Amounts remaining in your FSA at the end of the calendar year are not available for carryover.

Plan or Program	Coverage
All Voluntary Benefits	Payroll deductions stop. May continue coverage by converting to home billing. Call provider directly for more details.
Group Long-Term Care Insurance (LTCI) (As of Jan. 1, 2013, this Plan was closed to new enrollees)	Payroll deductions stop. May continue coverage by converting to home billing. Call provider directly for more details.

Continuing Coverage After Transfer to a Non-Pilot Position

If you transferred to a non-pilot position within FedEx Express on or after November 2, 2015, and your participation in FedEx Express benefit programs is no longer provided under the terms of the Agreement, in general, your eligibility to participate in the FedEx Express benefit plans will depend upon your employment status. You should refer to the most current Your Employee Benefits book and Retirement website for non-pilots for a full discussion of benefits available to non-pilot personnel.

Continuing Coverage After Retirement

You are eligible for most of the retiree benefits described in this section if you retire or terminate employment with the Company at age 55 or older and have the required years of service for eligibility for a particular benefit. If you contemplate returning to work at FedEx Express or another FedEx Company and you are eligible for Retiree Health Coverage, you must elect coverage within the appropriate timeframe. Retiree Health Coverage can be deferred if the pilot is eligible for coverage as an active employee under a FedEx health plan or enrolled in COBRA, but Retiree Health Coverage must be deferred or elected timely.

The provisions are described under each plan. See key points below.

Plan or Program	Coverage
Medical Benefit, includes mental health/substance abuse and prescription drugs	Payroll deductions stop. If pre-65, you and your eligible dependents may enroll in the Federal Express Corporation Retiree Group Health Plan for Pilots. Or elect medical coverage under the Federal Express Corporation Group Health Plan for Pilots through COBRA. You may be eligible to defer retiree health. Call PBA at 1.866 795.6353 for more information. If you or your spouse are age 65 or older and meet the age and service requirements for the Federal Express Corporation Retiree Group Health Plan for Pilots, you and/or your spouse may participate in ALPA's FedEx Pilot's Post Medicare Retiree Premium Reimbursement Plan (PRP).
Dental Benefit	Same as medical benefit.
Vision Benefit and Advantage Eye Care Program	Same as medical benefit.

Plan or Program	Coverage
Long-Term Disability (LTD), includes Supplementary Disability Benefit	Coverage ends.
Basic Life Insurance	Coverage ends. Conversion available. 31-day election grace period.
Pilot Optional Life Insurance Spouse Optional Life Insurance Child Optional Life Insurance	Coverage ends. If eligible, Retiree Optional Life may be available along with conversion. 31-day election grace period.
Basic Accidental Death and Dismemberment (AD&D)	Coverage ends. Conversion available. 31-day election grace period.
Optional Accidental Death and Dismemberment (AD&D)	Coverage ends. Conversion available. 31-day election grace period.
Business Travel Accident	Coverage ends.
Pension Plan	If vested, may receive monthly benefits as early as age 55 (reduction for early benefit commencement).
Pilots' Retirement Savings Plan (PRSP)	Distributions available or generally can be deferred until age 72.
Health Savings Account (HSA)	Company contributions stop. The HSA will be converted to a non-sponsored account.
Health Reimbursement Account (HRA)	Company credits stop. The HRA will be converted to a Spend Down HRA.
Dependent Care Flexible Spending Account (FSA)	Payroll deductions stop. Reimbursement for eligible expenses incurred prior to retirement must be filed by March 31 of the following year.
Health Care Flexible Spending Account (FSA): Full Purpose and Limited Purpose	Payroll deductions stop. Reimbursement for eligible expenses incurred prior to retirement must be filed by March 31 of the following year or you can elect to continue participation for the remainder of the year through COBRA using after-tax dollars. Amounts remaining in your FSA at the end of the calendar year are not available for carryover.
All Voluntary Benefits	Payroll deductions stop. May continue coverage by converting to home billing. Call provider directly for more details.
Group Long-Term Care Insurance (LTCI) (As of Jan. 1, 2013, this Plan is closed to new enrollees)	Payroll deductions stop. May continue coverage by converting to home billing.

Important Information to Understand Prior to Retirement

- **If Eligible for Retiree Health**
  Once PBA receives notification of your retirement, an email containing important retiree health information will be sent to you.
- **Prescriptions**
  Prior to your retirement date, you should ensure routine prescription(s) are filled for you and your covered dependents to accommodate at least two to three weeks after

retirement. This will provide adequate time to receive your Retiree Health Coverage communications and make your election.

- **Default Enrollment in Medical, Dental, and/or Vision Plan Options**
  Eligible retired pilots and/or eligible dependents are assigned default plans. The retiree plans will be in effect the day after your retirement date. You will have an enrollment period and be allowed to change your default options/tiers, if applicable.
- **Retiree Health Coverage Communications**
  Your Retiree Health Coverage communications will be sent via FedEx 2-day delivery to your home address in the HR system. Enclosed will be a letter providing an overview, a deadline to make an election, and instructions for accessing our benefits website fedexpilots.bswift.com.
- **Failure to Pay**
  If you fail to pay by the deadline indicated in your Retiree Health Letter, Retiree Health Coverage will be terminated retroactive to the day after your retirement; you will be responsible for any claims incurred following retirement and you will be unable to re-enroll. You must go through the enrollment process even if you wish to remain in the default options.
- **Maintain Contact Information**
  Maintain your address through fedexpilots.bswift.com to ensure receipt of billing invoices or benefit communications. If moving to Hawaii, you may have new medical plan options to choose from.
  Enter a personal email address to ensure receipt of electronic communications.
- **Medicare Age**
  On your retirement date, if you and/or your spouse are eligible for Medicare due to attaining age 65, the individual who is Medicare Age eligible or older will not be eligible for Retiree Health Coverage. You may be eligible to participate in ALPA's FedEx Premium Reimbursement Plan (PRP).
- **Defer Retiree Health Coverage**
  If you elect to defer your Retiree Health Coverage, you must notify Pilot Benefits Administration (PBA) by the election deadline to avoid retro-termination of coverage and claim liability.
- **Vacation**
  If you go on vacation immediately after your retirement, you should make arrangements to have your Retiree Health communications forwarded to you, so you can make your election by your enrollment deadline.
- **COBRA**
  You will receive a COBRA offer, separate from your Retiree Health Coverage letter, offering you the opportunity to elect pilot medical, dental, and/or vision coverage under the Federal Express Corporation Group Health Plan for Pilots. If you meet the age and service requirements for Retiree Health Coverage, you can defer your Retiree Health Coverage and elect COBRA coverage for up to 18 months by paying the full active cost, plus 2%, or you can choose to elect Retiree Health Coverage. If you are participating in the Health Care FSA, you will be offered the opportunity to continue the coverage with after-tax dollars through the end of the calendar year in which you retire. If you are going to elect to participate in Retiree Health, you do not need to take any action on COBRA.

- **Retiree Health Coverage Cancellation**
  If you elect Retiree Health Coverage, you can cancel it at any time, but you will not have the opportunity to enroll at a later date.

- **Pension Benefits**
  Contact the Retirement Service Center at 1.855.604.6221 or go online at retirement.fedex.com at least 30 days (but no earlier than 90 days) prior to your pension benefit commencement date to request a retirement kit. Contact Fidelity at 1.833.383.3339 or go online at netbenefits.com after your retirement to request a distribution of your PRSP, if desired.

If you contemplate returning to work at FedEx Express or another FedEx Company, you should take the following steps:

1. You should promptly contact Fidelity and/or the Retirement Service Center for information on receiving plan distributions or commencing pension benefits. If a pilot does not commence receipt of distribution/benefits BEFORE returning to work, the pilot may not be able to receive distributions/benefits until a subsequent termination of employment.
2. Pilots eligible for Retiree Health Coverage must elect coverage by the deadline provided in their Retiree Health Letter. Retiree Health Coverage has to be deferred if the pilot is eligible for coverage as an active employee or eligible dependent under a FedEx health plan, but Retiree Health Coverage must be elected in a timely manner.

Continuing Coverage for Your Survivors If You Die While an Active Pilot

If you die while an active FedEx Express pilot, your eligible survivors may be entitled to continue some of your benefits. The provisions are described under each plan. See key points below.

Plan or Program	Coverage
Medical Benefit, includes mental health/substance abuse and prescription drugs	Dependent coverage can be continued under either: • If Retiree Health eligible: a. Retiree Health, OR b. COBRA at the active pilot rates for 24 months, followed by up to 36 months of COBRA at the full COBRA rate. If selecting this option, you must call Pilot Benefits Administration to defer Retiree Health. At the end of COBRA, you may be eligible to enroll in Retiree Health. • If **not** Retiree Health eligible, you may enroll in COBRA at the active pilot rates for 24 months, followed by up to 36 months of COBRA at the full COBRA rate.
Dental Benefit	Same as medical benefit.
Vision Benefit and Advantage Eye Care Program	Same as medical benefit.

Plan or Program	Coverage
Spouse Optional Life Insurance Child Optional Life Insurance	Coverage ends. There is a 31-day election grace period for dependents to elect portability, if eligible, or conversion coverage.
Optional Accidental Death and Dismemberment (AD&D)	Family coverage continues for 18 months, at no cost following the pilot's accidental death. Dependents can elect individual coverage after 18 months of free coverage.
Pension Plan (including the former Flying Tiger Line (FTL) Fixed Pension Plan)	If the Pilot was vested on the date of death, the surviving spouse may be eligible to receive part of the benefit based on the Pilot's years of credited service for benefit accrual and average earnings.
FTL Variable Annuity Pension Plan for Pilots	Surviving spouse of a former FTL Pilot may be eligible for a death benefit from the Plan.
Pilots' Retirement Savings Plan (PRSP)	Distributions available to beneficiary(ies).
Health Savings Account (HSA)	Company contributions stop. The HSA will be converted to a non-sponsored account. Ownership of the HSA will be passed to the designated account beneficiary on file at HealthEquity.
Health Reimbursement Account (HRA)	Company credits stop. The HRA will be converted to a Spend Down HRA for use by the eligible spouse and eligible dependents under age 27.
Dependent Care Flexible Spending Account (FSA)	Reimbursement for eligible expenses incurred prior to pilot's death must be filed with HealthEquity by March 31 of the year following pilot's death.
Health Care Flexible Spending Account (FSA): Full Purpose and Limited Purpose	Reimbursement for eligible expenses incurred prior to pilot's death must be filed with HealthEquity by March 31 of the year following pilot's death, or you can elect to continue participation for the remainder of the year through COBRA using after-tax dollars. Amounts remaining in your FSA at the end of the calendar year are not available for carryover.
All Voluntary Benefits	Spouse may continue coverage by making payments directly to provider. Contact provider for more detail.
Group Long-Term Care Insurance (LTCI) (As of Jan. 1, 2013, this Plan was closed to new enrollees)	Other enrolled family members may continue coverage by making premium payments directly to MetLife.

Continuing Coverage for Your Survivors If You Die After You Retire

If you die after your retirement from FedEx Express, your eligible survivors may be entitled to continue the following benefits. The provisions are described under each plan. See key points below.

