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. To locate particular items, refer to the detailed Index, with cross-references, at the end of the book. Handy quick-reference tabs allow you to find a section quickly. Each page is coded within each section and is also dated.

Tabbed sections and appendices are:

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Health (H)
Disability (D)
Life Insurance (L)
Retirement (R)
Jumpseat (J)
Other Benefits (O)
What to Do When (W)
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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.

OBTAINING COPIES

Additional copies of the Pilot Benefit Book may be ordered by the Pilot Administration Center through ePro, part number 163009 (CD) or part number 156288 (paper).
## Benefit Plan/Program

### Federal Express Corporation Group Health Plan for Pilots/
Federal Express Corporation Retiree Group Health Plan for Pilots

- **Anthem – Medical Plans**
  - Base Plan for Active and Pre-65 Retired Pilots
  - Buy Up Plan for Active and Pre-65 Retired Pilots
  - High Deductible Plan for Pre-65 Retired Pilots

- **International Plan**

- **Local HMOs**

### Wellness Programs

- **Wellness Centers**
  - WHQ: 901-434-9365
  - WTC: 901-263-5160
  - COS: 719-484-2434
  - CTC: 901-397-3101
  - DAL: 469-524-6044

### Disability

- **Federal Express Corporation Long Term Disability Plan for Pilots (LTD), including Supplementary Disability Benefit**
  - Aetna Life Insurance Company

### Retirement Plans

- **FedEx Corporation Employees’ Pension Plan**
- **Federal Express Corporation Non-Qualified Pension Plan for Pilots**
- **Federal Express Corporation Non-Qualified Section 415 Excess Pension Plan for Pilots**
- **The Flying Tiger Line Inc. Variable Annuity Pension Plan for Pilots (VAPPP)**
- **Federal Express Corporation Pilots’ Retirement Savings Plan**
- **Federal Express Corporation Pilots’ Money Purchase Pension Plan**
  - **FedEx Retirement Service Center**
    - **FedEx Retirement Service Center**
    - **FedEx Retirement Service Center**
    - **The Vanguard Group**
    - **The Vanguard Group**

### Other Benefits

- **Federal Express Corporation Dependent Care Reimbursement Account (DCRA)**
  - WageWorks
- **Group Legal Services Plan for Federal Express Corporation and Affiliated Employers (MetLaw)**
  - MetLife/Hyatt Legal Plans
- **Federal Express Corporation Health Care Savings Account for Pilots (HCSC)**
  - WageWorks
- **Federal Express Corporation Health Reimbursement Arrangement for Retired Pilots (HRA)**
  - WageWorks
- **Federal Express Corporation Group Long-Term Care Insurance**
  - MetLife
- **Federal Express Corporation METPAY Personal Property Insurance**
  - MetLife
- **Work/Life Resource and Referral**
  - LifeCare®

### Eligibility and Enrollments

- **Health, Life Insurance, DCRA, HCSC, and HRA**
  - FedEx Express Pilot Benefits Administration

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*Who to Contact*

(See other side for phone numbers and Internet addresses.)

- **Medical**: Anthem Blue Cross (Anthem)
- **Prescription Drug**: Anthem Pharmacy Services (retail & mail order)
- **Health Information Line**: Anthem 24/7 Nurse Line
- **Health Education and Coaching**: Anthem MyHealthCoach Program
- **Maternity Program**: Future Moms
- **Mental Health and Substance Abuse**: Anthem MHSA
- **Employee Assistance Program (EAP)**: Anthem EAP
- **Condition Management**: Anthem Condition Care
- **Dental**: MetLife
- **Vision**: Davis Vision

- **Medical**: GeoBlue
- **Prescription Drug**: GeoBlue
- **Mental Health and Substance Abuse**: GeoBlue
- **Employee Assistance Program (EAP)**: GeoBlue
- **Dental**: MetLife
- **Vision**: Davis Vision

- **Medical**: Local HMO
- **Prescription Drug**: Local HMO
- **Mental Health and Substance Abuse**: Local HMO
- **Employee Assistance Program (EAP)**: Anthem EAP
- **Dental**: MetLife
- **Vision**: Davis Vision

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*Eligibility and Enrollments*

- **Health, Life Insurance, DCRA, HCSC, and HRA**
  - FedEx Express Pilot Benefits Administration

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<td>Anthem Blue Cross (Anthem)</td>
<td>Medical benefits for Base Plan, Buy Up Plan and High Deductible Plan</td>
<td>Medical: 1-866-406-0982 <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
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<td>Prescription drug benefits (retail and mail order) through Anthem Pharmacy Services for Base Plan, Buy Up Plan and High Deductible Plan</td>
<td>Prescription Drug (retail order and mail order): 1-800-700-2541 or <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
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<td>1-866-621-0130</td>
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<td><a href="http://www.anthemEAP.com">www.anthemEAP.com</a></td>
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<td>GeoBlue</td>
<td>Medical, prescription drug and MHA benefit for the International Plan</td>
<td>1-855-282-3517 in the US Call collect outside US +1-610-254-8769</td>
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<td>for pilots who are internationally based</td>
<td><a href="mailto:customerservice@geo-blue.com">customerservice@geo-blue.com</a></td>
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<td>24/7 Assistance – Provided by HTH Worldwide</td>
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<td></td>
<td>Collect Calls Accepted +1-610-254-8771</td>
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<td><a href="mailto:globalhealth@hthworlwide.com">globalhealth@hthworlwide.com</a></td>
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<td>The Company Store Online–FedEx Collection</td>
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<td>Davis Vision</td>
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<td>1-888-60-FEDEX (1-888-603-3339)</td>
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<td><a href="http://www.davisvision.com">www.davisvision.com</a></td>
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<td>1-800-523-2847 TTY</td>
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<td>Internationally based call collect: 518-220-6000</td>
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<td>Employee Reduced-rate Shipping</td>
<td>FedEx Shipping benefits for eligible active and retired Pilots</td>
<td>Online at the FedEx portal or by notifying FedEx Express Revenue Services at 1-800-622-1147</td>
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<td>common stock through payroll deductions</td>
<td>FedEx Corporation Finance Department, 1-901-818-7100</td>
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<td>Offers a variety of banking services</td>
<td>For Customer Service, call 1-901-344-2500 from the Memphis area or toll-free, nationwide 1-800-228-8513.</td>
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<td><a href="http://www.fecca.com/">http://www.fecca.com/</a></td>
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<td>Eligibility and enrollment for Health, Life Insurance and Dependent Care Reimbursement Account (DCRA), Health Care Savings Account (HCSA) and Health Reimbursement Arrangement for Retired Pilots (HRA)</td>
<td>1-866-795-6353 or <a href="mailto:PBA@fedex.com">PBA@fedex.com</a> 915436353 in Memphis FedEx Benefits Online: <a href="https://fedex.ehr.com">https://fedex.ehr.com</a></td>
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<td>• FedEx Corporation Employees' Pension Plan</td>
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<td>• Federal Express Corporation Non-Qualified Pension Plan for Pilots</td>
<td>1-866-720-4890 TTY</td>
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<td>• Federal Express Corporation Non-Qualified Section 415 Excess Pension Plan for Pilots</td>
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<td>• FTL Variable Annuity Pension Plan for Pilots</td>
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<td>• FTL Fixed Pension Plan</td>
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<td>Global Travel</td>
<td>Offers eligible pilots and retirees discount privileges for both business</td>
<td>FedEx Express Intranet site (keyword: global travel) 1-901-397-2700</td>
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<td>and personal travel</td>
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<td>LifeCare®</td>
<td>Resource and referral program to assist with work/life issues</td>
<td>1-877-LIFEFDX (1-877-543-3339)</td>
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<td><a href="http://www.lifecare.com">www.lifecare.com</a></td>
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<td>Company Name: fedex</td>
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<td></td>
<td></td>
<td>Password: your FedEx employee number (add leading zeros to make a 10-digit password) 1-800-346-9188 TTY</td>
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<tr>
<td>MetLife: Auto, Home, Personal Property</td>
<td>MetPay: Personal property insurance program for automobiles, renters,</td>
<td>1 800 GET-MET (1-800-438-6388)</td>
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<td>homes, condominiums, boats and recreational vehicles</td>
<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
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<td>MetLife: Dental</td>
<td>Benefits for Pilots Base Dental Plan and Buy Up Dental Plans</td>
<td>1-800-540-5233</td>
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<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
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<td>1-888-638-4863 TTY</td>
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<td>For Internationally Based: 800-962-1401 using AT&amp;T access code</td>
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<td>MetLife/Hyatt Legal Plans: Group Legal Services Plan</td>
<td>MetLaw: Prepaid Group Legal Services</td>
<td>1 800 GET-MET (1-800-438-6388)</td>
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<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
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<td>Tuition Assistance Program</td>
<td>Tuition reimbursement</td>
<td>1-901-434-9822</td>
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<td><a href="mailto:tuition.assistance@fedex.com">tuition.assistance@fedex.com</a></td>
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<td>• Federal Express Corporation Pilots’ Retirement Savings Plan</td>
<td><a href="http://www.vanguard.com">www.vanguard.com</a></td>
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<td>• Federal Express Corporation Pilots’ Money Purchase Pension Plan</td>
<td>1-800-523-1188 English</td>
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<td></td>
<td>1-800-523-8004 TTY</td>
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<td>1-800-828-4497 Spanish</td>
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<td>WageWorks</td>
<td>• Dependent Care Reimbursement Account (DCRA)</td>
<td><a href="http://www.wageworks.com">www.wageworks.com</a></td>
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<tr>
<td></td>
<td>• Health Care Savings Account (HCSA) for Pilots</td>
<td>1-877-924-3967</td>
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<tr>
<td></td>
<td>• Health Reimbursement Arrangement for Retired Pilots (HRA)</td>
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<tr>
<td>Wellness Programs</td>
<td>• Wellness Centers</td>
<td>WHQ: 901-434-9365</td>
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<td>• Membership and programs at FedEx facilities</td>
<td>WTC: 901-263-5160</td>
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<td>COS: 719-484-2434</td>
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<td>CTC: 901-397-3101</td>
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<td>DAL: 469-524-6044</td>
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2013 Pilot Benefits Directory
For Pilots and Covered Dependents Who Participate in FedEx Express Benefit Plans and Programs
Save for future reference.
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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. The benefits programs described in this book are available to active and retired pilots. For purposes of this book, the term “pilot” means an employee of Federal Express Corporation 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), which was initially effective on May 31, 1999, and amended on February 28, 2011. 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.

Pilots participate in certain benefit enhancements. However, the Company is not obligated to continue providing these enhanced benefits should they be unavailable or discontinued for any reason for all employees.

Some examples of these enhancements are:

- Group Legal Services Plan
- Long-Term Care Insurance (effective January 1, 2013, this plan is closed to new enrollees)
- METPAY℠ Program
- Tuition Assistance Program
- LifeCare
- Employee Stock Purchase Plan (ESPP)
- Company Service Awards
- Smoking Cessation Assistance
- Global Travel

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

Each benefit in this book is based on a formal plan document or contract. If there is a conflict between this book and the official plan documents, the plan documents always govern. You are not entitled to, nor denied benefits, because of a misstatement in, or omission from this book.

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.
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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Plans, Programs &amp; Services</th>
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| Medical (includes Mental Health/Substance Abuse, Prescription Drug, Dental and Vision benefits) | Group Health Plan for Pilots  
Retiree Group Health Plan for Pilots |
| Employee Assistance Program (EAP) | Anthem: EAP |
| Long Term Disability including Supplementary Disability Benefit | Long Term Disability (LTD) Plan for Pilots |
| Life Insurance | • Basic Life Insurance Plan  
• Optional Life Insurance Plan  
• Retiree Optional Life Insurance Plan  
• Basic Accidental Death and Dismemberment (AD&D) Plan  
• Optional Accidental Death and Dismemberment (AD&D) Plan  
• Business Travel Accident Plan  
• CRAF Business Travel Accident Plan |
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<th>Benefit</th>
<th>Benefit Plans, Programs &amp; Services</th>
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</thead>
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<td>• Non-Qualified Pension Plan for Pilots (Compensation Limit Plan)</td>
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<tr>
<td></td>
<td>• Non-Qualified Section 415 Excess Pension Plan for Pilots</td>
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<td></td>
<td>• FTL Variable Annuity Pension Plan for Pilots</td>
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<td></td>
<td>• Pilots’ Retirement Savings Plan (PRSP), including Pre-tax/401(k), Employer Matching on Pre-tax/401(k), After-tax, Sick Bank and if eligible, Catch-up contributions</td>
</tr>
<tr>
<td></td>
<td>• Pilots’ Money Purchase Pension Plan (PMPPP)</td>
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<td>*<em>Salary Deferral Plans</em></td>
<td>• Dependent Care Reimbursement Account (DCRA) Plan*</td>
</tr>
<tr>
<td></td>
<td>• Health Care Contribution Account Plan*</td>
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<tr>
<td></td>
<td>• Health Care Savings Account (HCSA) Plan for Pilots (also known as the Health Care Spending Account (HCSA)*</td>
</tr>
<tr>
<td><strong>HRA VEBA Trust</strong></td>
<td>• Health Reimbursement Arrangement (HRA) for Retired Pilots</td>
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<tr>
<td>*<em>Voluntary Benefit Plans</em></td>
<td>• Group Legal Services Plan for Federal Express Corporation and Affiliated Employers (GLSP)*</td>
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<td>• Group Long-Term Care Insurance (LTCI)* [closed to new enrollees, effective 1/1/2013]</td>
</tr>
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<td></td>
<td>• METPAYSM Program—auto, home and personal property insurance*</td>
</tr>
<tr>
<td>*<em>Other Plans, Programs and Services</em></td>
<td>• Catalog Store</td>
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<td>• Credit Association</td>
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<td>• Employee Reduced-rate Shipping</td>
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<td>• Employee Stock Purchase Plan (ESPP)</td>
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<tr>
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<td>• Flower Program</td>
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<td>• Global Travel</td>
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<td>• LifeCare® Employee Resource and Referral Program</td>
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<td>• Wellness Programs</td>
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<td>• Service Awards</td>
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<td>• Retirement Awards</td>
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<td></td>
<td>• Tuition Assistance Program</td>
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</tbody>
</table>

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

With respect to pilots, the Company may terminate, modify or suspend any benefit plan or program only as permitted by the terms of the Collective Bargaining Agreement.

**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 Summary Plan Descriptions (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 for Health & Welfare or the Retirement Service Center for Retirement Plans, as applicable. A reasonable charge may be made to cover the cost of copying. 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 four categories:

- Trusteed Plans
- Insured Plans
- General Asset Plans
- Salary Deferral 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.

<table>
<thead>
<tr>
<th>Trusteed Plans</th>
<th>Trustee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flying Tiger Line Inc. Variable Annuity Pension Plan for Pilots (VAPPP)</td>
<td>State Street Bank and Trust Company 2 Avenue de Lafayette, 2nd Floor Boston, MA 02111</td>
</tr>
<tr>
<td>Long Term Disability Plan (LTD)</td>
<td></td>
</tr>
<tr>
<td>FedEx Corporation Employees’ Pension Plan (Pension Plan)</td>
<td>Mercer Trust Company 1 Investors Way Norwood, MA 02062</td>
</tr>
<tr>
<td>Health Reimbursement Arrangement (HRA) for Retired Pilots</td>
<td>Vanguard Fiduciary Trust Company Attn: Plan #093015 100 Vanguard Boulevard Malvern, PA 19355</td>
</tr>
<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)</td>
<td>Vanguard Fiduciary Trust Company Attn: Plan #092482 100 Vanguard Boulevard Malvern, PA 19355</td>
</tr>
<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)</td>
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</tbody>
</table>

**Insured Plans** — For insured plans, premiums are paid to an insurance company. Benefit payments are paid by the insurance company. Local HMOs, which are available in certain areas, and the International Plan are considered insured health plans.

<table>
<thead>
<tr>
<th>Insured Plans</th>
<th>Insurance Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Insurance Plan</td>
<td>Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066</td>
</tr>
<tr>
<td>Optional Life Insurance Plan Retiree Optional Life Insurance Plan</td>
<td>Prudential Insurance Co. of America P.O. Box 8517 Philadelphia, PA 19176</td>
</tr>
</tbody>
</table>
### General Asset Plans

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

<table>
<thead>
<tr>
<th><strong>Insured Plans</strong></th>
<th><strong>Insurance Company</strong></th>
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</thead>
<tbody>
<tr>
<td>Basic Accidental Death and Dismemberment (AD&amp;D) Plan</td>
<td>National Union Fire Insurance Company of Pittsburgh, PA</td>
</tr>
<tr>
<td>Optional Accidental Death and Dismemberment (AD&amp;D) Plan</td>
<td>175 Water Street, 18th Floor New York, NY 10038</td>
</tr>
<tr>
<td>Business Travel Accident Plan</td>
<td></td>
</tr>
<tr>
<td>CRAF Business Travel Accident Plan</td>
<td></td>
</tr>
<tr>
<td>Group Legal Services Plan for Federal Express Corporation and Affiliated Employers (GLSP)</td>
<td>MetLaw (Hyatt Legal Plans) 1111 Superior Avenue Cleveland, OH 44114-2507 1-800-GET-MET8 (1-800-438-6388) <a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
</tr>
<tr>
<td>METPAYSM Program – (Voluntary Personal Property Insurance)</td>
<td>Metropolitan Life Insurance Company Voluntary Benefits Group 501 Route 22, Third Floor Bridgewater, NJ 08807 1-800-GET-MET8 (1-800-438-6388) <a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
</tr>
<tr>
<td>Group Long-Term Care Insurance (LTCI) [Effective 1/1/2013, this Plan is closed to new enrollees.]</td>
<td>Metropolitan Life Insurance Company Voluntary Benefits Group 501 Route 22, Third Floor Bridgewater, NJ 08807 1-800-GET-MET8 (1-800-438-6388)</td>
</tr>
</tbody>
</table>

### Salary Deferral Plans

**Salary deferral plans** are paid out of the pretax salary deferrals of pilots. Salary deferral plans include:

- Health Care Contribution Account Plan. See page H-14 for an explanation of this account.
- Dependent Care Reimbursement Account Plan. See page O-3 for an explanation of this account.
- Health Care Savings Account Plan for Pilots. See page O-10 for an explanation of this account.
**Claim Administration**

Benefit payments are made by the following companies for the identified benefits. These companies are sometimes referred to as “claims paying administrators.” See “Claims and Appeals” on page I-17 for information on the claims and appeals process.

Refer to the following chart for the appropriate address of where to send claims and appeals:

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<th>Claims Administration</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Health: Medical Base Plan Buy Up Plan Retiree Group Health: Medical Base Plan Buy Up Plan High Deductible Plan</td>
<td>Anthem Blue Cross 3179 Temple Avenue, Suite 200 Pomona, CA 91768 1-866-406-0982 <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007</td>
<td><strong>Send benefit appeals to:</strong> Anthem Blue Cross 21555 Oxnard Street Attention: Appeals Department, 6J Woodland Hills, CA 91367 or Anthem Blue Cross Grievance and Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310 <strong>Send eligibility appeals to:</strong> FedEx Express Pilot Benefits Administration Appeals 3660 Hacks Cross Road Building F-2, Delivery Code 7512 Memphis, TN 38125-8800</td>
</tr>
<tr>
<td>Group Health: Medical Retiree Group Health: Medical</td>
<td></td>
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</tr>
<tr>
<td>Group Health: Prescription Drug Base Plan Buy Up Plan Retiree Group Health: Prescription Drug Base Plan Buy Up Plan High Deductible Plan</td>
<td>Anthem Pharmacy Services, administered by Express Scripts, Inc. (ESI) Mail Order or Retail Express Scripts, Inc. (ESI) P.O. Box 66558 St. Louis, MO 63166-6558 or Express Scripts, Inc. (ESI) 4600 N. Hanley St. Louis, MO 63134 1-866-406-0982 <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
<td><strong>Send benefit appeals to:</strong> Anthem Blue Cross 21555 Oxnard Street Attention: Appeals Department, 6J Woodland Hills, CA 91367 or Anthem Blue Cross Grievances and Appeals P.O. Box 4310 Woodland Hills, CA 91365-4310 <strong>Send eligibility appeals to:</strong> FedEx Express Pilot Benefits Administration Appeals 3660 Hacks Cross Road Building F-2, Delivery Code 7512 Memphis, TN 38125-8800</td>
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<tr>
<td>Plan</td>
<td>Claims Administration</td>
<td>Appeals</td>
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<tr>
<td>Group Health: Dental</td>
<td>MetLife Group Dental Claims</td>
<td><strong>Send benefit appeals to:</strong></td>
</tr>
<tr>
<td>Retiree Group Health: Dental</td>
<td>P.O. Box 981282</td>
<td>MetLife/FedEx Dental Claims</td>
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<tr>
<td></td>
<td>El Paso, TX 79998-1282</td>
<td>P.O. Box 14589</td>
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<tr>
<td></td>
<td>1-800-540-5233</td>
<td>Lexington, KY 40512</td>
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<td></td>
<td>COMAIL: ELP/TX/79906-0000</td>
<td><strong>Overnight Letter Mailing:</strong></td>
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<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
<td>MetLife/FedEx Dental Claims</td>
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<td></td>
<td>P.O. Box 14589</td>
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<td>Lexington, KY 40512</td>
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<td>Davis Vision</td>
<td><strong>Send eligibility appeals to:</strong></td>
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<td>Group Health: Vision</td>
<td>Vision Care Processing Unit</td>
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<tr>
<td></td>
<td>Latham, NY 12110</td>
<td>3660 Hacks Cross Road</td>
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<tr>
<td></td>
<td>1-888-60-FEDEX (1-888-603-3339)</td>
<td>Building F-2, Delivery Code 7512</td>
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<td><a href="http://www.davisvision.com">www.davisvision.com</a></td>
<td>Memphis, TN 38125-8800</td>
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<td>Davis Vision</td>
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<td>Attn: Quality Assurance/Patient Advocate Department</td>
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<tr>
<td><strong>Group Health: Mental Health/Substance Abuse</strong>&lt;br&gt;Retiree Group Health: Mental Health/Substance Abuse</td>
<td><strong>Anthem MHSA</strong>&lt;br&gt;3179 Temple Avenue, Suite 200&lt;br&gt;Pomona, CA 91768&lt;br&gt;1-866-406-0982&lt;br&gt;www.anthem.com/ca&lt;br&gt;or&lt;br&gt;Anthem Blue Cross&lt;br&gt;P.O. Box 60007&lt;br&gt;Los Angeles, CA 90060-0007</td>
<td><strong>Send benefit appeals to:</strong>&lt;br&gt;Anthem MHSA&lt;br&gt;9655 Granite Ridge Drive&lt;br&gt;Appeals Department, 6th Floor&lt;br&gt;San Diego, CA 92123&lt;br&gt;1-800-728-9498&lt;br&gt;FAX 1-805-384-3171&lt;br&gt;or&lt;br&gt;BH—Grievances and Appeals&lt;br&gt;P.O. Box 23330&lt;br&gt;San Diego, CA 92193&lt;br&gt;<strong>Send eligibility appeals to:</strong>&lt;br&gt;FedEx Express Pilot Benefits&lt;br&gt;3660 Hacks Cross Road&lt;br&gt;Building F-2, Delivery Code 7512&lt;br&gt;Memphis, TN 38125-8800</td>
</tr>
<tr>
<td><strong>Group Health: Mental Health/Substance Abuse</strong>&lt;br&gt;Retiree Group Health: Mental Health/Substance Abuse</td>
<td></td>
<td><strong>Send eligibility appeals to:</strong>&lt;br&gt;FedEx Express Pilot Benefits&lt;br&gt;Administration Appeals&lt;br&gt;3660 Hacks Cross Road&lt;br&gt;Building F-2, Delivery Code 7512&lt;br&gt;Memphis, TN 38125-8800</td>
</tr>
<tr>
<td><strong>Long Term Disability (LTD), including Supplementary Disability Benefit</strong></td>
<td><strong>Aetna Life Insurance Company</strong>&lt;br&gt;FedEx Disability Claims Unit&lt;br&gt;1600 SW 80th Terrace&lt;br&gt;Plantation, FL 33324&lt;br&gt;1-800-757-0207</td>
<td><strong>Send benefit appeals to:</strong>&lt;br&gt;Aetna Life Insurance Company&lt;br&gt;FedEx Disability Claims Unit&lt;br&gt;1600 SW 80th Terrace&lt;br&gt;Plantation, FL 33324&lt;br&gt;1-800-757-0207</td>
</tr>
<tr>
<td>Plan</td>
<td>Claims Administration</td>
<td>Appeals</td>
</tr>
<tr>
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</tr>
<tr>
<td>Dependent Care Reimbursement Account (DCRA) Plan</td>
<td>WageWorks, Inc. P.O. Box 14053 Lexington, KY 40512 1-800-924-3967 <a href="http://www.wageworks.com">www.wageworks.com</a> fax: 1-877-353-9236</td>
<td>WageWorks Claims Appeal Board P.O. Box 991 Mequon, WI 53092-0991</td>
</tr>
<tr>
<td>Health Care Savings Account (HCSA) Plan for Pilots</td>
<td>for questions on claims or account balances call: 1-977-864-6644 Account Balance information also at <a href="http://www.ibenefit">www.ibenefit</a> center.com Claims information also at <a href="http://www.wageworks.com">www.wageworks.com</a> Mail claims to: WageWorks, Inc. P.O. Box 14053 Lexington, KY 40512 Submit online claims at <a href="http://www.wageworks.com">www.wageworks.com</a> Fax claims to: Fax: 1-877-353-9236</td>
<td>FedEx Express Pilot Benefits Administration Appeals 3660 Hacks Cross Road Building F-2, Delivery Code 7512 Memphis, TN 38125-8800</td>
</tr>
<tr>
<td>Health Reimbursement Arrangement for Retired Pilots</td>
<td></td>
<td>Send first level claims appeals to: WageWorks Claims Appeal Board P.O. Box 991 Mequon, WI 53092-0991 Send second level and eligibility appeals to: FedEx Express Benefit Appeals 3660 Hacks Cross Road Building F-2, Delivery Code 7512 Memphis, TN 38125-8800</td>
</tr>
<tr>
<td>Pension* Non-Qualified Pension Plan for Pilots (Compensation Limit Plan)*</td>
<td>FedEx Retirement Service Center 540 Lake Cook Road Suite 600 Deerfield, IL 60015 1-866-303-0556</td>
<td>FedEx Retirement Appeals c/o Retirement Service Center P.O. Box 980 Deerfield, IL 60015 Or overnight: 540 Lake Cook Road, Suite 600 Deerfield, IL 60015</td>
</tr>
<tr>
<td>Non-Qualified Section 415 Excess Pension Plan for Pilots* FTL Variable Annuity Pension Plan for Pilots*</td>
<td>The Vanguard Group, Inc. Attn: Plan #093015 100 Vanguard Boulevard Malvern, PA 19355 1-800-523-1188 <a href="http://www.vanguard.com">www.vanguard.com</a></td>
<td>FedEx Corporation Attn: Retirement Appeals Committee 1000 Ridgeway Loop Road, 5th Floor Memphis, TN 38120</td>
</tr>
<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)*</td>
<td>The Vanguard Group, Inc. Attn: Plan #092482 100 Vanguard Boulevard Malvern, PA 19355 1-800-523-1188 <a href="http://www.vanguard.com">www.vanguard.com</a></td>
<td>FedEx Corporation Attn: Retirement Appeals Committee 1000 Ridgeway Loop Road, 5th Floor Memphis, TN 38120</td>
</tr>
<tr>
<td>Plan</td>
<td>Claims Administration</td>
<td>Appeals</td>
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</tr>
<tr>
<td>Basic Accidental Death and Dismemberment (AD&amp;D) Insurance</td>
<td>Chartis Domestic Claims Accident &amp; Health</td>
<td><strong>Send claims appeals to:</strong></td>
</tr>
<tr>
<td>Optional AD&amp;D Insurance</td>
<td>P.O. Box 25987</td>
<td>Chartis Domestic Claims Accident &amp; Health</td>
</tr>
<tr>
<td>Business Travel Accident Insurance</td>
<td>Shawnee Mission, KA 66225</td>
<td>P.O. Box 25987</td>
</tr>
<tr>
<td>CRAF Business Travel Accident Insurance</td>
<td></td>
<td>Shawnee Mission, KA 66225</td>
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<tr>
<td></td>
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<td><strong>Send eligibility appeals to:</strong></td>
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<tr>
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<td>FedEx Express Pilot Benefits Appeals</td>
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<td>3660 Hacks Cross Road</td>
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<td>Building F-2, Delivery Code 7512</td>
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<td>Memphis, TN 38125-8800</td>
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<tr>
<td>Basic Life Insurance</td>
<td>Lincoln National Life Insurance Company</td>
<td><strong>Send claims appeals to:</strong></td>
</tr>
<tr>
<td></td>
<td>8801 Indian Hills Drive Omaha, NE 68114-4066</td>
<td>Lincoln National Life Insurance Company</td>
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<tr>
<td></td>
<td></td>
<td>8801 Indian Hills Drive Omaha, NE 68114-4066</td>
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<td><strong>Send eligibility appeals to:</strong></td>
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<td>FedEx Express Pilot Benefits Appeals</td>
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<td>Memphis, TN 38125-8800</td>
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<tr>
<td>Optional Life Insurance</td>
<td>Prudential Insurance Co. of America Group Life Claims Division</td>
<td><strong>Send claims appeals to:</strong></td>
</tr>
<tr>
<td>Retiree Optional Life Insurance</td>
<td>P.O. Box 8517</td>
<td>Prudential Insurance Co. of America Group Life Claims Division</td>
</tr>
<tr>
<td></td>
<td>Philadelphia, PA 19176</td>
<td>P.O. Box 8517</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Philadelphia, PA 19176</td>
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<tr>
<td></td>
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<td><strong>Send eligibility appeals to:</strong></td>
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<td>3660 Hacks Cross Road</td>
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<td>Building F-2, Delivery Code 7512</td>
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<td>Memphis, TN 38125-8800</td>
</tr>
<tr>
<td>Group Legal Services Plan (GLSP) (MetLaw)</td>
<td>Hyatt Legal Plans</td>
<td><strong>Send claims appeals to:</strong></td>
</tr>
<tr>
<td></td>
<td>1111 Superior Avenue Cleveland, OH 44114-2507</td>
<td>Hyatt Legal Plans</td>
</tr>
<tr>
<td></td>
<td>1-800-GET-MET8 (1-800-438-6388)</td>
<td>1111 Superior Avenue Cleveland, OH 44114-2507</td>
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<tr>
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<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
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<td><strong>Send eligibility appeals to:</strong></td>
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<td>FedEx Express Pilot Benefits Appeals</td>
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<td>3660 Hacks Cross Road</td>
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<td></td>
<td></td>
<td>Building F-3, Delivery Code 7546</td>
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<td></td>
<td></td>
<td>Memphis, TN 38125-8800</td>
</tr>
</tbody>
</table>
### Plan Administration