Plan	Coverage
Medical Benefit, includes mental health/substance abuse and prescription drugs	If the retiree was covered under the Federal Express Corporation Retiree Group Health Plan for Pilots, dependent coverage continues based on eligibility.

Plan	Coverage
Dental Benefit	Same as medical benefit.
Vision Benefit and Advantage Eye Care Program	Same as medical benefit.
Retiree Optional Life Insurance	Covered dependents are eligible for conversion benefits.
Pension Plan	If selected at retirement, beneficiary receives benefits in accordance with the specific provisions of the Plan.
Pilots' Retirement Savings Plan (PRSP)	Distribution available to beneficiary.
Non-Sponsored Health Savings Account (HSA)	Ownership will be passed to the account beneficiary on file.
Spend Down Health Reimbursement Account (HRA)	The Spend Down HRA may be used by the spouse and eligible dependents under age 27.
Pre-Medicare Retiree HRA	The HRA will remain in the deceased pilot's name. Remaining HRA funds will be available for use by the spouse and eligible dependents under age 27.
All Voluntary Benefits	Spouse may continue coverage by making payments directly to provider. Contact provider for more detail.
Group Long-Term Care Insurance (LTCI) (As of Jan. 1,2013, this Plan was closed to new enrollees)	Other enrolled family members may continue coverage by making premium payments directly to MetLife.

Coverage During a Paid Leave of Absence (Disability or Workers' Compensation)

During the time that you are using your sick bank, benefits continue as if you were an active pilot. If you have a paid leave of absence (Disability or Workers' Compensation), some benefit coverages continue, such as medical, dental, and/or vision benefits. Income protection is described in "Long-Term Disability (LTD) Plan for Pilots." The provisions are described under each plan. See key points below.

Plan	Coverage
Medical Benefit, includes mental health/substance abuse and prescription drugs	Coverage may continue as if you were active. You will have 31 days following the leave of absence (LOA) start date to make relevant changes to your benefits and coverage tiers (such as waiving coverage or dropping dependents). Rates will remain the same as if you were active. For the first 90 days of LOA, FedEx pays your portion of the premiums on your behalf and accumulates the premium amounts as arrears. Upon return from LOA (or if issued any

Plan	Coverage
	checks through FedEx Payroll while on LOA), you will pay back the arrears in small increments. If you remain on LOA for more than 90 days, bswift will mail a monthly invoice to your home address in the HR system. **FAILURE TO PAY WILL RESULT IN COVERAGE TERMINATION.**
Dental Benefit	Same as medical benefit.
Vision Benefit and Advantage Eye Care Program	Same as medical benefit.
Long-Term Disability (LTD)	If eligible, coverage may continue.
Basic Life Insurance	Coverage continues at no cost.
Pilot Optional Life Insurance Spouse Optional Life Insurance Child Optional Life Insurance	Same as medical benefit.
Basic Accidental Death and Dismemberment (AD&D)	Coverage continues at no cost.
Optional Accidental Death and Dismemberment (AD&D)	Same as medical benefit.
Business Travel Accident	Coverage ends but is reinstated when you return to active employment status.
Pension Plan	You may continue to earn service credit during paid leaves.
Pilots' Retirement Savings Plan (PRSP)	Distributions may be available on total disability. Contributions through FedEx Payroll stop.
Health Savings Account (HSA)	Employer contributions will continue. If you are contributing to your HSA through payroll deductions, your contributions will stop immediately. If you fail to pay your medical premiums following 90 days of leave, your medical coverage is cancelled and the HSA Employer contribution will cease.
Health Reimbursement Account (HRA)	Employer credits will continue. If you fail to pay your medical premiums following 90 days of leave, your medical coverage will be cancelled and the HRA credits will cease.
Dependent Care Flexible Spending Account (FSA)	Payroll deductions stop. You may continue to send eligible claims for dependent care expenses incurred prior to your leave start date. Claims may be sent directly to HealthEquity. When you return to work, if you do not re-enroll within 31 days, you are not allowed to enroll for the rest of the calendar year, unless you have a Change in Family Status event and make your election within 31 days following the event date. If you make a Dependent Care FSA election during Annual Benefits Enrollment, but you are on a leave of absence as of January 1 of the new plan year, your election amount will be set to zero. You will have 31 days following your return to work to re-enroll if you return in the Plan year following the year your leave commenced. Otherwise, you must wait until the next Annual Benefits Enrollment to enroll.

Plan	Coverage
Health Care Flexible Spending Account (FSA): Full Purpose and Limited Purpose	Payroll deductions stop. Your Health Care FSA contributions will automatically accrue for the first 90 days of your LOA. If your leave extends beyond 90 days, your Health Care FSA election will be cancelled on the 91st day of leave, and you will be eligible to continue participation through COBRA using after-tax dollars. Any eligible health care expenses incurred prior to the 91st day of leave are reimbursable and must be filed by March 31 of the following year. If you return to work during the same calendar year, the amount accrued for the first 90 days will be deducted from your check on a prorated basis. If you wish to re-enroll in the Health Care FSA, you may re-elect coverage within 31 days following the date you return to work, in accordance with Plan rules. Otherwise, you cannot re-enroll until the next Annual Benefits Enrollment. If you make a Health Care FSA election during Annual Benefits Enrollment, but you are on LOA as of January 1 of the new plan year, your election amount will be set to zero. You will have 31 days following your return to work to re-enroll if you return in the Plan year following the year your leave commenced. Otherwise, you must wait until the next Annual Benefits Enrollment to enroll.
All Voluntary Benefits	Payroll deductions stop. May continue coverage by converting to home billing.
Group Long-Term Care Insurance (LTCI) (As of Jan. 1, 2013, this Plan was closed to new enrollees)	Payroll deductions stop. May continue coverage by converting to home billing.
Tuition Assistance Program	Coverage may continue for eligible courses.

Coverage During an Unpaid Leave of Absence (Personal, Medical, etc.)

If you have an unpaid leave of absence, some of your FedEx Express benefits can be continued. The effect of an unpaid leave of absence on your benefit plan participation is described here. See key points below.

Plan	Coverage
Medical Benefit, includes mental health/substance abuse and prescription drugs	Coverage may continue as if you were active. You will have 31 days following the leave of absence (LOA) start date to make relevant changes to your benefits and coverage tiers (such as waiving coverage or dropping dependents). Rates will remain the same as if you were active. For the first 90 days of LOA, FedEx pays your portion of the premiums on your behalf and accumulates the premium amounts as arrears. Upon return from LOA (or if issued any

Plan	Coverage
	checks through FedEx Payroll while on LOA), you will pay back the arrears in small increments. If you remain on LOA for more than 90 days, bswift will mail a monthly invoice to your home address in the HR system. **FAILURE TO PAY WILL RESULT IN COVERAGE TERMINATION.**
Dental Benefit	Same as medical benefit.
Vision Benefit and Advantage Eye Care Program	Same as medical benefit.
Long-Term Disability, includes Supplementary Disability Benefit	Coverage ends but is reinstated when you return to active employment status.
Basic Life Insurance	Coverage continues at no cost.
Pilot Optional Life Insurance Spouse Optional Life Insurance Child Optional Life Insurance	Same as medical.
Basic Accidental Death and Dismemberment (AD&D)	Coverage continues at no cost.
Optional Accidental Death and Dismemberment (AD&D)	Same as medical.
Business Travel Accident	Coverage ends but is reinstated when you return to active employment status.
Pension Plan	Years of credited service generally do not include periods of unpaid leaves of absence.
Pilots' Retirement Savings Plan	Distributions may be available on total disability. Participants may be eligible for suspension of loan repayments while on leave. Hardship or in-service withdrawals may be available. Loans and distributions (other than a total disability distribution) are not available. Contributions through FedEx Payroll stop.
Health Savings Account (HSA)	Employer contributions will continue; if you are contributing to your HSA through payroll deductions, your contributions will stop immediately. If you fail to pay your medical premiums following 90 days of leave, your medical coverage is cancelled, and the HSA Employer contribution will cease.
Health Reimbursement Account (HRA)	Employer credits will continue. If you fail to pay your medical premiums following 90 days of leave, your medical coverage will be cancelled and the HRA Employer credits will cease.

Plan	Coverage
Dependent Care Flexible Spending Account (FSA)	Payroll deductions stop. You may continue to send eligible claims for dependent care expenses directly to HealthEquity in accordance with Plan rules. When you return to work, if you do not re-enroll within 31 days, you are not allowed to enroll for the rest of the calendar year, unless you have a Change in Family Status event and make your election within 31 days following the event date. If you make a Dependent Care FSA election during Annual Benefits Enrollment, but you are on a leave of absence as of January 1 of the new plan year, your election amount will be set to zero. You will have 31 days following your return to work to re-enroll if you return in the Plan year following the year your leave commenced. Otherwise, you must wait until the next Annual Benefits Enrollment to enroll.
Health Care Flexible Spending Account (FSA): Full Purpose and Limited Purpose	Payroll deductions stop. You may continue to send eligible claims for health care expenses directly to HealthEquity in accordance with Plan rules. Your Health Care FSA contributions will automatically accrue for the first 90 days of your approved leave of absence. If your leave extends beyond 90 days, your Health Care FSA election will be cancelled on the 91st day of leave and you will be eligible to elect to continue participation through COBRA using after-tax dollars. Any eligible health care expenses incurred prior to the 91st day of leave are reimbursable and must be filed by March 31 of the following year. If you return to work during the same calendar year, the amount accrued for the first 90 days will be deducted from your check on a prorated basis. If you return to work in the same calendar year the leave commenced, and you wish to re-enroll in the Health Care FSA, you may re-elect coverage within 31 days following the date you return to work, in accordance with Plan rules. Otherwise, you cannot re-enroll until the next annual enrollment. If you make a Health Care FSA election during Annual Benefits Enrollment, but you are on a leave of absence as of January 1 of the new plan year, your election amount will be set to zero. You will have 31 days following your return to work to re-enroll if you return in the Plan year following the year your leave commenced. Otherwise, you must wait until the next Annual Benefits Enrollment to enroll.
MetLife Auto & Home Group Insurance Program (Voluntary Personal Property Insurance); All Voluntary Benefits	Payroll deductions stop. May continue coverage by converting to home billing.
Group Long-Term Care Insurance (LTCI) (As of Jan. 1, 2013, this Plan was closed to new enrollees)	Payroll deductions stop. May continue coverage by converting to home billing.
Tuition Assistance Program	Coverage ends.

Note: If termination or death occurs while on a leave of absence, see “Continuing Coverage After Employment Termination.”

Coverage During a Military Leave of Absence

If you are on a military leave of absence (MLOA), some of your FedEx Express benefits can be continued. The effect of an MLOA on your benefit plans is described here.

The effective date of active military service is the date of MLOA as shown in the HR System. The end of active military service is that date provided under Uniformed Services Employment and Reemployment Rights Act (USERRA). See key points below.