#### Plan Identification

The IRS has assigned employer identification number 71-0427007 to FedEx Express. 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.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Plan Number</th>
<th>Plan Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>FedEx Corporation Employees’ Pension Plan</td>
<td>002</td>
<td>FedEx Retirement Service Center*</td>
</tr>
<tr>
<td>Flying Tiger Line Inc. Variable Annuity Pension Plan for Pilots (VAPPP)</td>
<td>004</td>
<td>FedEx Retirement Service Center*</td>
</tr>
<tr>
<td>Federal Express Corporation Non-Qualified Pension Plan for Pilots</td>
<td>N/A</td>
<td>For Overnight Delivery send to:</td>
</tr>
<tr>
<td>Federal Express Corporation Non-Qualified $415 Excess Pension Plan for Pilots</td>
<td>N/A</td>
<td>540 Lake Cook Road, Suite 600</td>
</tr>
</tbody>
</table>

*For Domestic Relations Orders, contact or send orders to:*

Mercer
QDRO Administration
400 W. Market Street, Suite 700
Louisville, KY 40202-3346
1-502-561-4572 (toll call)
1-888-598-7260 (toll free)
1-502-561-8999 (fax)

You may also request contact via email at QDRO@mercer.com.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Plan Number</th>
<th>Plan Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Express Corporation Pilots’ Money Purchase Pension Plan (PMPPP)</td>
<td>006</td>
<td>The Vanguard Group, Inc.* Attn: Plan #093015 (PRSP) or Attn: Plan #092482 (PMPPP)</td>
</tr>
<tr>
<td>Federal Express Corporation Pilots’ Retirement Savings Plan (PRSP)</td>
<td>007</td>
<td>100 Vanguard Boulevard Malvern, PA 19355 1-800-523-1188 1-800-749-7273 for hearing impaired <a href="http://www.Vanguard.com">www.Vanguard.com</a></td>
</tr>
<tr>
<td>Federal Express Corporation Group Health Plan for Pilots</td>
<td>527</td>
<td>FedEx Express Employee Benefits 3660 Hacks Cross Road Building F-2, Delivery Code 7512 Memphis, TN 38125-8800 1-866-795-6353 Nationwide 1-901-434-6353 Memphis area</td>
</tr>
<tr>
<td>(Medical, Prescription Drug, Mental Health/Substance Abuse, Eligibility, Dental, Vision)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FedEx Corporation Business Travel Accident CR A Business Travel Accident Insurance</td>
<td>503</td>
<td>National Union Fire Insurance of Pittsburgh, PA 175 Water Street, 18th Floor New York, NY 10038</td>
</tr>
<tr>
<td>FedEx Corporation Accidental Death and Dismemberment Insurance including Optional AD&amp;D</td>
<td>504</td>
<td></td>
</tr>
<tr>
<td>Federal Express Corporation Employee Assistance Program for Pilots (Anthem)</td>
<td>529</td>
<td>FedEx Express Employee Benefits 3660 Hacks Cross Road Building F 2nd Floor, Delivery Code 7512 Memphis, TN 38125-8800 1-866-795-6353 Nationwide 1-901-434-6353 Memphis area</td>
</tr>
<tr>
<td>Federal Express Corporation Basic Life Insurance</td>
<td>511</td>
<td>Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68014</td>
</tr>
<tr>
<td>Federal Express Corporation Health Care Savings Account Plan for Pilots</td>
<td>524</td>
<td></td>
</tr>
<tr>
<td>Federal Express Corporation Retiree Group Health Plan for Pilots</td>
<td>528</td>
<td></td>
</tr>
<tr>
<td>(Medical, Prescription Drug, Mental Health/Substance Abuse, Eligibility, Dental, Vision)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Express Corporation Dependent Care Reimbursement Account Plan</td>
<td>516</td>
<td></td>
</tr>
<tr>
<td>Federal Express Corporation Health Care Contribution Plan</td>
<td>517</td>
<td></td>
</tr>
</tbody>
</table>
**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)
- Federal Express Corporation Pilots’ Money Purchase Pension Plan (PMPPP)
- The Flying Tiger Line Inc. Variable Annuity Pension Plan for Pilots (VAPPP)
- Federal Express Corporation Dependent Care Reimbursement Account Plan (DCRA)
- Federal Express Corporation Health Care Savings Account (HCSA) Plan for Pilots
- Federal Express Corporation Health Care Contribution Plan
- Federal Express Corporation Health Reimbursement Arrangement for Retired Pilots
- Federal Express Corporation Group Long-Term Care Insurance Plan
- Group Legal Services for Federal Express Corporation and Affiliated Employers Plan
- FedEx Corporation Business Travel Accident Plan
- FedEx Corporation Accidental Death & Dismemberment Insurance Plan, including Optional AD&D
- Federal Express Corporation Basic Life Insurance Plan
- Federal Express Optional Life Insurance Plan
- Federal Express Corporation Long Term Disability Plan for Pilots

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<table>
<thead>
<tr>
<th>Plan</th>
<th>Plan Number</th>
<th>Plan Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Express Corporation Long Term Disability Plan for Pilots</td>
<td>523</td>
<td>FedEx Express Employee Benefits 3660 Hacks Cross Road Building F 3rd Floor, Delivery Code 7546 Memphis, TN 38125-8800 1-866-795-6353 Nationwide 1-901-434-6353 Memphis area</td>
</tr>
<tr>
<td>Federal Express Corporation Optional Life Insurance Plan</td>
<td>514</td>
<td>The Prudential Insurance Company of America 751 Broad Street Newark, NJ 07102</td>
</tr>
<tr>
<td>Federal Express Corporation Group Long-Term Care Insurance Plan [Effective 1/1/2013, this plan is closed to new enrollees]</td>
<td>521</td>
<td>FedEx Express Employee Benefits 3660 Hacks Cross Road Building F 3rd Floor, Delivery Code 7546 Memphis, TN 38125-8800 1-866-795-6353 Nationwide 1-901-434-6353 Memphis area</td>
</tr>
<tr>
<td>Group Legal Services for Federal Express Corporation and Affiliated Employers Plan</td>
<td>522</td>
<td>FedEx Express Employee Benefits 3660 Hacks Cross Road Building F 3rd Floor, Delivery Code 7546 Memphis, TN 38125-8800 1-901-434-9822</td>
</tr>
</tbody>
</table>

*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 the Vanguard Group, Inc. for the PMPPP and the PRSP.*
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 administrators 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 summary plan descriptions. 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 60) 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 summary plan description 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.

**Notice of Privacy Practices**

“We” refers to the Federal Express Corporation Group Health Plan for Pilots and the Federal Express Corporation Retiree Group Health Plan for Pilots, also referred to as “Plan.” “You” or “yours” refers to individual participants in the Plan. If you are covered by an insured health plan option under the Plan you will receive a separate notice from the insurer or HMO.

**Purpose of Notice** — We are required by federal law to protect the privacy of your individual health information (referred to in this notice as “Protected Health Information”). We are also required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information and to abide by the terms of this notice, as it may be updated from time to time.

**Use and Disclosure of Protected Health Information** — Under applicable law, we are permitted to use and disclose your Protected Health Information, without your authorization, for treatment, payment and health care operations purposes.

For treatment purposes, such use and disclosure may take place in providing health care information to a health care provider for the purpose of treating you. For example, we may disclose Protected Health Information to your Primary Care Physician for the purpose of providing health care services to you.

For payment purposes, such use and disclosure may take place to determine responsibility for coverage and benefits, such as when we confer with other health plans to resolve coordination of benefits issues. We also may use your Protected Health Information for other payment-related purposes, such as to assist in making plan eligibility and coverage determinations, or for utilization review activities.

For health care operations purposes, such use and disclosure may take place in a number of ways involving plan administration, including for quality assessment and improvement, vendor review and underwriting activities. Your information could be used, for example, to assist in the evaluation of one or more vendors who support us or other health-related benefits and services available under the Plan.

We may disclose your Protected Health Information to the plan sponsor in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose Protected Health Information to the plan sponsor in connection with payment, treatment or health care operations.
In addition, we may use or disclose your Protected Health Information without your authorization under conditions specified in federal regulations, including:

- As required by law, provided the use or disclosure complies with and is limited to relevant requirements of such law
- For public health activities
- To an appropriate government authority regarding victims of abuse, neglect or domestic violence
- To a health oversight agency for oversight activities authorized by law
- In connection with judicial and administrative proceedings
- To a law enforcement official for law enforcement purposes
- To a coroner or medical examiner for the purpose of identifying a deceased person
- To cadaveric organ, eye or tissue donation programs
- For research purposes, as long as certain privacy-related standards are satisfied
- To avert a serious threat to health or safety
- For specialized government functions (for example, military and veterans activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- For Worker’s Compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault, and
- To a Business Associate of the Plan, provided that such Business Associate enters into an agreement with the Plan as required by the privacy regulations.

We may disclose to one of your family members, to a relative, to a close personal friend or to any other person identified by you, Protected Health Information that is directly relevant to the person’s involvement with your care or payment related to your care. In addition, we may use or disclose Protected Health Information to notify a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, there is an emergency or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do whatever in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person’s involvement with your health care.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization in writing at any time.

You may ask us to restrict uses and disclosures of your Protected Health Information to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request. Effective February 17, 2010, we will comply with any restriction request if the request pertains solely to health care for which you have paid in full. You may exercise this right by contacting the individual or office identified at the end of this notice. They will provide additional information to you.

You have the right to request the following with respect to your Protected Health Information: (i) inspection and copying; (ii) amendment or correction; (iii) an accounting of certain disclosures of this information by us (you are not entitled to an accounting of disclosures made for payment, treatment or health care operations, or
disclosures made pursuant to your written authorization); and (iv) the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

You have the right to request in writing that you receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that disclosure could pose a danger to you.

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured Protected Health Information.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information we maintain. If we change this notice, you will receive a new notice by mail or in a new Pilot Benefit Book edition or supplement.

If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below under “Contacting Us” or to the regional office of the Office of Civil Rights (OCR). You should call the OCR at 1-800-368-1019 for assistance in determining the appropriate OCR regional office to which your complaint should be sent. You will not be retaliated against for filing a complaint.

**Contacting Us —** You may exercise the rights described in this notice by contacting the office identified below. They will provide you with additional information. The contact is:

Federal Express Corporation
Employee Benefits Administration Manager
3660 Hacks Cross Road
Building F-2, Delivery Code 7512
Memphis, TN 38125-8800
1-866-795-6353 or 1-901-434-6353 in Memphis area

Effective date of notice: June 1, 2012

**Claims and Appeals**

**Filing a Claim — Your Rights**

If you think you are eligible to participate or 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 Plans

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Description</th>
<th>To Make Initial Claim Determination</th>
<th>Extension by Claims Paying Administrator</th>
<th>To Request Missing Claim Information from Claimant</th>
<th>For Claimant to Provide Missing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Claims for Medical (including MHSA and pharmacy), * Dental and/or Vision</td>
<td>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</td>
<td>72 hours after receipt of the claim, unless you don't provide enough information</td>
<td>None</td>
<td>24 hours after receipt of the claim</td>
<td>You have 48 hours to provide missing information</td>
</tr>
<tr>
<td>Pre-service Claims (non urgent) for Medical (including MHSA and pharmacy), * Dental and/or Vision</td>
<td>Any request for services requiring precertification made in advance of receiving care</td>
<td>15 days after receipt of the claim</td>
<td>15 days; extension notice must be sent before the first 15-day period runs out</td>
<td>5 days after receipt of claim</td>
<td>You have 45 days to provide missing information</td>
</tr>
<tr>
<td>Post-service Claims for Medical (including MHSA and pharmacy), * Dental and/or Vision</td>
<td>Any other type of claim; a claim after care is received</td>
<td>30 days after receipt of the claim</td>
<td>15 days extension notice sent before the first 30-day period runs out</td>
<td>Anytime during determination period</td>
<td>You have 45 days to provide missing information</td>
</tr>
<tr>
<td>Concurrent Care (will be reclassified as Urgent Care, Pre-service or Post-service Care) for Medical (including MHSA and pharmacy), * Dental and/or Vision</td>
<td>Reduction of a specific number of treatments, or previously approved ongoing treatments, or termination of treatment</td>
<td>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</td>
<td>Determined by claim type</td>
<td>Determined by claim type</td>
<td>Determined by claim type</td>
</tr>
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</table>
### Claims Processing Periods for Health and Welfare Plans and Retirement Plans

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<tr>
<th>Claim Type</th>
<th>Description</th>
<th>To Make Initial Claim Determination</th>
<th>Extension by Claims Paying Administrator</th>
<th>To Request Missing Claim Information from Claimant</th>
<th>For Claimant to Provide Missing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Accidental Death &amp; Dismemberment (AD&amp;D)</td>
<td>A claim is filed under the Basic AD&amp;D Plan</td>
<td>90 days after receipt of the claim</td>
<td>90 days; extension notice sent before the first 90-day period runs out</td>
<td>Before the end of the 90-day period</td>
<td>Determined by the insurance company</td>
</tr>
<tr>
<td>Optional Accidental Death and Dismemberment (AD&amp;D)</td>
<td>A claim filed under the Optional AD&amp;D Plan</td>
<td>90 days after receipt of the claim</td>
<td>90 days; extension notice sent before the first 90-day period runs out</td>
<td>Before the end of the 90-day period</td>
<td>Determined by the insurance company</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>A claim filed under the Business Travel Plan</td>
<td>90 days after receipt of the claim</td>
<td>90 days; extension notice sent before the first 90-day period runs out</td>
<td>Before the end of the 90-day period</td>
<td>Determined by the insurance company</td>
</tr>
<tr>
<td>CRAF Business Travel Accident</td>
<td>A claim filed under the CRAF Business Travel Accident Plan</td>
<td>90 days after receipt of the claim</td>
<td>90 days; extension notice sent before the first 90-day period runs out</td>
<td>Before the end of the 90-day period</td>
<td>Determined by the insurance company</td>
</tr>
<tr>
<td>Disability Claims</td>
<td>A claim filed under the Long Term Disability Plan</td>
<td>45 days after receipt of the claim</td>
<td>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)</td>
<td>Before the end of the 45-day period</td>
<td>45 days to provide missing information</td>
</tr>
</tbody>
</table>
### Claims Processing Periods for Health and Welfare Plans and Retirement Plans

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<th>For Claimant to Provide Missing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSA:</td>
<td>A claim filed for reimbursement of eligible dependent care expenses for DCRA or eligible medical expenses for HCSA</td>
<td>30 days after receipt of the claims</td>
<td>15 days; extension notice sent before the first 30-day period runs out</td>
<td>Before the Plan's claim-it-by date, which is May 31 for the preceding Plan year, and associated grace period.</td>
<td>Claims and all related documentation must be received before the Plan’s claim-it-by date, which is May 31 for the preceding Plan year and associated grace period.</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>A claim filed under the Basic Life Insurance Plan</td>
<td>90 days after receipt of the claim</td>
<td>90 days; extension notice sent before the first 90-day period runs out</td>
<td>Before the end of the 90-day period</td>
<td>Proof of loss must be provided within 90 days if reasonably possible. The time limits do not apply if the claimant lacks legal capacity.</td>
</tr>
<tr>
<td>Optional Life/Retiree Optional Life Insurance</td>
<td>A claim filed under the Optional Life Insurance Plan</td>
<td>45 days after receipt of the claim</td>
<td>Two 30-day extensions</td>
<td>Before the end of the 45-day period</td>
<td>Proof of loss must be provided within 90 days if reasonably possible. The time limits do not apply if the claimant lacks legal capacity.</td>
</tr>
<tr>
<td>Group Legal Services (GLSP) (MetLaw)</td>
<td>A claim filed under the GLSP</td>
<td>90 days after receipt of the claim</td>
<td>90 days; extension notice sent before the first 90-day period runs out</td>
<td>Before the end of the 90-day period</td>
<td>60 days from receipt of letter from MetLife requesting the missing information.</td>
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</table>
### Claims Processing Periods for Health and Welfare Plans and Retirement Plans

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<tr>
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<th>For Claimant to Provide Missing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Long-Term Care Insurance (LTCI) - Effective 1/1/2013, this plan is closed to new enrollees</td>
<td>A claim filed under the LTCI</td>
<td>90 days after receipt of the claim</td>
<td>90 days; extension notice sent before the first 90-day period runs out</td>
<td>Before the end of the 90-day period</td>
<td>20 days from the date of notification of additional information/documents.</td>
</tr>
<tr>
<td>Health Reimbursement Arrangement for Retired Pilots</td>
<td>A claim filed for reimbursement of eligible health care expenses</td>
<td>30 days after receipt of the claims</td>
<td>15 days; extension notice sent before the first 30-day period runs out</td>
<td>C/A—Claim would be initially denied, but can be resubmitted at any time within 180 days after the claim denial</td>
<td>N/A</td>
</tr>
<tr>
<td>FedEx Corporation Employees’ Pension Plan</td>
<td>A non-disability claim for benefit commencement, distribution, or other specific transaction is made</td>
<td>90 days after receipt of claim</td>
<td>90 days; extension notice must be communicated before the first 90 day period runs out</td>
<td>Anytime during the determination period</td>
<td>Determined by the Plan Administrator</td>
</tr>
<tr>
<td>FTL Variable Annuity Pension Plan for Pilots</td>
<td></td>
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</tr>
<tr>
<td>Non-Qualified Pension Plan for Pilots (Compensation Limit Plan)</td>
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<tr>
<td>Non-Qualified Section 415 Excess Pension Plan for Pilots</td>
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<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)</td>
<td></td>
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<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)</td>
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</tbody>
</table>
Medical

If you are enrolled in the Base, Buy Up or High Deductible Plan and use providers in the PPO, 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 if you are required to verify any charges made to your Health Care Spending Account (HCSA), 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 for Anthem.

How to file an out-of-network claim

1. Ask your provider to complete the standard medical claim form, or you can download a medical claim form from anthem.com/ca. Complete the “Employee” section of the form and give the form to your health care provider.

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 Anthem at Anthem Blue Cross, 3179 Temple Avenue, Suite 200, Pomona, CA 91768.

4. Or, have your provider send the bills to Anthem.
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 PRISM (if you are an active pilot) so you can receive your reimbursement checks and other correspondence. Retirees can contact Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area if your address changes.

See the Claims Filing and Processing Periods 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 Anthem 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 pharmacy that is not in the Anthem Pharmacy Services network, administered by Express Scripts, Inc., 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 50% of the cost of the prescription. 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.anthem.com/ca. 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 call Anthem Customer Service for instructions about filing a claim. Prescriptions submitted to a pharmacist are not a claim for benefits. You must file a claim for reimbursement first, and have your claim denied, before you can appeal it. To obtain a claim form, download the Prescription Reimbursement Form from www.anthem.com/ca.

Dental

Your dentist will normally file claims directly with MetLife. When your dentist files a claim, you will receive an explanation of benefits (EOB) from MetLife. The EOB will indicate the dates of service, charges and amounts covered. It will also indicate the coinsurance amount you are responsible for. 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 and/or if you are required to verify any charges made to your Health Care Spending Account (HCSA), if enrolled. You can view claim detail, eligibility or benefits online anytime at www.metlife.com/mybenefits.

How to file a Dental claim:
(1) Download a Dental Expense Claim Form from FedEx Benefits Online at fedex.ehr.com. Or request a form from MetLife by calling 1-800-540-5233. Complete the “Employee” section of the form and give the form to your dentist.
(2) Ask your dentist to complete the rest of the form and submit it to MetLife.
(3) Indicate if the benefit payment should be made to you or your dental provider by completing the appropriate “Assignment” section on the form.
(4) Keep a copy of all itemized bills, receipts and forms.