Plan	Coverage
Medical Benefit, includes mental health/substance abuse and prescription drugs	Coverage may continue as if you were active. You will have 31 days following the leave of absence (LOA) start date to make relevant changes to your benefits and coverage tiers (such as waiving coverage or dropping dependents). Rates will remain the same as if you were active. For the first 90 days of LOA, FedEx pays your portion of the contributions on your behalf and accumulates the contribution amounts as arrears. Upon return from LOA (or if issued any checks through FedEx Payroll while on LOA), you will pay back the arrears in small increments. If you remain on LOA for more than 90 days, bswift will mail a monthly invoice to your home address in the HR system. **FAILURE TO PAY WILL RESULT IN COVERAGE TERMINATION.**
Dental Benefit	Same as medical benefit.
Vision Benefit and Advantage Eye Care Program	Same as medical benefit.
Long-Term Disability (LTD), includes Supplementary Disability Benefit	Coverage ends effective the date of MLOA and will be reinstated upon your return to active work.
Basic Life Insurance	Coverage continues at no cost.
Pilot Optional Life Insurance Spouse Optional Life Insurance Child Optional Life Insurance	Same as medical benefit.
Basic Accidental Death and Dismemberment (AD&D)	Coverage continues at no cost.
Optional Accidental Death and Dismemberment (AD&D)	Same as medical benefit.
Business Travel Accident	Coverage ends but is reinstated when you return to active employment status.
Pension Plan	Your MLOA will be included in determining your years of credited service for eligibility, vesting, and benefit accrual if you return to employment within the period specified under federal law after the date you are released from active duty and have satisfied the requirements of USERRA. In the event of death during your MLOA, your accrued benefit will be based on your years of credited service for benefit accrual up to the

Plan	Coverage
	date of your death. If you are unmarried, no benefits are payable to a beneficiary. If you are married, a portion of your vested benefit will be paid monthly to your spouse. Your surviving spouse will receive a monthly pension based on your credited service and average earnings on your date of death. The benefit will be calculated as if you had chosen the 50% Joint and Survivor Annuity. Payment can begin on the first day of the month after: • Your date of death, if you die on or after your early retirement age, or • Your early retirement date if you die before you were eligible for early retirement.
Pilots' Retirement Savings Plan (PRSP)	If you return to employment and have satisfied the requirements of USERRA within the period specified after you are released from active duty, non-elective employer contributions will reflect the period of your military service. You may also make up any missed Pre-tax/401(k), Roth, After-tax, and if eligible, Catch-up and Roth Catch-up contributions. Make-up contributions may be made over a period that is three times the period of your military service, not to exceed five years. It is your responsibility to initiate any make-up contributions. If applicable, any contributions missed during your MLOA will be credited to your account within the time frame required by USERRA following your return to active work or the notification of your death is updated in the HR system. When a pilot returns from military leave, his crew position (and hence his crew status) is determined in accordance with the Collective Bargaining Agreement. If his crew status upon return is the same as the one he held when he went out on military leave, or if his new crew status is lateral, then no crew status change will be imputed. If the pilot selects an upgraded crew status, then the Company will use the following process: • The Company shall take no action on the upgraded crew status until the results of the pilot's attempt to train for his new crew status are known. • If the pilot fails training, then no crew status change will be imputed. • If the pilot successfully upgrades to his new crew status, then the Company will determine the imputed date for his new crew status by reference to the posting on the basis of which he was awarded his new crew status. His crew status will be deemed to have changed on the date the first junior pilot from that posting was activated into his crew status. For purposes of this analysis, junior pilots who are trained earlier than their seniority would have dictated, due to pilot requested training swaps, shall be considered as having activated in seniority order. If a pilot receives an imputed crew status change, then, from the date of his imputed crew status change forward, his imputed earnings will be increased by the same percentage as the percentage of increase in hourly rate owing to the crew status change. Your loan payments will be suspended while you are on MLOA. In order for an obligation or liability of a servicemember to be subject to the interest rate limitation set forth under the Servicemembers' Civil Relief Act, the servicemember shall provide to the Plan written notice

Plan	Coverage
	and a copy of the military orders calling the servicemember to military service and any orders further extending military service, not later than 180 days after the date of the servicemember's termination or release from military service. Upon receipt of written notice and a copy of orders calling a servicemember to military service, the Plan shall treat the debt in accordance with subsection (a) of the Servicemembers' Civil Relief Act, effective as of the date on which the servicemember is called to military service.
Health Savings Account (HSA)	Employer contributions will continue; if you are contributing to your HSA through payroll deductions, your contributions will stop immediately. If you fail to pay your medical premiums following 90 days of leave, your medical coverage is cancelled, and the HSA Employer contribution will cease.
Health Reimbursement Account (HRA)	Company credits to the HRA continue while on military leave. If you fail to pay your medical premiums following 90 days of leave, your medical coverage is cancelled, and the HRA Employer contribution will cease.
Dependent Care Flexible Spending Account (FSA)	Payroll deductions stop. You may continue to send eligible claims for dependent care expenses directly to HealthEquity in accordance with Plan rules. When you return to work, if you do not re-enroll within 31 days, you are not allowed to enroll for the rest of the calendar year, unless you have a Change in Family Status event and make your election within 31 days following the event date. If you make a Dependent Care FSA election during Annual Benefits Enrollment, but you are on a leave of absence as of January 1 of the new plan year, your election amount will be set to zero. You will have 31 days following your return to work to re-enroll if you return in the Plan year following the year your leave commenced. Otherwise, you must wait until the next Annual Benefits Enrollment to enroll.
Health Care Flexible Spending Account (FSA): Full Purpose and Limited Purpose	Payroll deductions stop. You may continue to send eligible claims for health care expenses directly to HealthEquity in accordance with Plan rules. Your Health Care FSA contributions will automatically accrue for the first 90 days of your military leave. If your leave extends beyond 90 days, your Health Care FSA election will be cancelled on the 91st day of leave and you will be eligible to elect to continue participation through COBRA using after-tax dollars. If you return to work within the same calendar year, the amount accrued for the first 90 days will be deducted from your check on a prorated basis. If you return to work in the same calendar year the leave commenced, and you wish to re-enroll in the Health Care FSA, you may re-elect coverage within 31 days following the date you return to work, in accordance with Plan rules. Otherwise, you cannot re-enroll until the next annual enrollment. If you make a Health Care FSA election during Annual Benefits Enrollment, but you are on a leave of absence as of January 1 of the new plan year, your election amount will be set to zero. You will have 31 days following your return to work to re-enroll if you return in the Plan year following the year your leave commenced. Otherwise, you must wait until the next Annual Benefits Enrollment to enroll.
All Voluntary Benefits	Payroll deductions stop. May continue coverage by converting to home billing.
Group Long-Term Care Insurance (LTCI)	Payroll deductions stop. May continue coverage by converting to home billing.

Plan	Coverage
(As of Jan. 1, 2013, this Plan was closed to new enrollees)	
Tuition Assistance Program	Coverage ends. You may be eligible for reimbursement for courses which began or ended during a leave. Courses which both began and ended during a leave are not eligible. You are not eligible for reimbursement if you are on leave during the entire course.

Note: You are responsible to keep contact information updated while on MLOA.

Generally speaking, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides that employees who return from a period of military service which does not exceed five years (or such longer period as may be required by the employee's military orders) will be restored to their previous employment position with such seniority, status, pay, and benefits that would have accrued if they had not left for military service.

In order to be afforded these protections under USERRA, affected employees must make application for reemployment and return to employment with the employer:

1. If the period of military service is less than 31 days, no later than the first full regularly scheduled work period on the first full calendar day following the completion of the period of military service (allowing eight hours for transportation from the place of military service to the employee's residence); or
2. If the period of military service is more than 30 days but less than 181 days, no later than 14 days after the completion of the period of military service; or
3. If the period of military service is greater than 180 days, no later than 90 days following the completion of the period of military service.

Coverage During an Unpaid Suspension

If you are on an unpaid suspension, some of your benefits can be continued. The effect of a suspension on your benefit plan participation is described here. Unless otherwise noted, these discussions apply to suspensions without pay. See below key points.

Plan	Coverage
Medical Benefit, includes mental health/substance abuse and prescription drugs	Coverage may continue as if you were active. You will have 31 days following the suspension start date to make relevant changes to your benefits and coverage tiers (such as waiving coverage or dropping dependents). bswift will mail a monthly invoice to your home address in the HR system. You will be responsible for the full monthly costs - Company cost plus pilot cost - from the first day of suspension. **FAILURE TO PAY WILL RESULT IN COVERAGE TERMINATION.**
Dental Benefit	Same as medical benefit.
Vision Benefit and Advantage Eye Care Program	Same as medical benefit.

Plan	Coverage
Long-Term Disability (LTD), includes Supplementary Disability Benefit	Coverage ends but is reinstated when the suspension ends.
Basic Life Insurance	Coverage continues at no cost.
Pilot Optional Life Insurance Spouse Optional Life Insurance Child Optional Life Insurance	Same as medical.
Basic Accidental Death and Dismemberment (AD&D)	Coverage continues at no cost.
Optional Accidental Death and Dismemberment (AD&D)	Same as medical.
Business Travel Accident	Coverage ends but is reinstated when the suspension ends.
Pension Plan	Years of credited service generally do not include periods of unpaid suspension.
Pilots' Retirement Savings Plan (PRSP)	Distributions from the PRSP are not available until you terminate, retire, or meet the disability eligibility as defined under the provisions of the PRSP. You cannot take a loan from the PRSP while you are on suspension; however, you may take any available hardship or in-service withdrawals based on plan limitations.
Health Savings Account (HSA)	Company contributions continue, as long as you pay the full cost monthly from the first day of suspension billing. If you are contributing to your HSA through payroll deductions, your contributions will stop immediately. If you fail to pay your medical premiums while on suspension, your medical coverage is cancelled, and the HSA Employer contribution will cease.
Health Reimbursement Account (HRA)	Company credits continue, as long as you pay the full cost monthly from the first day of suspension billing. If you fail to pay your medical premiums while on suspension, your medical coverage is cancelled, and the HRA Employer contribution will cease.
Dependent Care Flexible Spending Account (FSA)	Payroll deductions stop. Reimbursement for eligible expenses incurred prior to suspension must be filed by March 31 of the following year.
Health Care Flexible Spending Account (FSA): Full Purpose and Limited Purpose	Payroll deductions stop. Reimbursement for eligible expenses incurred prior to suspension must be filed by March 31 of the following year. You will be eligible to elect to continue participation through COBRA using after-tax dollars.
All Voluntary Benefits	Payroll deductions stop. May continue coverage by converting to home billing.
Group Long-Term Care Insurance (LTCI) (As of Jan. 1, 2013, this Plan was closed to new enrollees)	Payroll deductions stop. May continue coverage by converting to home billing.
Tuition Assistance Program	You are not eligible for reimbursement.

CLAIMS AND APPEALS

When you use your FedEx benefit plans, you are initiating a claim with the plan administrator. In many cases, this claim is initiated and managed on your behalf, through your provider. In other cases, you must take action to file a claim. The plan administrator, in response to your claim, makes a determination about your benefits. If you disagree with the plan administrator's decision, you have the ability to appeal it through designated channels.

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Claim Administration

Benefit payments are made by the claims paying administrators. Below is a list of the plan benefits offered to you and the claims paying administrator for each plan benefit. See **Claims – Filing a Claim**, and **Eligibility Appeals – Filing an Appeal** later in this section, for more information on the claims and appeals process.