If MetLife is the secondary coverage, you will need to submit your claim to MetLife along with documentation of the claim payment made by the primary coverage. Be sure to include an EOB from any other insurance, when applicable.
If you assign payment to the provider, benefits will be paid to the provider. Typically, the check will be sent within two weeks after the claim is received. MetLife will also send an EOB to you and your provider. You must file your claim within one year from the date of treatment. See the Claims Filing and Processing Periods chart to see when claims are usually processed for this benefit. Supply additional information if asked. It is your responsibility to ensure that MetLife 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. 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 if you are required to verify any charges made to your Health Care Spending Account (HCSA), if enrolled.

**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. Keep a copy of all itemized bills, receipts and forms.
4. Ask your provider to complete all applicable areas on the claim form.
5. Send your completed form and itemized receipts to:
   
   Davis Vision
   Vision Care Processing Unit
   P.O. Box 1525
   Latham, NY 12110

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 immediately to report a job-related injury or illness. Your Manager will look into the details of your report, enter the necessary information into the Intranet Injury Reporting System and complete the appropriate forms. Call Aetna 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 sick bank period. If you do not file a LTD claim for benefits, you will not be able to receive LTD benefits when your Workers’ Compensation benefits end.**

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.

**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 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 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 bank runs 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. If your claim is not compensable, you will be placed on LTD, if eligible.

**Long Term Disability (LTD) Plan for Pilots**

- Call Aetna Life Insurance Company (“Aetna”) at 1-800-757-0207 at least 48 hours before the exhaustion of your regular and disability sick bank accounts. You must file your LTD claim with Aetna, and let Aetna know if your address changes while you are disabled. Claims received more than 60 days after the exhaustion of sick leave will not be paid.

- Tell your Manager that you have filed a LTD claim, and confirm with him or her that your address and telephone number are up-to-date in PRISM. Your Manager will then update PRISM, placing you on LTD status.

- If you have a work-related illness or injury, let your Manager know so he or she can complete a First Report of Injury. (Refer to “Workers’ Compensation” listed on page 24 for more information.) You must also file a claim with Aetna to receive LTD benefits for a work-related claim.

- Notify all other disability benefit programs under which you may be eligible for benefits, including your state plan if you work in California, Rhode Island or Puerto Rico.

- Give your health care professional permission to release information about your LTD claim to Aetna’s disability case manager.

- Complete and return all forms and information requested by Aetna to the address provided in the initial disability packet. **Aetna cannot begin paying LTD benefits until all forms are completed and returned.**

- Keep your Manager informed during your disability period about how long you are expected to be disabled. If your disability commenced prior to May 31, 1999, please reference the 1998 Your Employee Benefits book and the 1999 Supplement to the Your Employee Benefits book for information on your disability benefits.

**Flexible Spending Accounts**

**Important for HCSA and DCRA**

1. If you have changed your address with WageWorks, you are responsible for providing WageWorks with any address updates.

2. If you have provided WageWorks with your e-mail address, you are responsible for providing WageWorks with any updates.

3. If you have provided WageWorks with your e-mail address, all your FSA communications will be sent to that e-mail address, unless you change your default communication method to mail delivery.

**Dependent Care Reimbursement Account (DCRA)**

You can file a claim any time you have eligible dependent care expenses of at least $5 ($20 if using “Pay My Provider”). DCRA claims are only paid up to the amount of money available in the account. Additional approved charges are pended for future payment.

- A claim for an amount less than $5 is acceptable, so you can use any remaining balance in your account.

- The cutoff date for submitting claims for dependent care expenses for the previous year is May 31 for the preceding Plan year’s funds. 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 May 31 of the following year.

- WageWorks provides online information regarding your DCRA at www.wageworks.com.
• You can request reimbursement of eligible expenses through “Pay Me Back” (via Direct Deposit or check) or “Pay My Provider.”

• Regardless of the method of reimbursement you choose, you must save your detailed receipts for your records.

Pay Me Back

Some expenses are easier to pay for first and then receive reimbursement at a later date. The Pay Me Back method of reimbursement requires you to provide your detailed receipts to verify your reimbursement. The process to file your Pay Me Back reimbursement is:

Complete and Submit a Dependent Care Pay Me Back Claim Form with your eligible dependent care expense detailed receipt(s).

You have two options to file a Pay Me Back Claim:

(1) Complete and submit a paper Dependent Care Pay Me Back claim form. You can download a form located on the Claim Forms page at www.wageworks.com. Fax your completed form and detailed proof of expense (receipts, invoices) to WageWorks at 1-877-353-9236 (the number is also provided on the claim form), or mail your form and photocopies of your proof of expense to:
   WageWorks, Inc., Claims Administrator, P.O. Box 14053
   Lexington, KY 40512

(2) Submit your Pay Me Back claim request online. Log in to your WageWorks account, complete the online Pay Me Back claim form and scan and submit your supporting documentation. Even if you prefer to fax or mail your claim, this feature adds convenience by allowing you to complete and print the prepopulated online form. All claims submitted online will be displayed on your account dashboard as a Pay Me Back claim.

How to File a Pay Me Back Claim Online


(2) Click on the “Dependent Care” tab.

(3) Select “Online Claims.”

(4) Fill in all the information requested on the form and submit.

(5) Scan receipts or other supporting documentation.

(6) Attach supporting documentation to your claim by using the upload utility (or print the pre-populated online claim form and submit it along with your documentation to the fax number referenced on the form).

To speed processing, make sure your supporting documentation includes the provider’s name, date of service, type of service (which includes a description of the service received) and the amount you were charged as it is required as validation by the IRS. Most claims will be processed within one to two days after they are received, and payments are sent shortly thereafter.

Claims may be filed any time you have eligible dependent care expenses of at least $5 except for your final claim for reimbursement. You can elect to receive your Pay Me Back reimbursement of your eligible DCRA expenses that you have paid for out-of-pocket by:

• Direct Deposit, or

• Check mailed to your home address via U.S. mail.

Direct Deposit

You can request Direct Deposit of your reimbursement of eligible expenses when you create your profile online at www.wageworks.com or call WageWorks Customer Service at 1-877-924-3967. You will need to provide your banking information to set
up Direct Deposit. It is your responsibility to notify WageWorks immediately of any changes in the status of your bank account, such as a bank account closure or change in bank account number. Should you decide to cancel your Direct Deposit arrangement, reimbursement checks will be mailed to your home address once WageWorks receives and processes your reimbursement request.

The standard turnaround time for Direct Deposit reimbursement request is two business days from the time WageWorks transmits deposit authorization to your bank. You should verify that the deposit is made into your bank account before attempting to withdraw funds.

If you are a current participant in the DCRA with Direct Deposit and will participate in the DCRA in the new calendar year, WageWorks will automatically carry your Direct Deposit information forward.

**Attach your Proof of Service.** 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 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 DCRA Pay Me Back form to certify the amounts paid for services rendered are accurate.

**Keep a copy of your form and proof of expenses for your records.**

**Pay My Provider**

With the Pay My Provider option, you can pay your providers directly from your DCRA. If your DCRA expenses meet the following guidelines, Pay My Provider may be advantageous for you if:

- You have predictable dependent care expenses each month.
- Your dependent care provider does not require payment in advance.
- Your provider will accept monthly payments.

**Why you may prefer to use Pay My Provider:**

- No claim forms to file and no need to get reimbursement.
- Works like a bill pay service.
- Deducts automatically from your Dependent Care Reimbursement Account.
- Convenient method to pay for eligible dependent care services on a monthly basis.

**How to use Pay My Provider:**

1. Log in to [www.wageworks.com](http://www.wageworks.com).
2. Click on the “Dependent Care” tab.
3. Click “Request Pay My Provider.”
4. Confirm or enter your e-mail address.
5. Enter your provider information, dependent information and payment amount(s).
(6) Scan and upload your detailed invoice, or other detailed support,
(7) WageWorks will make the requested payment(s) from your DCRA account and mail it directly to your provider.
(8) WageWorks will send you an e-mail each time a requested payment is made.

**NOTE:** Not all providers can be paid through Pay My Provider.

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**Health Care Spending Account (HCSA)**

- You can file a claim any time you have eligible health care expenses of at least $5 ($20 if using “Pay My Provider”). With the HCSA, you have access to the full annual contribution amount anytime during the year.
  - A claim for an amount less than $5 is acceptable, so you can use any remaining balance in your account.
  - You have additional time to incur eligible expenses that can be reimbursed from your HCSA funds. You will have from January 1 until March 15 of the following year to incur eligible expenses.
  - The cutoff date for submitting claims for health care expenses is May 31 of the following year.
- WageWorks provides online information regarding your HCSA at [www.wageworks.com](http://www.wageworks.com).
- You can pay for eligible health care products and services with the convenient HCSA debit card (the WageWorks Health Care Card).
  - It works just like your bank's debit card. You use it an approved healthcare merchant or non-medical merchant with the IIAS inventory system.
  - The money is deducted from your HCSA account.
  - **Important:** When you use your card, you will need to keep your receipts in case WageWorks needs to verify a charge per IRS regulations.
- You can request reimbursement of eligible expenses through “Pay Me Back” (via Direct Deposit or check) or “Pay My Provider.”
- Regardless of the method of reimbursement you choose, you must save your detailed receipts for your records.
- Unverified card transactions that are not resolved will result in taxable income reported on your W-2.

**Pay Me Back**

Some expenses are easier to pay for first and then receive reimbursement at a later date. There are also providers that do not accept a debit card without a PIN as a payment method. This means you are either required to pay for these expenses out-of-pocket at the time of service or when you receive the bill. You should always save your detailed receipts to submit with your reimbursement request. IRS regulations require you to maintain documentation to verify your expenses.

This method of reimbursement requires you to complete a Pay Me Back Claim Form and submit it with your eligible health care expense receipts or invoices.

You have two options to file a Pay Me Back Claim:

(1) Complete and submit a paper Health Care Pay Me Back claim form. You can download a form located on the Claim Forms page at [www.wageworks.com](http://www.wageworks.com). Fax your completed form and detailed proof of expense (receipts, invoices, EOBs) to WageWorks at 1-877-353-9236 (the number is also provided on the claim form), or mail your form and photocopies of your proof of expense to:

WageWorks, Inc., Claims Administrator, P.O. Box 14053
Lexington, KY 40512
(2) Submit your Pay Me Back claim request online. Log in to your WageWorks account, complete the online Pay Me Back claim form and scan and submit your supporting documentation. Even if you prefer to fax or mail your claim, this feature adds convenience by allowing you to complete and print the prepopulated online form. All claims submitted online will be displayed on your account dashboard as a Pay Me Back claim.

How to File a Pay Me Back Claim Online

2. Click on the “Health Care” tab.
3. Select “Online Claims.”
4. Fill in all the information requested on the form and submit.
5. Scan receipts, EOBs and other supporting documentation.
6. Attach supporting documentation to your claim by using the upload utility (or print the pre-populated online claim form and submit it along with your documentation to the fax number referenced on the form).

To speed processing, make sure your supporting documentation includes the provider’s name, date of service, type of service (which includes a description of the service received) and the amount you were charged or your cost (for example, your deductible or the portion not covered by your insurance) as required as validation by the IRS. Most claims will be processed within one to two days after they are received, and payments are sent shortly thereafter.

Direct Deposit

You can request Direct Deposit of your reimbursement when you create your profile online at www.wageworks.com or you can call WageWorks Customer Service at 1-877-924-3967. You will need to provide your banking information to setup Direct Deposit. It is your responsibility to notify WageWorks immediately of any changes in the status of your bank account, such as a bank account closure or change in bank account number. Should you decide to cancel your Direct Deposit arrangement, reimbursement checks will be mailed to your home address once WageWorks receives and processes your reimbursement request.

The standard turnaround time for Direct Deposit reimbursement request is two business days from the time WageWorks transmits deposit authorization to your bank. You should verify that the deposit is made into your bank account before attempting to withdraw funds.

Pay My Provider

With the Pay My Provider option, you can pay your providers directly from your HCSA. It is a convenient way for you to pay for recurring or regularly scheduled eligible health care expenses such as orthodontic care or physical therapy. You can also use Pay My Provider to pay the balance of a bill your health plan doesn’t cover. The payment amount must be $20 or more.

How to Use Pay My Provider

2. Click on the “Health Care” tab.
3. Click “Request Pay My Provider.”
4. Confirm or enter your e-mail address.
5. Enter your provider information.
6. Enter patient information.
7. Enter your payment amount(s).
8. Scan and upload your detailed invoice, or other detailed support.
(9) WageWorks will make the requested payment(s) from your account and mail it directly to your provider.

(10) WageWorks will send you an e-mail each time a requested payment is made.