Plan	Claims Paying Administrator	Appeals
Medical Plan Options Active Pilots: CDHP Purple Plan CDHP Orange Plan Buy Up Plan Retired Pilots: CDHP Purple Plan CDHP Orange Plan Buy Up Plan High Deductible Plan	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007 1.866.406.0982 www.anthem.com/ca	***Send benefit appeals to:*** Anthem Grievances and Appeals P.O. Box 54159 Los Angeles, CA 90054 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Administration Appeals 3620 Hacks Cross Road Building B-2 Memphis, TN 38125-8800

Plan	Claims Paying Administrator	Appeals
Prescription Drug Active Pilots: CDHP Purple Plan CDHP Orange Plan Buy Up Plan Retired Pilots: CDHP Purple Plan CDHP Orange Plan Buy Up Plan High Deductible Plan	Retail, Mail Order, or Specialty Express Scripts, Inc. One Express Way St. Louis, MO 63121 www.express-scripts.com	***Send benefit appeals to:*** Express Scripts, Inc. Attn: Administrative Appeal Department P.O. Box 66587 St. Louis, MO 63166-6587 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Administration Appeals 3620 Hacks Cross Road Building B-2 Memphis, TN 38125-8800

Plan	Claims Paying Administrator	Appeals

Health Savings Account (HSA)
 	
Health Reimbursement Account (HRA)
 	
Flexible Spending Accounts (FSA)
• Health Care FSA
  • Full Purpose
  • Limited Purpose
 	
• Dependent Care Flexible Spending Account Plan (Dependent Care FSA)
 	
Pre-Medicare Retiree HRA
	HealthEquity
	15 West Scenic Pointe Drive, Suite 100
	Draper, UT 84020
	
	Customer Service:
	1.844.281.0925
	Fax Number:
	1.801.999.7829
	https://www.healthequity.com/
		Send benefit appeals to:
		HealthEquity
		15 West Scenic Pointe Drive, Suite 100
		Draper, UT 84020
		
		Send eligibility appeals to:
		FedEx Express Pilot Benefits Administration Appeals
		3620 Hacks Cross Road
		Building B-2
		Memphis, TN 38125-8800
		
		Send second level claims and eligibility appeals to:
		Pilot Fiduciary Appeals Committee
		3620 Hacks Cross Road
		Building B-2
		Memphis, TN 38125-8800

Dental Active and Retired Pilots	Cigna P.O. Box 188037 Chattanooga, TN 37422-8037 (Toll-free) In U.S.: 1.800.CIGNA24	***Send benefit appeals to:*** Cigna Dental Appeals P.O. Box 188044 Chattanooga, TN 37422 Fax-1.859.550.2680 ***Overnight Letter Mailing:*** Cigna Dental C/O Firstsource 1232 Premier Dr, Suite 100 Chattanooga, TN 37421 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Administration Appeals 3620 Hacks Cross Road Building B-2 7103 Memphis, TN 38125-8800

Plan	Claims Paying Administrator	Appeals
Dental Active FDA Pilots	Cigna Global Dental P.O. Box 15800 Wilmington, DE 19850 Fax: 1.800.243.6998 Inside U.S.: 1.800.441.2668 (global toll-free) 1.302.797.3100 (global direct dial, can call collect outside the U.S.) www.CignaEnvoy.com	***Send benefit appeals to:*** ATTN: Appeals Department P.O. Box 15800 Wilmington, DE 19850 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Administration Appeals 3620 Hacks Cross Road Building B-2 Memphis, TN 38125-8800
Vision Active and Retired Pilots	Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110 1.888.60.FEDEX (1.888.603.3339) www.davisvision.com	***Send benefit appeals to:*** Davis Vision Attn: Quality Assurance/Patient Advocate Department P.O. Box 791 Latham, NY 12110 ***Overnight Letter Mailing:*** Davis Vision Attn: Quality Assurance/Patient Advocate Department 711 Troy-Schenectady Rd., Suite 301 Latham, NY 12110-2488 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Administration Appeals 3620 Hacks Cross Road Building B-2 Memphis, TN 38125-8800
Mental Health/ Substance Abuse Active and Retired Pilots	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007 1.866.406.0982 www.anthem.com/ca	***Send benefit appeals to:*** Anthem Grievances and Appeals. P.O. Box 54159 Los Angeles, CA 90054 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Administration Appeals 3620 Hacks Cross Road Building B-2 Memphis, TN 38125-8800

Plan	Claims Paying Administrator	Appeals
Long-Term Disability (LTD) Plan for Pilots, which includes Supplementary Disability Benefit	The Hartford P.O. Box 14867 Lexington, KY 40512 1.800.757.0207	***Send benefit appeals to:*** The Hartford P.O. Box 14868 Lexington, KY 40512 Or FAX 1.833.357.5152
Pension Plan* Non-Qualified Pension Plan for Pilots (Compensation Limit Plan)* Non-Qualified Section 415 Excess Pension Plan for Pilots* Flying Tiger Line (FTL) Variable Annuity Pension Plan for Pilots*	***Overnight Mail:*** FedEx Retirement Service Center DEPT 04471 8770 New Trails Drive The Woodlands TX 77381 ***Postal Mail:*** FedEx Retirement Service Center DEPT 04471 6411677387-4116* P.O. Box 64065 The Woodlands, TX 77387-4065 1.855.604.6221 retirement.fedex.com	***Claims:*** FedEx Retirement Service Center (RSC) Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407 1.855.604.6221 1.855.604.6221 (hearing-impaired will need to call in with local relay service) ***Overnight and Appeals:*** FedEx Retirement Service Center (RSC) Claims and Appeals Management Attn: Box 1407 4 Overlook Point Ste 4OB Lincolnshire, IL 60069
Pilots' Retirement Savings Plan (PRSP)*	FedEx Retirement Services Attn: PRSP Claims 30 FedEx Parkway 2nd Floor Horizontal Collierville, TN 38017	FedEx Corporation Attn: Retirement Appeals Committee 30 FedEx Parkway 2nd Floor Horizontal Collierville, TN 38017

Plan	Claims Paying Administrator	Appeals
Basic Life Insurance Optional Life Insurance Basic Accidental Death and Dismemberment (AD&D) Insurance (including Business Travel Accident Insurance and CRAF Accident Insurance) Optional AD&D Insurance Retiree Optional Life Insurance	Securian Life Insurance Company Claims Dept. P.O. Box 64114 St. Paul, MN 55164-0114 1.888.658.0193 FAX 1.877.494.8401	***Send claims appeals to:*** Securian Life Insurance Company Claims Dept. P.O. Box 64114 St. Paul, MN 55164-0114 1.888.658.0193 FAX 1.877-494-8401 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Appeals 3620 Hacks Cross Road Building B-2, Memphis, TN 38125-8800
MetLife Legal Plans	MetLife Legal Plans 1111 Superior Avenue Cleveland, OH 44114-2507 1.844.4METFDX (1.844.463.8339) www.metlife.com/fedex	***Send claims appeals to:*** MetLife Legal Plans 1111 Superior Avenue Cleveland, OH 44114-2507 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Appeals 3620 Hacks Cross Road Building B-2 Memphis, TN 38125-8800
Group Long-Term Care Insurance Plan (LTCI) (As of Jan. 1, 2013, this Plan is closed to new enrollees)	Metropolitan Life Insurance Company Long-Term Care P.O. Box 14634 Lexington, KY 40512-4634 1.844.4METFDX (1.844.463.8339) www.metlife.com/fedex	***Send claims appeals to:*** Metropolitan Life Insurance Company Long-Term Care Group P.O. Box 14634 Lexington, KY 40512-4634 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Appeals 3620 Hacks Cross Road Building B-2 Memphis, TN 38125-8800

Plan	Claims Paying Administrator	Appeals
COBRA	HealthEquity WageWorks P.O. Box 223684 1.800.526.2720 FAX: 1.833.514.6416	***Send COBRA Level I & II appeals to:*** WageWorks Attn: Appeals Department 13560 Morris Road Alpharetta, GA 30004 ***Fax:*** Attn: Appeals Department Fax Number 1.800.676.3734 ***Send eligibility appeals to:*** FedEx Express Pilot Benefits Administration Appeals 3620 Hacks Cross Road Building B-2 Memphis, TN 38125-8800
*For Domestic Relations Orders, contact or send orders to: FedEx Qualified Order Center P.O. Box 1433 Lincolnshire, IL 60069-1433 1.855.604.6221 1.855.604.6221 (hearing-impaired will need to call in with local relay service) Website: www.qocenter.com ***Overnight:*** FedEx Qualified Order Center 4 Overlook Point Lincolnshire, IL 60089-1433		

Claims and Appeals

Filing a Claim—Your Rights

If you think you are eligible to participate or are eligible for a health and welfare benefit or retirement benefit, you or your authorized representative must file a claim. You alone are responsible for making sure your claim is filed accurately and on time.

When you or your authorized representative have filed the completed claim form, along with any required documentation, where applicable, the claims paying administrator will process your claim according to the following claim categories:

CLAIMS PROCESSING PERIODS FOR HEALTH AND WELFARE PLANS AND RETIREMENT

Claim Type	Description	To Make Initial Claim Determination	Extension by Claims Paying Administrator	To Request Missing Claim Information from Claimant	For Claimant to Provide Missing Information
Urgent Care Claims for Medical (including HMSA), Pharmacy, Dental, and/or Vision*	Care/treatment involves a serious threat to life or health or involves severe pain, or your ability to regain maximum function, as determined by a physician knowing your condition	72 hours after receipt of the claim, unless you don't provide enough information 48 hours after the receipt of the missing claim information or the end of the period you were given to provide the specified information	None	24 hours after receipt of the claim	You have 48 hours to provide missing information
Pre-service Claims (non-urgent) for Medical (including HMSA), Pharmacy, Dental, and/or Vision*	Any request for services requiring precertification made in advance of receiving care	15 days after receipt of the claim	15 days; extension notice must be sent before the first 15-day period runs out	5 days after receipt of claim	You have 45 days to provide missing information

CLAIMS PROCESSING PERIODS FOR HEALTH AND WELFARE PLANS AND RETIREMENT

Claim Type	Description	To Make Initial Claim Determination	Extension by Claims Paying Administrator	To Request Missing Claim Information from Claimant	For Claimant to Provide Missing Information
Post-service Claims for Medical (including HMSA), Pharmacy, Dental, and/or Vision*	Any other type of claim; a claim after care is received	30 days after receipt of the claim	15 days extension notice sent before the first 30-day period runs out	Anytime during the determination period	You have 45 days to provide missing information
Concurrent Care (will be reclassified as Urgent Care, Pre-service or Post-service Care) for Medical (including HMSA), Pharmacy, Dental, and/or Vision*	Reduction of a specific number of treatments, or previously approved ongoing treatments, or termination of treatment	Urgent care Notice of denial provided 24 hours in advance of reduction if claim is submitted at least 24 hours before the end of the approved treatment Non-urgent care; determined by type of claim	Determined by claim type	Determined by claim type	Determined by claim type
Basic Accidental Death and Dismemberment (AD&D) (Including Business Travel Accident and CRAF Accident Insurance)	A claim is filed under the Basic AD&D Plan	Within 10 calendar days of receipt of all requested information	N/A	Within 10 calendar days of receipt of the claim submission	Determined by the insurance company

CLAIMS PROCESSING PERIODS FOR HEALTH AND WELFARE PLANS AND RETIREMENT

Claim Type	Description	To Make Initial Claim Determination	Extension by Claims Paying Administrator	To Request Missing Claim Information from Claimant	For Claimant to Provide Missing Information
Optional Accidental Death and Dismemberment (AD&D)	A claim filed under the Optional AD&D Plan	Within 10 calendar days of receipt of all requested information	N/A	Within 10 calendar days of receipt of the claim submission	Determined by the insurance company
Disability Claims	A claim filed under the Long-Term Disability Plan	45 days after receipt of the claim	30 days; extension notice sent before the 45-day period runs out (an additional 30 days if extension is sent before the first 30-day extension period runs out)	Before the end of the 45-day period	45 days to provide missing information
Flexible Spending Account (FSA): Dependent Care Flexible Spending Account Health Care Flexible Spending Account (Full Purpose and Limited Purpose FSA)	A claim filed for reimbursement of eligible dependent care expenses for the Dependent Care Flexible Spending Account or eligible health care expenses for the Health Care Flexible Spending Account	30 days after receipt of the claim	N/A	Claims and all related documentation must be received before the Plan's run out period ends, which is March 31 of the following year.	Claims and all related documentation must be received before the Plan's run out period ends, which is March 31 of the following year.
MetLife Legal Plans	A claim filed under the MetLife Legal Plans	90 days after receipt of the claim	90 days; extension notice sent before the first 90-day period runs out	Before the end of the 90-day period	60 days from receipt of letter from MetLife requesting the missing information

CLAIMS PROCESSING PERIODS FOR HEALTH AND WELFARE PLANS AND RETIREMENT

Claim Type	Description	To Make Initial Claim Determination	Extension by Claims Paying Administrator	To Request Missing Claim Information from Claimant	For Claimant to Provide Missing Information
Group Long-Term Care Insurance (LTCI) (As of Jan. 1, 2013, this Plan is closed to new enrollees)	A claim filed under the LTCI	90 days after receipt of the claim	90 days; extension notice sent before the first 90-day period runs out	Before the end of the 90-day period	20 days from the date of notification of additional information/ documents
FedEx Corporation Employees' Pension Plan FTL Variable Annuity Pension Plan for Pilots Non-Qualified Pension Plan for Pilots (Compensation Limit Plan) Non-Qualified Section 415 Excess Pension Plan for Pilots Pilots' Retirement Savings Plan (PRSP)	A non-disability claim for benefit commencement, distribution, or other specific transaction is made	90 days after receipt of claim	90 days; extension notice must be communicated before the first 90-day period runs out	Anytime during the determination period	Determined by the Plan Administrator

CLAIMS PROCESSING PERIODS FOR HEALTH AND WELFARE PLANS AND RETIREMENT

Claim Type	Description	To Make Initial Claim Determination	Extension by Claims Paying Administrator	To Request Missing Claim Information from Claimant	For Claimant to Provide Missing Information
FedEx Corporation Employees' Pension Plan FTL Variable Annuity Pension Plan for Pilots Non-Qualified Pension Plan for Pilots (Compensation Limit Plan) Non-Qualified Section 415 Excess Pension Plan for Pilots Pilots' Retirement Savings Plan (PRSP)	A disability related claim for benefit service, or commencement, distribution, or other specific transaction is made	45 days after receipt of claim	30 days; extension notice must be communicated before the first 45-day period runs out	Anytime during the determination period	45 days

*It is your responsibility to provide information to support your claim. If you are enrolled in GeoBlue or Cigna Global Dental, refer to the certificate or schedule of benefits for the applicable vendor to view the procedures for filing a claim.

Filing a Claim

Medical

If you are enrolled in the CDHP Purple HSA, CDHP Purple HRA, CDHP Orange HSA, CDHP Orange HRA, Buy Up Plan, or High Deductible Plan, and use providers in the Anthem network, you are not responsible for filing claims—your provider will file claims directly for you. When your provider files an in-network claim for charges requiring coinsurance, you will receive an explanation of benefits (EOB) from Anthem. The EOB will indicate the dates of service, charges, and amounts covered. You should keep your EOB. You will need it if you file a claim with any other insurance coverage that is secondary to your FedEx coverage and/or to verify any charges made to your Health Care Flexible Spending Account, if enrolled. When you use out-of-network providers, you must file claims yourself. You will receive an EOB from Anthem that will contain the same information as an EOB for an in-network claim.

You can print and/or view in-network and out-of-network claim details, eligibility, or benefits online anytime at www.anthem.com/ca or on the Sydney App for Anthem.

How to file an Out-of-Network Medical claim:

1. Ask your provider to complete the standard medical claim form, or you can download a medical claim form from www.anthem.com/ca. Complete the appropriate sections of the form and submit to Anthem. Only submit a claim form if your provider did not submit the charge on your or your dependent's behalf.
2. Keep a copy of all itemized bills, receipts, and forms.
3. Send the original completed form with related itemized bills within one year of the service to the address shown on the claim form.

Be sure to include an EOB from any other insurance, if applicable. Anthem will review the claim material and process the claim for payment or denial. Anthem may also pend your benefit payment if you need to provide more information. Anthem will send you an EOB and a check (if applicable). Be sure your address is correct in the HR System (if you are an active pilot, including those on a leave of absence), so you can receive your reimbursement checks and other correspondence. Retirees/dependents of retirees should maintain their mailing address through https://fedexpilots.bswift.com.

See the **Claims Processing Periods for Health and Welfare Plans and Retirement Plans** chart for normal processing times. Supply additional information if asked. It is your responsibility to ensure that Anthem receives claims within one year from the date you incur the medical expense. **Benefits will not be paid if claims are received after one year from the date of service.**

Pharmacy

Retail Pharmacy

When you use a network pharmacy, simply present your Express Scripts pharmacy ID card and identify yourself as a participant. You pay the appropriate copayment or coinsurance and your claim is filed electronically by the pharmacy.

Filing a Pharmacy Claim

If you use a retail pharmacy that is not in the Express Scripts network, it is considered out-of-network. You will pay the full cost of the prescription when you pick it up and then submit a claim form. You will be reimbursed at the out-of-network benefit level based on the medical plan option in which you are enrolled at the time of service. See the most recent Pilot Enrollment Guide or Pre-65 Retiree Enrollment Guide for plan benefits. The guides are located on https://fedexpilots.bswift.com under the Educate tab. Prescriptions submitted to a pharmacist are not a claim for benefits. You must send the original, itemized prescription receipt attached to a completed out-of-network claim form to the address on the claim form. Claim forms are available at www.express-scripts.com. A claim for reimbursement can also be submitted via the Express Scripts website. Log in to your account and navigate to Benefits, click on Forms, and scroll down to submit a claim online. Claims must be filed within one year of the date of the prescription.

If your pharmacist tells you that your prescription is not covered, you must file a claim with Express Scripts Customer Service. Once that claim has been denied, you have the right to file an appeal.

Dental

Your in-network dentist should file claims directly with Cigna. When your dentist files a claim, you will receive an EOB from Cigna. The EOB will indicate the dates of service, charges, and amounts covered. It will also indicate the amount for which you are responsible. Your dentist will bill you directly for this amount. You should keep your EOB. You will need it if you file a claim with any other insurance coverage that is secondary to your FedEx Dental benefit coverage. You can view claim detail, eligibility, or benefits online anytime at www.mycigna.com.

How to file an Out-of-Network Dental claim:

1. Download a Dental Expense Claim Form from Pilot Benefits Online at https://fedexpilots.bswift.com, or request a form from Cigna by calling 1.800.311.4725 if you are domestic based. FDA pilots should call Cigna Global Dental at 1.800.441.2668; complete & submit the form according to the instructions noted on the form.
2. Keep a copy of all itemized bills, receipts, and forms.

If Cigna is the secondary coverage, you will need to submit your claim to Cigna along with documentation of the claim payment made by the primary coverage. Be sure to include an EOB from any other insurance. You must file your claim within one year from the date of treatment. Supply additional information if asked. It is your responsibility to ensure that Cigna receives claims within one year from the date you incur the dental expense. **Benefits will not be paid if claims are received after one year from the date of service.**

Vision

When using in-network providers, you are not responsible for filing claims. Your in-network provider will submit your claim to Davis Vision, who will pay your provider directly. Upon request, Davis Vision will issue an EOB for in-network claims. When you use out-of-network providers, you must file claims yourself. You will receive an EOB from Davis Vision for out-of-network claims. You can view eligibility or benefits online anytime at www.davisvision.com. You should keep any receipts or EOBs.

How to file an out-of-network Vision claim:

1. If you see an out-of-network provider for your eye care services, you must pay the full cost at the time of service. Out-of-network claims are paid directly to you and only up to a scheduled amount.
2. Claim forms are available online at www.davisvision.com or by calling Davis Vision at 1.888.603.3339.
3. Follow the directions on the form for filing a claim.
4. Keep a copy of all itemized bills, receipts, and forms.

You have one year from the date you incurred the charge to file a claim. **Benefits will not be paid if claims are received after one year from the date of service.**

Workers' Compensation

Contact your Manager (or designee/PAC) immediately to report a job-related injury or illness. The PAC will look into the details of your report, enter the necessary information into the Intranet Injury Reporting System, and complete the appropriate forms.

Per Section 14.F.1 of the Collective Bargaining Agreement, if you sustain a workers' compensable injury or illness covered by Section 16 of the Collective Bargaining Agreement, you will be eligible for up to 168 credit hours (CH) of occupational injury/illness leave for each occupational injury or illness. All injuries that result from a single accident are regarded as one injury for purposes of the 168 CH.

Call The Hartford at 1.800.757.0207 if it appears the work-related disability will extend beyond the sick bank period. **You are required to file a claim for LTD benefits within 60 days following exhaustion of your workers' compensation allowance and sick banks. If you do not file a claim for LTD benefits, you will not be able to receive LTD benefits when your Workers' Compensation allowance and sick banks are exhausted.**

Here's how it typically works:

You will first use your accrued regular and disability sick bank credit hours until your Workers' Compensation claim is approved. At that point, your sick bank CH are reimbursed and deducted from your Workers' Compensation allowance. You then draw from remaining credit hours from your Workers' Compensation allowance until it is exhausted. If you are still unable to work, you use your accrued regular and disability sick bank and have the option of drawing from your vacation bank before being placed on LTD, if eligible. You will not be placed on LTD until after you exhaust your Workers' Compensation and sick bank accounts. If your sick banks run out before your Workers' Compensation claim is approved, scheduled pay hours (scheduled trips/R-days, etc.) will be dropped without pay. The pay will be restored if the claim is deemed compensable, and you have credit hours remaining in your Workers' Compensation allowance. If your claim is not compensable, you will be placed on LTD, if eligible.