NOTE: There must be sufficient funds available in your account to remit the entire payment. No partial payments can be issued from the account.

Pay By Health Care Choice Card

With the Health Care Choice Card, you can pay for eligible health care expenses at the time of service or point of sale. Simply swipe your card at the register (select “Credit” if asked) and funds are deducted automatically from your HCSA. When you use your Health Care Choice Card, there’s no need to submit a reimbursement claim form. However, for card usage that WageWorks is unable to substantiate, you will be required to submit a copy of the receipt to WageWorks.

Important — Always save your receipts in case they are needed to verify your expenses with WageWorks or the IRS. On an annual basis any unverified/unsubstantiated debit card transactions for the previous plan year will be reported as taxable income on your W-2.

Health Reimbursement Arrangement for Retired Pilots (HRA)

- You can file a claim any time you have eligible health care expenses of at least $5 ($20 if using “Pay My Provider”). With the HRA, you have access to your used HRA balance at any time.
  - A claim for an amount less than $5 is acceptable, so you can use any remaining balance in your account.

- WageWorks provides online information regarding your HRA at www.wageworks.com.

- You can pay for eligible health care products and services with the convenient HRA debit card (the WageWorks Health Care Card).
  - It works just like your bank's debit card. You use it an approved healthcare merchant or non-medical merchant with the IIAS inventory system.
  - The money is deducted from your HRA account.
  - Important: When you use your card, you will need to keep your receipts in case WageWorks needs to verify a charge per IRS regulations.

- You can request reimbursement of eligible expenses through “Pay Me Back” (via Direct Deposit or check) or “Pay My Provider.”

- Regardless of the method of reimbursement you choose, you must save your detailed receipts for your records.

- Unverified card transactions that are not resolved will result in taxable income reported on your W-2.

Pay Me Back

Some expenses are easier to pay for first and then receive reimbursement at a later date. There are also providers that do not accept a debit card without a PIN as a payment method. This means you are either required to pay for these expenses out-of-pocket at the time of service or when you receive the bill. You should always save your detailed receipts to submit with your reimbursement request. IRS regulations require you to maintain documentation to verify your expenses.

This method of reimbursement requires you to complete a Pay Me Back Claim Form and submit it with your eligible health care expense receipts or invoices. You can download a form at www.wageworks.com “Need a claim form.” You can fax your completed form and proof of expenses (receipts, invoices, etc.) to 1-877-353-9236 (the number is also provided on the claim form) or mail your form and photocopies of your proof of expenses to:

WageWorks, Inc., P.O. Box 14053, Lexington, KY 40512
An Explanation of Benefits statement, often referred to as an EOB, will satisfy proof of a claim for you and your eligible dependents. An EOB is a statement received from the claims paying administrator that details benefits paid/not paid under the terms of the health plan. It is the unpaid benefits that may be eligible for reimbursement from the HRA. In order to receive reimbursement for your retiree health premiums, you must submit a copy of your cancelled check or a copy of your monthly pension check which shows the deduction for your monthly retiree health premium.

In addition to the above documents, you must submit a copy of your initial enrollment letter (and annual enrollment letters thereafter) which was included with your retiree health enrollment packet to WageWorks as proof of the amount of retiree health premiums. You may contact Pilot Benefits Administration if you need a duplicate copy of the initial enrollment letter.

You can elect to receive reimbursement of your eligible HRA expenses by:

- Direct Deposit, or
- Check mailed to your home address via U.S. mail.

**Direct Deposit**

You can request Direct Deposit of your reimbursement when you create your profile online at www.wageworks.com or you can call WageWorks Customer Service at 1-877-924-3967. You will need to provide your banking information to setup Direct Deposit. It is your responsibility to notify WageWorks immediately of any changes in the status of your bank account, such as a bank account closure or change in bank account number.

The standard turnaround time for Direct Deposit reimbursement request is two business days from the time WageWorks transmits deposit authorization to your bank. You should verify that the deposit is made into your bank account before attempting to withdraw funds.

Should you decide to cancel your Direct Deposit arrangement, reimbursement checks will be mailed to your home address once WageWorks receives and processes your cancellation request.

**Pay By Health Care Choice Card**

With the Health Care Choice Card, you can pay for eligible health care expenses at the time of service or point of sale. Simply swipe your card at the register (select “Credit” if asked) and funds are deducted automatically from your HRA. When you use your Health Care Choice Card, there’s no need to submit a reimbursement claim form. However, for card usage that WageWorks is unable to substantiate, you may be required to submit a copy of the receipt to WageWorks.

*Important* — Always save your receipts in case they are needed to verify your expenses with WageWorks or the IRS. Be sure to validate all card transaction where WageWorks is requesting additional support as all debit card transactions not validated will be reported as taxable income to you. On an annual basis any unverified/unsubstantiated debit card transactions for the previous plan year will be reported as taxable income on your W-2.

**New Retiree** — Once you retire and meet the eligibility requirements on page R-6, your card will be sent to your home address with Terms and Conditions for card usage within two to three weeks following the date of your retirement.

**Pay My Provider**

With the Pay My Provider option, you can pay your provider directly from your HRA. It is a convenient way for you to pay for recurring or regularly scheduled eligible health care expenses such as orthodontic care or physical therapy. You can also use Pay My Provider to pay the balance of a bill your health plan does not cover. The payment amount must be $20 or more.
How to Use Pay My Provider

2. Click on the “Health Care” tab.
3. Click “Request Pay My Provider.”
4. Confirm or enter your e-mail address.
5. Enter your provider information.
6. Enter patient information.
7. Enter your payment amount(s).
8. Scan and upload your detailed invoice, or other detailed support.
9. WageWorks will make the requested payment(s) from your account and mail it directly to your provider.
10. WageWorks will send you an e-mail each time a requested payment is made.

NOTE: There must be sufficient funds available in your account to remit the entire payment. No partial payments can be issued from the account.

Basic and Optional Life Insurance

Your beneficiary(ies) should notify your Manager or Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area, of your death. Pilot Benefits Administration will send your beneficiary(ies) the necessary forms to complete.

Your beneficiary(ies) must complete the necessary forms, provide certified death certificates and return these to the address listed in Pilot Benefits Administration’s written instructions. These should be returned in the self-addressed envelope provided. The beneficiary(ies) should receive the proceed(s) four or five weeks after submitting the necessary forms.

Basic and Optional Accidental Death & Dismemberment (AD&D)

If you or one of your covered dependents need to file a claim, you must notify Pilot Benefits Administration within 20 days (or as soon as possible) after any loss covered by this policy. If notice cannot be given within the 20 days, it must be given as soon as reasonably possible. Pilot Benefits Administration will send you or your beneficiary(ies) the necessary forms to complete. Be sure to complete claims accurately and thoroughly. In case of your or a covered dependent’s death, a certified death certificate must also be provided. Missing or incorrect information may delay the approval process. If you have questions, contact Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6343 in the Memphis area.

Business Travel Accident

If you or one of your covered dependents need to file a claim, you must notify Pilot Benefits Administration within 20 days (or as soon as possible) after any loss covered by this policy. If notice cannot be given within the 20 days, it must be given as soon as reasonably possible. Pilot Benefits Administration will send you or your beneficiary(ies) the necessary forms to complete. Be sure to complete claims accurately and thoroughly. In case of your or a covered dependent’s death, a certified death certificate must also be provided. Missing or incorrect information may delay the approval process. If you have questions, contact Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6343 in the Memphis area.

CRAF Business Travel Accident

If you or one of your covered dependents need to file a claim, you must notify Pilot Benefits Administration within 20 days (or as soon as possible) after any loss covered by this policy. If notice cannot be given within the 20 days, it must be given as soon as reasonably possible. Pilot Benefits Administration will send you or your beneficiary(ies) the necessary forms to complete. Be sure to complete claims accurately and thoroughly. In case of your or a covered dependent’s death, a certified death certificate must also be provided. Missing or incorrect information may delay the approval process. If you have questions, contact Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6343 in the Memphis area.
**Group Long-Term Care Insurance (LTCI)**

*Effective 1/1/2013, this plan is closed to new enrollees*

For specific information about the claims filing procedures, call MetLife at 1-800-GET-MET8 (1-800-438-6388) from 8:00 a.m. to 11:00 p.m. ET, Monday through Friday.

**Group Legal Services Plan (GLSP) (MetLaw)**

To receive benefits, you must obtain a case number via MetLife’s website at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits) or MetLife’s Client Service Center at 1-800-GET-MET8 (1-800-438-6388). 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. For more specific information, refer to “How do I use the Plan?” under the Legal tab on [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits) or call MetLife’s Client Service Center from 8:00 a.m. to 7:00 p.m. ET, Monday through Friday.

**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, contact Vanguard, at 1-800-523-1188.

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 Nonqualified 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 1-866-303-0556.

**Retirement—Non-Disability Claims**

*All Retirement Plans*

If you think you are eligible for a retirement benefit under the Pilots’ Retirement Savings Plan (PRSP) or the Pilots’ Money Purchase Pension Plan (PMPPP), you must file a claim. You alone are responsible for making sure your claim is filed accurately. To file a claim, contact Vanguard, at 1-800-523-1188.

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 Nonqualified 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 1-866-303-0556.

**Denial of Your Claim—Your Rights**

*If Your Claim Is Denied for Medical (including Mental Health/Substance Abuse and Pharmacy), Dental, Vision, HCSA, DCRA and/or HRA*

If your claim is denied, in whole or in part, the claims paying administrator will send you an explanation that 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,
- 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.

Additional Requirements for Medical (including Mental Health/Substance Abuse and Pharmacy), Dental and/or Vision Claims 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 claim involved.

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,

- 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.

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,

- 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.

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.**

**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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Deadline for Filing Appeal</th>
<th>Deadline for Extension of Filing Appeal</th>
<th>Deadline for Final Determination</th>
<th>Group Responsible for Final Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (including pharmacy and MHSA)</td>
<td></td>
<td>N/A</td>
<td>72 hours</td>
<td>Anthem for Medical</td>
</tr>
<tr>
<td>Dental/Vision</td>
<td></td>
<td></td>
<td>15 days first level;</td>
<td>MetLife for Dental</td>
</tr>
<tr>
<td>Urgent Care Claims</td>
<td>180 days for first level appeal after receiving the claim denial notice; 60 days after receiving the first level appeal denial notice</td>
<td></td>
<td>15 days second level</td>
<td>Davis Vision for Vision</td>
</tr>
<tr>
<td>Pre-service Claims</td>
<td></td>
<td></td>
<td>30 days first level;</td>
<td></td>
</tr>
<tr>
<td>Post-service Claims</td>
<td></td>
<td></td>
<td>30 days second level</td>
<td></td>
</tr>
<tr>
<td>Concurrent Care Claims</td>
<td></td>
<td></td>
<td>Will be classified as urgent care, preservice or post-service.</td>
<td></td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>60 days after receiving the claim denial notice</td>
<td>60 days from the Company’s receipt of request for review</td>
<td>60 days from receipt of request for review</td>
<td>Applicable Life Insurance Carrier</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>180 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>45 days from receipt of appeal</td>
<td>Applicable Life Insurance Carrier</td>
</tr>
<tr>
<td>Basic AD&amp;D</td>
<td>60 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>60 days</td>
<td>National Union ERISA Appeals Committee</td>
</tr>
<tr>
<td>Optional AD&amp;D</td>
<td>60 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>60 days</td>
<td>National Union ERISA Appeals Committee</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>60 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>60 days</td>
<td>National Union ERISA Appeals Committee</td>
</tr>
<tr>
<td>CRAF Business Travel Accident</td>
<td>60 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>60 days</td>
<td>National Union ERISA Appeals Committee</td>
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</thead>
<tbody>
<tr>
<td>Disability</td>
<td>180 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>45 days after receipt of the appeal and all supporting documentation</td>
<td>Aetna Appeal Review Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A 45-day extension may be requested by Aetna.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>DCRA</td>
<td>180 days after receiving the claim denial notice</td>
<td>The review committee may grant an extension based on the circumstances.</td>
<td>30 days first level; 30 days second level</td>
<td>WageWorks first level/ FedEx Fiduciary Appeals Committee second level</td>
</tr>
<tr>
<td>HCSA</td>
<td>180 days after receiving the claim denial notice</td>
<td>The review committee may grant an extension based on the circumstances.</td>
<td>30 days first level; 30 days second level</td>
<td>WageWorks first level/ FedEx Fiduciary Appeals Committee second level</td>
</tr>
<tr>
<td>HRA</td>
<td>180 days after receiving the claim denial notice</td>
<td>The review committee may grant an extension based on the circumstances.</td>
<td>30 days first level; 30 days second level</td>
<td>WageWorks first level/ FedEx Fiduciary Appeals Committee second level</td>
</tr>
<tr>
<td>Group Legal Services (GLSP)</td>
<td>60 days after receiving the claim denial notice</td>
<td>The reviewer may grant an extension based on the circumstances.</td>
<td>60 days from receipt of appeal A 30-day extension may be requested.</td>
<td>Hyatt Legal Plans, a MetLife Company</td>
</tr>
</tbody>
</table>
## Timeframe for Appeal Process

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<tr>
<th>Plan</th>
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<tbody>
<tr>
<td><strong>Group Long-Term Care Insurance (LTCI)</strong></td>
<td>60 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>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.</td>
<td>MetLife</td>
</tr>
<tr>
<td><strong>FedEx Corporation Employees’ Pension Plan</strong></td>
<td>Retirement Non-disability appeals 60 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>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.</td>
<td>Retirement Appeals Committee</td>
</tr>
<tr>
<td><strong>FTL Variable Annuity Pension Plan for Pilots</strong></td>
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<tr>
<td><strong>Non-Qualified Pension Plan for Pilots (Compensation Limit Plan)</strong></td>
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<tr>
<td><strong>Non-Qualified Section 415 Excess Pension Plan for Pilots</strong></td>
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<tr>
<td><strong>Pilots’ Retirement Savings Plan (PRSP)</strong></td>
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<tr>
<td><strong>Pilots’ Money Purchase Pension Plan (PMPPP)</strong></td>
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</tbody>
</table>
Introduction

**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 Aetna does not utilize that Claim/Appeal Authorization/Release of Information. Please contact Aetna 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.