Long-Term Disability (LTD) Plan for Pilots

- Contact the Pilot Administration Center (PAC) to determine the date your sick banks will exhaust and your LTD will be effective. Confirm that your address and telephone number are up to date in the personnel system. The PAC will update your status to LTD in the personnel system at the appropriate time.
- Call The Hartford Insurance Company ("Hartford") at 1.800.757.0207 at least 48 hours before the exhaustion of your regular and disability sick bank accounts. You are responsible for reporting your LTD claim to Hartford, and you must advise Hartford if your address changes while you are on LTD. Claims received more than 60 days after the exhaustion of sick **banks will** not be paid.
- If you have a work-related illness or injury, you must report it immediately to the PAC. If you exhaust the workers' compensation allowance, your accrued RSA and all DSA, you must file a claim with Hartford to receive LTD benefits for a work-related illness/injury.
- Notify all other disability benefit programs under which you may be eligible for benefits, including your state plan if you work in statutory states (example: California, Rhode Island, or Puerto Rico). There may be filing limitations with the other disability benefit programs. These filing deadlines may be prior to the date your LTD begins. Please contact the disability programs to determine if you are eligible for benefits and applicable filing deadlines.

- Complete and return all forms and information requested by Hartford to the address provided in the initial disability packet. **Hartford cannot begin administering LTD benefits until the personnel system is updated to reflect your LTD status and the requested forms are completed and returned to Hartford.**
- Keep the PAC informed during your disability period about how long you are expected to be disabled.

Health Savings Account (HSA)

HealthEquity administers the HSA:

- HealthEquity provides online information regarding your HSA at https://www.healthequity.com.
- HealthEquity Member Services is available 24/7/365 by calling 1.844.281.0925.
- You can submit expenses for reimbursement through the HealthEquity member portal, the HealthEquity mobile app, or by submitting a Reimbursement claim form.
- You can also request payment directly to your provider through the HealthEquity member portal.
- The HealthEquity HSA debit card can be used to pay for eligible health care expenses at the time of service or point of sale.

Save your detailed receipts for your records.

- Keep a copy of claim forms and supporting documentation
- You can take a photo on your phone or upload a scanned document to your computer.
- HealthEquity offers an easy-to-use Documentation Library that allows you to upload and store receipts within the member portal.

Health Reimbursement Account (HRA)

HealthEquity is the administrator for the HRA:

- HealthEquity provides online information regarding your HRA at https://www.healthequity.com.
- HealthEquity Member Services is available 24/7/365 by calling 1.844.281.0925.
- You can submit eligible health care expenses for reimbursement through the HealthEquity member portal, the HealthEquity mobile app, or by submitting a Reimbursement claim form.
- You can also request payment directly to your provider through the HealthEquity member portal.
- You must save your detailed receipts for your records.
- HealthEquity offers an easy-to-use Documentation Library that allows you to upload and store receipts within the member portal.

There is no debit card associated with the HRA and substantiation is required. To substantiate the expense, you will be required to submit an itemized invoice, EOB, or other approved documentation.

You will have from January 1 until December 31 to incur eligible expenses. The cutoff date for submitting claims for health care expenses is March 31 of the following year.

If you are enrolled in one of the CDHP HRA medical options and you plan to re-enroll in an HRA medical option for the following year, you will start the new plan year with two HRAs at HealthEquity: one with any remaining credits from the prior year and an account for the new year. This is necessary to allow you to continue to file any eligible expenses from the prior year through March 31 of the subsequent year. Once the filing period expires on March 31, any credits that remain in your prior year HRA will be added to your new (current) year HRA.

Pre-Medicare Retiree HRA

HealthEquity is the administrator for the Pre-Medicare HRA:

- HealthEquity provides online information regarding your HRA at https://www.healthequity.com.
- HealthEquity Member Services is available 24/7/365 by calling 1.844.281.0925.
- You can submit eligible health care expenses for reimbursement through the HealthEquity member portal, the HealthEquity mobile app, or by submitting a Reimbursement claim form.
- You can also request payment directly to your provider through the HealthEquity member portal.
- Regardless of the method of payment or reimbursement you choose, you must save your detailed receipts for your records.
- HealthEquity offers an easy-to-use Documentation Library that allows you to upload and store receipts within the member portal.

HealthEquity will open a separate HRA for you (and your spouse) to allow each of you to receive the $4,813.

There is no debit card associated with the Pre-Medicare Retiree HRA and substantiation is required. To substantiate the expense, you will be required to submit an itemized invoice, EOB, or other approved documentation.

You will have from January 1 until December 31 to incur eligible expenses. The cutoff date for submitting claims for health care expenses is March 31 of the following year.

If you (and your spouse) are currently enrolled in the Pre-Medicare HRA, and you remain enrolled in the subsequent year, you will start the new plan year with two HRAs at HealthEquity: one with any remaining credits from the prior year and an account for the new year.

This is necessary to allow you to continue to file any eligible expenses from the prior year through March 31 of the subsequent year. Once the filing period expires on March 31, any credits that remain in your prior year HRA will be added to your new year HRA.

Dependent Care Flexible Spending Account (Dependent Care FSA)

HealthEquity is the administrator for the Dependent Care FSA:

- HealthEquity provides online information regarding your Dependent Care FSA at https://www.healthequity.com.
- HealthEquity Member Services is available 24/7/365 by calling 1.844.281.0925.

- You may submit expenses for reimbursement through the HealthEquity member portal, the HealthEquity mobile app, or by submitting the Dependent Care Reimbursement Account (DCRA) claim form.
- The Reimbursement claim form is available on the member portal or by calling HealthEquity Member Services.
- You can also request payment directly to your provider through the HealthEquity member portal.

  NOTE: Not all providers can be paid through Pay My Provider.
- There must be sufficient credits available in your account to remit the entire payment. No partial payments can be issued from the account.

Regardless of the method of reimbursement you choose, you must save your detailed receipts for your records.

- Keep a copy of claim forms and supporting documentation.
- You can take a photo on your phone or upload a scanned document to your computer.
- HealthEquity offers an easy-to-use Documentation Library that allows you to upload and store receipts within the member portal. This allows you to securely organize documents to be referenced in the future.

Dependent Care FSA claims are only paid up to the amount of money available in the account. Additional approved charges are pended for future payment.

The cutoff date for submitting claims for dependent care expenses is March 31 of the following year. In other words, the dependent care expenses incurred from January 1 through December 31 in a calendar year can be submitted for reimbursement up to March 31 of the following year. Funds remaining at the end of the filing period are forfeited.

See IRS Publication 503 for a list of eligible dependent care expenses.

Health Care Flexible Spending Account (Health Care FSA) (including Full Purpose and Post-Deductible Limited Purpose FSA)

HealthEquity is the administrator for the Health Care FSA:

- HealthEquity provides online information regarding your Health Care FSA at https://www.healthequity.com.
- HealthEquity Member Services is available 24/7/365 by calling 1.844.281.0925.
- You can submit eligible health care expenses for reimbursement through the HealthEquity member portal, the HealthEquity mobile app, or by submitting a Reimbursement claim form.
- You can also request payment directly to your provider through the HealthEquity member portal.
- The HealthEquity Health Care FSA debit card can be used to pay for eligible health care expenses at the time of service or point of sale.
- Regardless of the method of payment or reimbursement you choose, you must save your detailed receipts for your records.
- You can take a photo on your phone or upload a scanned document to your computer.

- HealthEquity offers an easy-to-use Documentation Library that allows you to upload and store receipts within the member portal. This allows you to securely organize documents to be referenced in the future.

Important: Be sure to validate all card transactions where HealthEquity is requesting additional support as debit card transactions not validated by the claims filing date for the Plan Year will be reported as taxable income to you. Any unverified debit card transactions for the previous plan year will be reported as taxable income on your W-2.

With the Health Care FSA, you have access to the full annual contribution amount anytime during the year.

You will have from January 1 until December 31 to incur eligible expenses. The cutoff date for submitting claims for health care expenses is March 31 of the following year.

The Health Care FSA has a carryover feature that allows participants to carry over an amount specified annually by the IRS to pay for eligible expenses in the next plan year. Any unused balance in excess of the carryover amount left in your account after the deadline for requesting reimbursement will be forfeited. See the current Pilot Enrollment Guide for the carryover amount.

Health Care FSA funds rolled over to the next plan year are not available for use until after the runout period ends on March 31.

See IRS Publication 502 for a list of eligible health care expenses.

Basic and Optional Life Insurance

Your beneficiary(ies) should notify your Manager and Pilot Benefits Administration, 1.866.795.6353 or by email at PBA@fedex.com, of your death. Pilot Benefits Administration will reach out to your beneficiaries to obtain their address and phone number and confirm the benefit amount. Pilot Benefits Administration will file the employer portion of the claim with Securian. The beneficiaries will be sent a letter of condolence with instructions on how to file a claim.

Your beneficiary(ies) must file the claim with Securian, complete all requested forms, provide a copy of the certified death certificate, and return all information to Securian. The beneficiaries will work directly with Securian regarding the administration of the claim.

Basic and Optional Accidental Death and Dismemberment (AD&D)

If you, one of your covered dependents, or your beneficiary(ies) need to file a claim, you must notify Pilot Benefits Administration as soon as possible after any loss which may be covered by this policy. Pilot Benefits Administration will reach out to all beneficiaries to obtain their address and phone number and to confirm the benefit amount. Pilot Benefits Administration will file the employer portion of the claim with Securian. Securian will send you or your dependent a letter and instructions on how to file a claim. Be sure to complete claims accurately and thoroughly and return to Securian. In the case of a death, a copy of a certified death certificate must also be provided with the claim. Missing or incorrect information may delay the approval process. If you have questions, contact Pilot Benefits Administration at 1.866.795.6353 or by email at PBA@fedex.com.

Business Travel Accident

If you or one of your covered dependents need to file a claim, you must notify Pilot Benefits Administration as soon as possible after any loss covered by this policy. Pilot Benefits Administration will submit the employer portion of your claim to Securian. Securian will send you or your beneficiary(ies) the necessary forms to complete. Be sure to complete claims accurately and thoroughly. In case of a death, a certified death certificate must also be provided to Securian. Missing or incorrect information may delay the approval process. If you have questions, contact Pilot Benefits Administration at 1.866.795.6353 or by email at PBA@fedex.com.

CRAF Accident Insurance Policy

Your beneficiary(ies) must notify Pilot Benefits Administration as soon as possible after any loss covered by this policy. Pilot Benefits Administration will submit the employer portion of the claim to Securian. Securian will send you or your beneficiary(ies) the necessary forms to complete. Be sure to complete claims accurately and thoroughly. In case of a death, a certified death certificate must also be provided to Securian. Missing or incorrect information may delay the approval process. If you have questions, contact Pilot Benefits Administration at 1.866.795.6353 or by email at PBA@fedex.com.

Group Long-Term Care Insurance (LTCI)

As of January 1, 2013, this Plan is closed to new enrollees.

For specific information about the claims filing procedures, call MetLife at 1.844.4METFDX (1.844.463.8339) from 8:00 a.m. to 11:00 p.m. ET, Monday through Friday.

MetLife Legal Plans

To receive benefits, you must obtain a case number via MetLife's website at www.metlife.com/fedex or MetLife's Client Service Center at 1.844.4METFDX (1.844.463.8339). You must obtain a case number for services before contacting any attorney, whether in-network or out-of-network. No benefits will be paid for services incurred before you have received a case number.