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**Timeframe for Appeal Process**

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<tbody>
<tr>
<td>FedEx Corporation Employees' Pension Plan</td>
<td>Retirement Disability Appeals 180 days after receiving the claim denial notice</td>
<td>N/A</td>
<td>Disability Appeals 45 days unless additional time is required. Written notification will be provided for a 45 day extension and the reason for extension.</td>
<td>Retirement Appeals Committee</td>
</tr>
<tr>
<td>FTL Variable Annuity Pension Plan for Pilots</td>
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</tbody>
</table>

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*Pilot Benefit Book*
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.

**Appeals for Insured Plans**

The decision on appeals for insured plans, except the International Plan, is made by the applicable insurance company. See page I-4 for a list of insured plans.

**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.

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 Tennessee Department of Commerce and Insurance (TDCI).
- If the Tennessee Department of Commerce and Insurance (TDCI) denies the appeal, the pilot is then eligible to appeal the denial to the Pilot Benefit Review Board (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 Medical (including Mental Health/Substance Abuse and Pharmacy), Dental, Vision, HCSA, DCRA 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.

Your appeal will be reviewed by the applicable Plan fiduciary, (see chart above), that had no role in the initial claim denial. The review will be an independent one without giving the original denial any special consideration. 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 claims paying administrator will send you its decision in writing. If the 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
- 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
similarity 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

and 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 claim involved.

Independent Review Procedure for Medical, Including Mental Health/Substance

Abuse Claims

If you are not fully satisfied with Anthem's decision of the level two appeal review

regarding medical necessity or clinical appropriateness, you can ask to have your

appeal referred to an Independent Review Organization (IRO). The IRO is composed

of persons who are not employed by Anthem 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 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, you must notify Anthem's Appeal Coordinator within 180 days of

your receipt of the level two appeal denial. Anthem 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 Anthem's physician reviewer, you can ask to have

the review completed within three days. The Independent Review Program is a

voluntary program arranged by Anthem. If the Independent Review Organization

upholds the denial or you do not wish to pursue the Independent Review Procedure,

you may bring a civil action under ERISA or submit an appeal to the Pilot Benefit

Review Board (PBRB).

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

• 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 denial of the first level appeal

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
- 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 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. It grants a pilot the right to appeal a denied benefit claim to a board comprised of fellow pilots and Company personnel. If you elect to have your claim reviewed by the PBRB, you are precluded from filing a lawsuit under the Employee Retirement Income Security Act of 1974, as amended (ERISA) in court against the Company or one of its vendors. PBRB decisions are legally binding upon the Company, 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 file a request for a PBRB review.

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's 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.

Legal Action

If you want to take legal action for any reason related to your benefit claim, you may serve the summons and complaint on CT Corporation, which is the corporate agent responsible for receiving legal process. You may contact CT Corporation at 1-800-325-2671 for the physical address for serving legal process.

Plan Participation

Summary of Benefits

Most benefits discussed in this book are effective on a pilot’s date of hire, meaning the first day of initial new hire training or basic indoctrination. This may also be referred to, in this book, as your first day of active work.

The following table gives basic information about eligibility and contributions for specific benefits.
# HEALTH

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Health</strong></td>
<td>Medical (including Mental Health/ Substance Abuse and prescription drug coverage), dental and vision. Health plan options depend on pilot’s home ZIP code. Internationally based pilots are only eligible for the international medical plan.</td>
<td>First day of employment</td>
<td>You and the Company share the cost of Health coverage. Company pays a large part of the cost of pilot and dependent coverage. Your share depends on the option and coverage tier you choose.</td>
</tr>
<tr>
<td><strong>Anthem Employee Assistance Program (EAP)</strong></td>
<td>Employee Assistance Program (EAP)</td>
<td>First day of employment</td>
<td>Dependents and household members</td>
</tr>
</tbody>
</table>

For eligibility for the Retiree Group Health Plan, see page H-65.

# DISABILITY

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long Term Disability (LTD) including Supplementary Disability Benefit</strong></td>
<td>Partial earnings replacement if disabled due to illness or injury</td>
<td>First day after 180 days of cumulative permanent full-time service</td>
<td>No</td>
</tr>
</tbody>
</table>
# LIFE INSURANCE

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Life Insurance</strong></td>
<td>First day of active work</td>
<td>No</td>
<td>Company paid</td>
</tr>
<tr>
<td>Life Insurance in the amount of $800,000 or $300,000, $400,000 or $500,000 in lieu of $800,000</td>
<td>First day of active work</td>
<td>No</td>
<td>Company paid</td>
</tr>
<tr>
<td><strong>Optional Life Insurance</strong></td>
<td>First day of active work</td>
<td>Pilot can elect coverage for spouse. For married pilots, eligible children are automatically covered if spousal coverage is elected. For unmarried pilots, eligible children are automatically covered.</td>
<td>Pilot paid</td>
</tr>
<tr>
<td>Additional life insurance in increments of $100,000 up to a maximum of $1,000,000—no more than ten (10) times the pilot's basic annual salary</td>
<td>First day of active work</td>
<td>Pilot can elect coverage for spouse. For married pilots, eligible children are automatically covered if spousal coverage is elected. For unmarried pilots, eligible children are automatically covered.</td>
<td>Pilot paid</td>
</tr>
<tr>
<td><strong>Retiree Optional Life Insurance</strong></td>
<td>If pilot is an Optional Life Insurance participant at age 55 or older and actively at work prior to retirement/termination</td>
<td>Pilot can elect retiree optional life coverage for eligible spouse provided spouse was covered prior to retirement. No coverage available for dependent children.</td>
<td>Retiree paid</td>
</tr>
<tr>
<td>Retiree life insurance coverage for the same pre-retirement Optional Life coverage up to a maximum of $300,000</td>
<td>If pilot is an Optional Life Insurance participant at age 55 or older and actively at work prior to retirement/termination</td>
<td>Pilot can elect retiree optional life coverage for eligible spouse provided spouse was covered prior to retirement. No coverage available for dependent children.</td>
<td>Retiree paid</td>
</tr>
<tr>
<td><strong>Basic Accidental Death and Dismemberment Insurance (AD&amp;D)</strong></td>
<td>First day of active work</td>
<td>No</td>
<td>Company paid</td>
</tr>
<tr>
<td>$15,000 in case of death resulting from an accident. Percentage of death benefit paid for dismemberment. Plus: Travel Assistance Benefits.</td>
<td>First day of active work</td>
<td>No</td>
<td>Company paid</td>
</tr>
<tr>
<td><strong>Optional Accidental Death and Dismemberment Insurance (Optional AD&amp;D)</strong></td>
<td>First day of active work</td>
<td>Pilot can elect coverage for eligible dependents.</td>
<td>Pilot paid</td>
</tr>
<tr>
<td>Additional insurance in case of death or dismemberment resulting from an accident from $35,000 to $235,000. Plus: Travel Assistance Benefits</td>
<td>First day of active work</td>
<td>Pilot can elect coverage for eligible dependents.</td>
<td>Pilot paid</td>
</tr>
</tbody>
</table>
# LIFE INSURANCE

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business Travel Accident Insurance</strong></td>
<td>First day of active work</td>
<td>Eligible dependents traveling in accordance with Company business travel guidelines. Spouse Death Benefit – $100,000. Each Child Death Benefit – $50,000. Percentage of death benefit for dismemberment or paralysis due to an accident while traveling on Company business or flying in a Company aircraft.</td>
<td>Company paid</td>
</tr>
<tr>
<td>Plus: Travel Assistance Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CRAF Business Travel Accident Plan</strong></td>
<td>First day of active work</td>
<td>No</td>
<td>Company paid</td>
</tr>
<tr>
<td>If death occurs while on a CRAF mission, an additional $200,000 will be paid to designated beneficiaries under the AD&amp;D Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# RETIREMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pension</strong></td>
<td>First day of month coincident with or next following:</td>
<td>No</td>
<td>Company paid</td>
</tr>
<tr>
<td>Qualified defined benefit plan providing a specific monthly benefit based on pensionable earnings and years of credited service for benefit accrual. Pilot is eligible to receive benefits at normal retirement age of 60 or reduced benefits as early as age 55.</td>
<td>• your attainment of age 21, and &lt;br&gt;• 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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Non-Qualified Pension Plan for Pilots**         | First day of month coincident with or next following:                             | No                     | Company paid      |
| (Compensation Limit Plan)                        | • your attainment of age 21, and <br>• 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. |                        |                   |
| Non-qualified defined benefit plan providing the excess portion, if any, of your pension benefit based on your average pensionable earnings without regard to the annual compensation limits, up to a maximum of $260,000 less the benefit paid from the 415 Limit Plan. |                                                                                   |                        |                   |
### RETIREMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
</table>
| Non-Qualified Section 415 Excess Pension Plan for Pilots (the 415 Limits) | First day of 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. | No                     | Company paid          |
# RETIREMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
</table>
| Pilots’ Retirement Savings Plan (PRSP) | Qualified defined contribution plan featuring:  
- Pre-tax/401(k) contributions  
- Employer Matching contributions on Pre-tax/401(k) contributions  
- After-tax contributions,  
- Sick Bank contributions for eligible participants  
- Catch-up contributions for eligible participants  
- Rollover Accounts Pre-tax/401(k) employer match, catch-up and sick bank contributions and earnings on all contributions are tax-deferred until withdrawn. | For making Pre-tax/401(k), After-tax, and, if eligible, Catch-up and Rollover contributions, the first day of the month coincident with or next following:  
- your attainment of age 21, and  
- your completion of 6 months of employment. | No | Participants may make elective contributions through Pre-tax/401(k) and/or After-tax contributions, and if eligible, Catch-up contributions up to IRS and Plan limits. FedEx pays Employer Matching contributions on Pre-tax/401(k) contributions, Sick Bank contributions and all record keeping costs associated with the Plan. As typical with mutual funds, you will incur a cost when the investment fund in which you’re invested deducts fund operating expenses from fund assets. You may refer to the specific fund prospectus for information on the funds, expenses and trading restrictions. |
## RETIREMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
</table>
| **Pilots’ Money Purchase Pension Plan (PMPPP)**   | First day of 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 plan year after meeting the required 1,000 hours of service. | No                    | FedEx contributes 7% of your prior month’s eligible earnings [limited by Internal Revenue Code Section 401(a)(17) indexed for inflation] into your selected Vanguard investment fund options.  
As typical with mutual funds, you will incur a cost when the investment fund in which you’re invested deducts fund operating expenses from fund assets. You may refer to the specific fund prospectus for information on the funds, expenses and trading restrictions. |

For information regarding The Flying Tiger Line, Inc. Variable Annuity Pension Plan for Pilots (VAPPP), please contact the Retirement Service Center at 866-303-0556 to request a copy of the Summary Plan Description.