Retirement Disability Claims

(Pension Plan, Pilots' Retirement Savings Plan, FTL Variable Annuity Pension Plan for Pilots, Non-Qualified Pension Plan for Pilots (Compensation Plan), and/or Non-Qualified Section 415 Excess Pension Plan for Pilots)

If you think you are eligible for a disability retirement benefit under the Pilots' Retirement Savings Plan (PRSP), you must file a claim. You alone are responsible for making sure your claim is filed accurately. To file a claim, please submit your claim in writing to FedEx Retirement Services – Attn: PRSP Claims - 30 FedEx Parkway 2nd Floor Horizontal – Collierville, TN 38107.

If you believe you are eligible for a disability retirement benefit under the Pension Plan, the FTL Variable Annuity Pension Plan for Pilots, the Non-Qualified Pension Plan for Pilots (Compensation Plan), or the Non-Qualified Section 415 Excess Pension Plan for Pilots, you must file a claim. You alone are responsible for making sure your claim is filed accurately and on time. To file a claim, contact the Retirement Service Center (RSC), at 1.855.604.6221.

Retirement Non-Disability Claims (All Retirement Plans)

If you think you are eligible for a retirement benefit under the Pilots' Retirement Savings Plan (PRSP), you must file a claim. You alone are responsible for making sure your claim is filed accurately. To file a claim, please submit your claim in writing to FedEx Retirement Services – Attn: PRSP Claims – 30 FedEx Parkway 2nd Floor Horizontal – Collierville, TN 38017.

If you believe you are eligible for a retirement benefit under the Pension Plan, the FTL Variable Annuity Pension Plan for Pilots, the Non-Qualified Pension Plan for Pilots (Compensation Plan), or the Non-Qualified Section 415 Excess Pension Plan for Pilots, you must file a claim. You alone are responsible for making sure your claim is filed accurately and on time. To file a claim, contact the Retirement Service Center (RSC), at 1.855.604.6221.

Eligibility Appeals

Filing an Appeal—Your Rights

If you think you or an eligible dependent is eligible to participate in a health and welfare benefit, but participation in the plan benefit was denied or terminated, you have the right to file an appeal. There are two levels to an eligibility appeal. The first level appeal will be reviewed by the FedEx Express Pilot Benefits Administration and the second level by the Fiduciary Appeals Committee.

To appeal an eligibility denial decision, you must contact Pilot Benefits Administration at the address below or by calling 1.866.795.6353 or by email at PBA@fedex.com, within 180 days of the eligibility denial decision, to request a first level appeal.

FedEx Express Pilot Benefits Administration Appeals
3620 Hacks Cross Road
Building B-2 Delivery Code 7103
Memphis, TN 38125-8800

FedEx Express Pilot Benefits Administration will have 30 days to review and respond to your first level appeal. If eligibility for a plan benefit remains denied, you will have 180 days from the date of the adverse decision notice to request a second level appeal. You can submit information to perfect your claim by sending an email to PBA@fedex.com or by mail to:

Pilot Fiduciary Appeals Committee
3620 Hacks Cross Road
Building B-2 Delivery 7103
Memphis, TN 38125-8800

Please put "Eligibility Appeal" in the subject line of your correspondence.

The Fiduciary Appeals Committee will have 60 days to review and respond to your second level appeal. If eligibility for a plan benefit remains denied at this level, you will have 120 days from the date of the final adverse decision notice to file a request to proceed to the Pilot Benefit Review Board (PBRB) to the Air Line Pilots Association. The PBRB will have 120 days to rule on your case. To proceed to the PBRB or to discuss other options, contact the Air Line Pilots Association at 1770 Kirby Parkway, Suite 300, Memphis, TN 38138, or by phone at 1.866.339.2572, ext. 2208 within 120 days from the date of the final adverse decision notice. Since the health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the claimant may or may not have the right to bring a civil action in federal court under section 502(a) of ERISA depending on where the civil action is filed.

Appeals for Medical (including Mental Health/Substance Abuse), Pharmacy, Dental, Vision, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and HRA Claims

For most pre-service, post-service, and concurrent health care claims, there will be two levels of appeal. Both levels of appeal will be heard by the claims paying administrator. If a medical judgment is involved, the person reviewing your appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who had no role in the initial claim denial.

The Health Care and Dependent Care Flexible Spending Accounts will have the first level appeal heard by the claims paying administrator, and the second level appeal heard by the Fiduciary Committee.

Denial of Your Claim—Your Rights

If your claim is denied ***for Medical (including Mental Health/Substance Abuse), Pharmacy, Dental, Vision, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, HRA, or Pre-Medicare Retiree HRA***,* in whole or in part, the claims paying administrator will send you its decision in writing that may include:

- Patient information: name, member ID, address, phone number, date of birth
- Claim information: Date(s) of the service, your doctor's name/address/phone number
- The specific reason(s) for the denial.
- Reference to the specific plan provisions on which the decision is based.
- A description of additional information needed to support your claim on appeal and an explanation of why the additional information is needed.
- Information on how to appeal the denial of your claim.
- A description of the appeal procedures and applicable time limits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- A statement informing the claimant about the right to bring a civil action under ERISA or to submit an appeal to the Pilot Benefit Review Board (PBRB) after the second level of appeal.

Additional Requirements for Medical (including Mental Health/Substance Abuse), Pharmacy, Dental, and/or Vision Appeals only:

- If the adverse decision was based on medical necessity or experimental treatment or similar exclusion or limit (for example, a decision that the proposed service was not medically necessary or that it was experimental), either an explanation of the scientific or clinical judgment for the determination (applying the plan terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request.

- In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process.
- Information sufficient to identify the involved.

Independent Review Procedure for Medical, Including Mental Health/Substance Abuse Claims, and Pharmacy involving Medical Necessity

If you do not agree with Anthem or Express Script's decision of the level two appeal review regarding medical necessity or clinical appropriateness, you are required to have your appeal referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by the claims paying administrator—Anthem or Express Scripts, or any of its affiliates. Using the IRO will not affect your rights to any other benefits under the Plan. There is no charge for you to initiate this process. Anthem and Express Scripts will abide by the decision of the IRO. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review by an IRO, you must notify the appropriate claims paying administrator within 180 days of your receipt of the level two appeal denial. The claims paying administrator will then forward the file to the IRO. The IRO will make its decision within 30 days. If a delay would be detrimental to your condition, as determined by the administrator's physician reviewer, you can ask to have the review completed within three days. The independent review is arranged by the claims paying administrator. If the IRO upholds the denial, you may submit an appeal to the Pilot Benefit Review Board (PBRB).

If Your Claim Is Denied for Long-Term Disability

If the claim is denied, in whole or in part, a letter will be sent to you with an explanation of the following:

- The specific reason(s) for the denial, including an explanation of the basis for disagreeing with or not following views presented by (i) a health care professional treating the claimant, (ii) a vocational professional who evaluated the claimant, (iii) a medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the denial, regardless of whether the advice was relied upon in making the benefit determination, and (iv) a disability determination regarding the claimant made by the Social Security Administration,
- Reference to the specific plan provisions on which the decision is based,
- A description of additional information needed to support your claim on appeal and an explanation of why the additional information is needed,
- Information on how to appeal the denial of your claim,
- A description of the appeal procedures and applicable time limits,
- A copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol, or other similar criterion does not exist,
- If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

It is your responsibility to provide information to support your claim. It is not the responsibility of the Plan or the claims paying administrator to gather information for you in support of your claim.

If Your Claim is Denied for Retirement Disability Benefits

(Pension Plan, Pilots' Retirement Savings Plan, FTL Variable Annuity Pension Plan for Pilots, Non-Qualified Pension Plan for Pilots (Compensation Plan), and/or Non-Qualified Section 415 Excess Pension Plan for Pilots)

If the claim is denied, in whole or in part, a letter will be sent to you with an explanation of the following:

- The specific reason(s) for the denial, including an explanation of the basis for disagreeing with or not following views presented by (i) a health care professional treating the claimant, (ii) a vocational professional who evaluated the claimant, (iii) a medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the denial, regardless of whether the advice was relied upon in making the benefit determination, and (iv) a disability determination regarding the claimant made by the Social Security Administration,
- Reference to the specific plan provisions on which the decision is based,
- A description of additional information needed to support your claim on appeal and an explanation of why the additional information is needed,
- Information on how to appeal the denial of your claim,
- A description of the appeal procedures and applicable time limits,
- A copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar criterion does not exist,
- If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

It is your responsibility to provide information to support your claim. **It is not the responsibility of the Plan or the claims paying administrator to gather information for you in support of your claim.**

If Your Claim Is Denied for Retirement Non-Disability Benefits (All Retirement Plans)

If the claim is denied, in whole or in part, a letter will be sent to you with the following:

- The specific reason(s) for the denial,
- Reference to the specific plan provisions on which the decision is based,
- A description of additional information needed to support your claim on appeal and an explanation of why the additional information is needed,
- Information on how to appeal the denial of your claim,
- A description of the appeal procedures and applicable time limits.

It is your responsibility to provide information to support your claim. **It is not the responsibility of the Plan or the claims paying administrator to gather information for you in support of your claim.**

Appeals for Insured Plans

The decision on appeals for insured plans, except the International Plan, is made by the applicable insurance company.

Appeals for International Plan

The decision on appeals for the International Plan is made by the insurance company in accordance with the claims review procedures contained in the insurance certificate. If your appeal is denied, you must file an appeal with the Tennessee Department of Commerce and Insurance (TDCI) before the appeal is submitted to the Pilot Benefit Review Board (PBRB).

International pilots and their families are covered under the GeoBlue insured product. The following is the appeal process that a pilot must follow:

- Upon denial of a medical claim, the pilot/dependent must file any first or second level appeal with GeoBlue.
- If the pilot/dependent receives an adverse decision after the second level appeal, he/she must appeal to the TDCI.
- If the TDCI denies the appeal, the pilot is then eligible to appeal the denial to the PBRB or file suit in federal court. If appellant files suit in a federal court, he/she is no longer eligible for an appeal to the PBRB.
- If the PBRB overturns GeoBlue's decision, FedEx will pay the claim out of its general assets.

Appeals for Disability Claims

The claims paying administrator has the authority and discretion to interpret the Plan's provisions. The appeal decision is sent to you in writing and, if your appeal is denied, the decision letter will include:

- The specific reason(s) for the denial,
- Reference to the specific plan provisions on which the decision is based,
- A description of additional information needed to support your claim on appeal and an explanation of why the additional information is needed,
- Information on how to appeal the denial of your claim,
- A description of the appeal procedures and applicable time limits,
- A copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol, or other similar criterion does not exist,
- If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim of benefits,
- A statement informing the claimant about the right to proceed to the Pilot Benefit Review Board (PBRB) or the right to bring a civil action under ERISA, depending on where the civil action is filed.

Appeals for Retirement Disability Claims
(Pension Plan, Pilots' Retirement Savings Plan, FTL Variable Annuity Pension Plan for Pilots, Non-Qualified Pension Plan for Pilots (Compensation Plan), and/or Non-Qualified Section 415 Excess Pension Plan for Pilots)

If the appeal is denied, in whole or in part, a letter will be sent to you with an explanation of the following:

- The specific reason(s) for the denial,
- Reference to the specific plan provisions on which the decision is based,
- A description of additional information needed to support your claim on appeal and an explanation of why the additional information is needed,
- Information on how to appeal the denial of your claim,
- A description of the appeal procedures and applicable time limits,
- A copy of the internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination or a statement that such rule, guideline, protocol, or other similar criterion does not exist,
- If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request,
- A statement informing the claimant about the right to bring a civil action under ERISA or to submit an appeal to the Pilot Benefit Review Board (PBRB) after denial of the appeal.

It is your responsibility to provide information to support your claim. It is not the responsibility of the Plan or the Retirement Appeals Committee to gather information for you in support of your claim.

Appeals for Retirement Non-Disability Claims
(All Retirement Plans)

If the appeal is denied, in whole or in part, a letter will be sent to you with the following:

- The specific reason(s) for the denial,
- Reference to the specific plan provisions on which the decision is based,
- A description of additional information needed to support your claim on appeal and an explanation of why the additional information is needed,
- Information on how to appeal the denial of your claim,
- A description of the appeal procedures and applicable time limits,
- A statement informing the claimant about the right to bring a civil action under ERISA or to submit an appeal to the Pilot Benefit Review Board (PBRB) after denial of the appeal.

It is your responsibility to provide information to support your claim. It is not the responsibility of the Plan or the Retirement Appeals Committee to gather information for you in support of your claim.

Pilot Benefit Review Board

The Pilot Benefit Review Board (PBRB) is a final benefit review process that was negotiated as part of the Collective Bargaining Agreement. After completion of all mandatory levels of review, you may proceed to the PBRB. To proceed to the PBRB or to discuss other options, the claimant should contact the Air Line Pilots Association at 1770 Kirby Parkway, Suite 300, Memphis, TN 38138, or by phone at 1.866.339.2572, ext. 2208 within 120 days from the date of the final appeal denial letter. Since the health benefit plan is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), the claimant may or may not have the right to bring a civil action in federal court under section 502(a) of ERISA depending on where the civil action is filed.

PBRB decisions are legally binding upon the Company, the Air Line Pilots Association (the Association), and the pilot. It is a completely separate process from the Railway Labor Act grievance process.

When a pilot receives a final denial notice regarding the claims paying administrator's or an appeal committee's decision, the Association will send more detailed information to the pilot about the PBRB and its procedures, including the specific office addresses at the Association to which a request for PBRB review must be sent. **The pilot will have 120 days from the date of the final appeal denial letter to request a review by the PBRB.**

When convened, the PBRB will consist of six appointees: three from the Company and three from the Association. The PBRB will review all of the information regarding the pilot's claim that was reviewed by the claims paying administrator and/or appeal committee. If new and relevant information is provided by the pilot or is otherwise discovered in preparation for or during a PBRB hearing, the PBRB will recess and refer the case back to the appropriate claims paying administrator's and/or committee for a review. That review will normally be completed within 10 business days, although an additional 10 business days is allowed under certain circumstances.

In the event that the PBRB has a deadlock vote, the sitting board will select a neutral arbitrator from a designated list of arbitrators, who are experienced in airline and benefit issues. The PBRB as chaired by the arbitrator will then reconsider the case. A written decision of the vote will be issued within 30 days following the vote.

Each pilot should carefully consider whether to pursue a denied appeal and should carefully weigh the advantages of pursuing a review by either the PBRB or by a court. **Note that you only have 120 days from the date of your final appeal denial letter to file a request for a PBRB review.** It is therefore very important that you consider your options and make your decision as soon as possible after you receive your decision from the appropriate vendor or appeal committee. If you choose to go to the PBRB, you must file a written request for review to the Association. The PBRB has 120 days to rule on your case.

Appealing a Claim Denial—Your Rights

You or your authorized representative can request a full and fair review of a denied claim at what is referred to as the "appeal" level. All appeals will be reviewed by the appropriate claims paying administrator. From the date that you receive the written denial of the claim, you must submit your appeal request as outlined in writing in the denial letter. It is your responsibility to submit information to support your appeal.

Appeal filing and processing timeframes are as follows:

TIMEFRAME FOR APPEAL PROCESS

Plan	Deadline for Filing Appeal	Deadline for Extension of Filing Appeal	Deadline for Final Determination	Group Responsible for Final Review
Medical (including MHSA) **Dental and Vision**	180 days for first level appeal after receiving the claim denial notice 180 days after receiving the second appeal denial notice	N/A	60 days	Anthem for Medical and MHSA Express Scripts for Pharmacy Cigna for Dental Davis Vision for Vision
Urgent Care Claims			72 hours	
Pre-Service Claims			15 days first level; 15 days second level	
Post-Service Claims			30 days first level; 30 days second level	
Concurrent Care Claims			Will be classified as urgent care pre-service or post-service	

TIMEFRAME FOR APPEAL PROCESS

Plan	Deadline for Filing Appeal	Deadline for Extension of Filing Appeal	Deadline for Final Determination	Group Responsible for Final Review
Eligibility Denial—Medical	Pilot has 180 days to request a first level appeal		30 days	Pilot Benefits Administration
Dental Vision	Pilot has 180 days from the date of the level one adverse decision to request a second level appeal		60 days	Fiduciary Appeals Committee
Retiree Health	Pilot has 120 days from the date of the second level adverse decision to request a review by PBRB		120 days	Pilot Benefit Review Board
Basic Life Insurance	60 days after receiving the claim denial notice	60 days from receipt of an adverse claim determination	60 days from receipt of request for review; A 60-day extension may be requested	Securian Life Insurance Company
Optional Life Insurance	60 days after receiving the claim denial notice	60 days from receipt of an adverse claim determination	60 days from receipt of appeal; A 60-day extension may be requested	Securian Life Insurance Company
Basic AD&D (Including Business Travel Accident and CRAF Insurance)	60 days after receiving the claim denial notice	60 days from receipt of an adverse claim determination	60 days from receipt of appeal; A 60-day extension may be requested	Securian Life Insurance Company
Optional AD&D	60 days after receiving the claim denial notice	60 days from receipt of an adverse claim determination	60 days from receipt of appeal A 60-day extension may be requested	Securian Life Insurance Company
Disability	180 days after receiving the claim denial notice	N/A	45 days after receipt of the appeal and all supporting documentation;	The Hartford

TIMEFRAME FOR APPEAL PROCESS

Plan	Deadline for Filing Appeal	Deadline for Extension of Filing Appeal	Deadline for Final Determination	Group Responsible for Final Review
			A 45-day extension may be requested by Aetna; You may request a 30-day extension to supply additional information if the extension request is received before the 45-day determination period runs out	
Dependent Care Flexible Spending Account	First level: 180 days after receiving the claim denial notice Second level: 60 days after receiving the first level appeal denial notice	The review committee may grant an extension based on the circumstances	30 days first level; 30 days second level	HealthEquity first level; Fiduciary Appeals Committee second level
Health Care Flexible Spending Account	First level: 180 days after receiving the claim denial notice Second level: 60 days after receiving the first level appeal denial notice	The review committee may grant an extension based on the circumstances	30 days first level; 30 days second level	HealthEquity first level; Pilot Fiduciary Appeals Committee second level
Health Reimbursement Account (HRA)	First level: 180 days after receiving the claim denial notice Second level: 60 days after receiving the first level appeal denial notice			HealthEquity first level; FedEx Fiduciary Appeals Committee second level
Health Savings Account (HSA)	180 days after receiving the claim denial notice			HealthEquity first level; Fiduciary Appeals Committee second
	Second level: 60 days after receiving			

TIMEFRAME FOR APPEAL PROCESS

Plan	Deadline for Filing Appeal	Deadline for Extension of Filing Appeal	Deadline for Final Determination	Group Responsible for Final Review
	the first level appeal denial notice			
MetLife Legal Plans	60 days after receiving the claim denial notice	The reviewer may grant an extension based on the circumstances	60 days from receipt of appeal; A 30-day extension may be requested	MetLife
Group Long-Term Care Insurance (LTCI) (As of Jan. 1, 2013, this Plan is closed to new enrollees)	60 days after receiving the claim denial notice	N/A	60 days unless additional time is required. Written notification will be provided with the reason for extension; Final decision will be made no later than 120 days after receipt for appeal	MetLife
FedEx Corporation Employees' Pension Plan **FTL Variable Annuity Pension Plan for Pilots** **Non-Qualified Pension Plan for Pilots (Compensation Limit Plan)** **Non-Qualified Section 415 Excess Pension Plan for Pilots** **Pilots' Retirement Savings Plan (PRSP)**	Retirement Non-Disability Appeals 60 days after receiving the claim denial notice	N/A	Non-Disability Appeals 60 days unless additional time is required. Written notification will be provided for a 60-day extension and the reason for extension	Retirement Appeals Committee

TIMEFRAME FOR APPEAL PROCESS

Plan	Deadline for Filing Appeal	Deadline for Extension of Filing Appeal	Deadline for Final Determination	Group Responsible for Final Review
FedEx Corporation Employees' Pension Plan **FTL Variable Annuity Pension Plan for Pilots** **Non-Qualified Pension Plan for Pilots (Compensation Limit Plan)** **Non-Qualified Section 415 Excess Pension Plan for Pilots** **Pilots' Retirement Savings Plan (PRSP)**	Retirement Disability Appeals 180 days after receiving the claim denial notice	N/A	Retirement Disability Appeals 45 days unless additional time is required; Written notification will be provided for a 45-day extension and the reason for extension	Retirement Appeals Committee

Appeals by Authorized Representative

If you want an authorized representative (such as your spouse or another family member) to appeal for you, you must complete an Appeal Authorization/Release of Information form and submit it with your appeal request. (If applicable, your treating physician shall be permitted to act as your authorized representative for urgent care claims without completion of the form.) If you fail to authorize the disclosure under the "Release of Information," the plan will not provide your information to your authorized representative. Except as indicated on the form, information that is disclosed under this authorization may be subject to redisclosure by the authorized representative on the form and no longer protected by law. You can obtain the Claim/Appeal Authorization/Release of Information form by contacting the appropriate claims paying administrator.

For disability claims and appeals, please note that The Hartford does not utilize that Claim/Appeal Authorization/Release of Information. Please contact The Hartford at 1.800.757.0207 regarding designation of an authorized representative for your disability claim or appeal.

Incompetency and Filing an Appeal

If you are incompetent when you receive the claim denial notice and no guardian is appointed for you, your appeal will be timely if you submit it within the timeframes noted in the Timeframe for Appeal Process chart from the date you regain your competency. If you are incompetent when you receive the denial notice and a guardian is appointed for you, your appeal will be timely if your guardian or authorized representative submits it within the timeframes noted in the above chart following the date your guardian is appointed. If you or your authorized

representative does not file an appeal within these timeframes, you will be denied a review and you may be giving up legal rights to later contest the denial of benefits.

To support your appeal, you can submit written comments, documents, records, and other information relating to your claim to the address provided in the denial letter. This information will be reviewed by the claims paying administrator, which will make the final determination on your appeal.

As part of this appeal, you or your authorized representative can review, upon request and free of charge, all documents, records, and information used to make your benefit decision. For a copy of these documents, send your request to the address shown on the denial letter, or call the telephone number shown on the letter. You can include this request as part of your appeal.


FedEx
Express