## OTHER BENEFITS AND SERVICES

<table>
<thead>
<tr>
<th>Description</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Care Reimbursement Account (DCRA)</strong></td>
<td>First day of employment</td>
<td>Eligible dependent care expenses may be filed for eligible dependents (See “Other Benefits and Programs” for eligibility requirements.)</td>
<td>Pilot elects amount to be deducted from paycheck on pre-tax basis.</td>
</tr>
</tbody>
</table>
## OTHER BENEFITS AND SERVICES

<table>
<thead>
<tr>
<th>Health Care Savings Account (HCSA)</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money you set aside from your paycheck (pre-tax basis), to pay for eligible health-related expenses incurred by you and/or your eligible family members. Eligible expenses include such items as medical/dental deductibles, co-payments, over-the-counter drugs with a doctor’s prescription and other health related expenses not covered by your health plan option. Excludes reimbursement for monthly health care premiums which are automatically deducted from your pay on a pretax basis under the provisions of the Health Care Contribution Plan.</td>
<td>First day of employment To participate in the HCSA, pilots are not required to participate in a FedEx Express health plan option.</td>
<td>Eligible health care expenses may be filed for eligible dependents regardless of whether you elect to cover your eligible dependents under a FedEx Express health plan option.</td>
<td>Pilot elects amount to be deducted from paycheck on a pre-tax basis.</td>
</tr>
</tbody>
</table>

| Health Reimbursement Arrangement (HRA) for Retired Pilots | Plan allows reimbursement of eligible healthcare expenses for retired pilot and dependents after retirement and attainment of age 59 up to the retired pilot’s HRA account balance. Includes reimbursement for monthly retiree health care premiums. | • Active pilot on 8/25/2006, • Attained age 53 before 1/1/2007, • Expected to meet age and service requirements for retiree health on attainment of age 60 or older, and • Retires on or after 8/26/2006. Funds available for reimbursement upon the pilot’s death or the later of age 59 or retirement. | Yes | Employer Paid |

| Employee Stock Purchase Plan (ESPP) | Plan allows pilots to purchase FedEx stock through payroll deductions | 91<sup>st</sup> day of continuous permanent service. Managing Directors and above excluded. | No | Pilot paid |
## OTHER BENEFITS AND SERVICES

<table>
<thead>
<tr>
<th>Group Legal Services Plan (GLSP) (MetLaw)</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>GLSP provides a wide range of legal services at an affordable price through a network of attorneys nationwide. Examples of services: • Purchase, sale or refinancing of primary residence • Wills and estate planning • Defense of civil lawsuits</td>
<td>First day of active work; new enrollment or disenrollment may only be accomplished during the annual enrollment period each year; if no disenrollment during this period, coverage will continue into next year.</td>
<td>Spouse and eligible dependents</td>
<td>Pilot paid</td>
</tr>
<tr>
<td>Wellness Centers</td>
<td>Take advantage of membership and programs at FedEx health and fitness facilities.</td>
<td>First day of employment</td>
<td>No</td>
</tr>
<tr>
<td>LifeCare®</td>
<td>Referral and resource service to assist with Work/Life issues, involving child care, parenting, adoption, adult care and aging, health and wellness, emotional wellness, education, daily needs, financial concerns, concierge service, prenatal child safety and college kits with free products and helpful information. Available 24/7.</td>
<td>First day of employment</td>
<td>Dependents and household members</td>
</tr>
</tbody>
</table>
# OTHER BENEFITS AND SERVICES

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Pilot Eligibility</th>
<th>Dependent Eligibility</th>
<th>Company/Pilot Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Long-Term Care Insurance (LTCI) (MetLife)</strong></td>
<td>LTCI assists with cost of long-term care provided by a professional home care agency or a nursing home when individual is no longer able to care for self independently.</td>
<td>First day of active work Pilots can enroll within the first 90 days of becoming eligible for FedEx Express benefit programs or during the Annual Benefits Enrollment period, or make changes due to change in family status. A pilot may enroll at any time during the year; however, proof of good health will be required if elected outside of the initial 90-day eligibility period.</td>
<td>Spouse surviving spouse, parents, parents-in-law, grandparents and grand-parents-in-law (must provide proof of good health)</td>
</tr>
<tr>
<td><strong>METPAYSM Auto, Home and Personal Property Insurance</strong></td>
<td>Automobile, renters’, homeowners’ and other personal property insurance may be purchased at special group rates available in most states to those who qualify.</td>
<td>First day of active work</td>
<td>No</td>
</tr>
<tr>
<td><strong>Tuition Assistance</strong></td>
<td>Reimbursement for Qualifying educational expenses up to $3000 per calendar year</td>
<td>First day of active work</td>
<td>No</td>
</tr>
</tbody>
</table>

**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 beginning on page I-2 and only as permitted by the terms of the Collective Bargaining Agreement. 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., local HMO 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 or Pilots’ Money Purchase Pension 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 Pension Benefit Guaranty Corporation (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.

Pension Benefit Guaranty Corporation (PBGC)

Your vested Pension Plan benefits are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Pension Plan terminates without enough money to pay all benefits, the PBGC will step in to pay Pension Plan benefits up to a maximum amount prescribed for the year in which the Pension Plan terminates. The Pilots’ Retirement Savings Plan (PRSP) and the Pilots’ Money Purchase Pension Plan (PMPPP) are not insured by the PBGC since the PBGC does not insure qualified defined contribution plans.

Benefit Guarantees — The PBGC guarantee generally covers:

• Normal and early retirement benefits.

• Disability benefits if you become disabled before the Pension Plan terminates; and

• Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

• Benefits greater than the maximum guaranteed amount set by law for the year in which the Pension Plan terminates.

• Some or all benefit increases and new benefits based on Pension Plan provisions that have been in place for fewer than five years at the time the Pension Plan terminates.

• Benefits that are not vested because you have not worked long enough for the Company.
• Benefits for which you have not met all the requirements at the time the Pension Plan terminates.

• Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Pension Plan’s normal retirement age.

• Non-Pension Plan benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your Pension Plan has and how much the PBGC collects from employers.

Where to Get More Information — For more information about the PBGC and its guarantees, contact the FedEx Retirement Service Center, or, call the PBGC toll free at 1-800-400-7242 or write:

PBGC
P.O. Box 151750
Alexandria, VA 22315-1750

TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 1-800-400-7242. Additional information about the PBGC’s pension insurance program is available through the PBGC’s website on the Internet at www.pbgc.gov.
# Health Care—Medical, Dental and Vision 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 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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## Highlights

If you meet the eligibility requirements, you are eligible to elect the following health coverage, which includes:

- Medical (includes mental health/substance abuse and prescription drug)
- Dental
- Vision

Plus, you may also enroll your eligible dependents for health coverage, which includes:

- Medical (includes mental health/substance abuse and prescription drug)
- Dental
- Vision

## 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 the Company and the Air Line Pilots Association, International.

Medical, Dental and Vision 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.

<table>
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<th>Your Coverage Is Effective...</th>
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<tbody>
<tr>
<td>Active pilot*</td>
<td>Medical</td>
<td>Medical</td>
<td>On your first day of employment. You are automatically enrolled in Pilot Only health coverage. Dependent coverage is effective on your first day of employment if you enroll in Pilot &amp; Dependent(s) health coverage within 31 days following your hire date or by the deadline indicated in your new hire enrollment packet.</td>
</tr>
<tr>
<td></td>
<td>Dental</td>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vision</td>
<td>Vision</td>
<td></td>
</tr>
<tr>
<td>Retired or terminated pilot and meet the age and service requirements for Retiree Health Coverage**</td>
<td>Medical</td>
<td>Medical</td>
<td>On your retirement or termination date**</td>
</tr>
<tr>
<td></td>
<td>Dental</td>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vision</td>
<td>Vision</td>
<td></td>
</tr>
</tbody>
</table>

* If you transfer to a non-pilot position within Air Operations on or after May 31, 1999, and your participation in FedEx Express’ health coverage is provided under the terms of the May 31, 1999, Collective Bargaining Agreement, your participation will continue as described in this section.

** See Retiree Health Coverage.

Your Eligible Dependents

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

Effective January 1, 2011, you will be able to cover your eligible children under your Medical plan until their 26th birthday. However, a child age 23 or over is NOT ELIGIBLE to be covered under your Medical plan if he/she is eligible for other group medical coverage through his/her employer. If the child is not eligible for other group medical coverage, he/she can be covered to the 26th birthday with no restrictions. You will be able to cover your eligible children to their 23rd birthday for Dental and Vision benefits with no restrictions.

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

- Spouse: Legally married or Common-Law (as defined by the State where Common-Law status is established) spouse (the term “spouse” shall have the same meaning as set forth in 1 United States Code Annotated Section 7 (U.S.C.A. § 7) a person of the opposite sex who is a husband or a wife), and shall be deemed to refer solely to persons who have entered into a marriage, as defined in 1 U.S.C.A. § 7 (a legal union between one man and one woman as husband and wife).
- In California only, a domestic partner registered with the state of California.
Eligible Child

Effective January 1, 2011, an **eligible child** 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 of any age who meets the guidelines for mental or physical incapacitation before age 26 for Medical coverage and age 23 for Dental and/or Vision coverage. If you child becomes incapacitated before age 23, proof of the child's disability must be provided to Pilot Benefit Administration within 31 days of the child's 23rd birthday, 26th for Medical, to continue coverage. If you are a new hire, your incapacitated child may be eligible for coverage if he or she was covered by a previous plan immediately prior to your FedEx permanent hire date
- In California only, your domestic partner's child

*Legal documents must be provided

Provided your child meets the eligibility requirements, you can cover them (up to their 26th birthday for Medical and up to their 23rd birthday for Dental and Vision) without regard to:

- Student status (they no longer have to be a full-time student)
- Marital status (the child can be married; you cannot cover their dependents—spouse or children—on your plan)
- Tax dependency (you do not have to claim the child for tax purposes)
- Employment status (before age 23)
- Residency (they do not have to reside with you, or in the case of a stepchild, your spouse, or in California only, your domestic partner)
- Financial dependency (they do not have to be financially dependent on you or your spouse, or in California only, your domestic partner)

Your children cannot be covered as eligible dependents if they are:

- Also eligible as a pilot/non-pilot permanent full-time or permanent part-time employee of FedEx Express or a participating employer in the Federal Express Corporation Group Health Plan. See “If Your Spouse or Child Is Also a Pilot/Non-Pilot Employee Eligible for FedEx Express Benefits” on page H-7.

Your spouse/domestic partner (in California only) cannot be covered as an eligible dependent if he or she is:

- Also eligible as a pilot/non-pilot permanent full-time or permanent part-time employee of FedEx Express or a participating employer in the Federal Express Corporation Group Health Plan. See “If Your Spouse or Child Is Also a pilot/non-pilot Employee Eligible for FedEx Express Benefits” on page H-7.
  or
- On active duty in the armed forces of any country.
Medical coverage ends automatically on a child’s 26th birthday and Dental and/or Vision coverage ends automatically on a child’s 23rd birthday, unless incapacitated as described above. Following the date of coverage termination, Medical, Dental and/or Vision coverage may be continued for up to 36 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA) by paying the full cost of coverage. Pilot Benefits Administration may request proof of eligibility such as birth certificate, or marriage license, for any dependent.

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. Acceptance of the Dependent Maintenance Authorization and Agreement confirms that you have read and understand the terms of this agreement. You will be required to validate your dependents’ eligibility annually.

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 Medical, 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 children. 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.

Enrollment

Enrollment in your benefits is done via FedEx Benefits Online at https://fedex.ehr.com. In the event you do not have access to the Internet, you can call Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area.

FedEx Benefits Online provides you with self-service access to your benefits information. From the main menu, you can select the:

- EDUCATE module for additional information about your benefit options and links to online resources.
- EVALUATE module for decision support tools that help you compare plan benefits and costs based on your personal health care needs. You can even estimate the
appropriate amount to contribute to the Health Care Spending Account (HCSA). You can also estimate your life insurance coverage needs.

- ENROLL module to make your Health, Flexible Spending Accounts and Life Insurance coverage elections and designate your beneficiaries for your life insurance benefits.

If you wish to enroll for Pilot & Child(ren), Pilot & Spouse or Pilot & Family Medical, Dental and/or Vision coverage, you must list your dependents and validate their eligibility for FedEx benefits. See “If You Have a Change in Family Status or Employment Event” on page H-9.

FedEx Express offers the Anthem Blue Cross (Anthem) coverage in all areas of the United States except for Hawaii. Due to Hawaii regulations, Hawaii Medical Service Association (HMSA) is offered, and will be treated as the Base Plan for contributions, and Health Plan Hawaii Plus is offered as a local HMO. The Anthem medical coverage to choose from is either the Base Plan or the Buy Up Plan. There is an HMO in California, Kaiser, that a pilot may be able to select as an alternative to Anthem coverage. Eligibility is based on your home ZIP code in PRISM. Continued availability of any local HMO is not guaranteed.

For pilots who are internationally based or considered Expatriates, there is separate coverage under the International Plan. The International Plan provides full coverage for the pilot and any covered dependents while international and/or in the United States.

**Annual Benefits Enrollment**

In the fall, eligible pilots are given the opportunity to enroll in or change their Medical and/or Dental plan option for the next calendar year. FedEx also offers you the opportunity to enroll in Vision coverage for yourself and any eligible dependents. This is referred to as the Annual Benefits Enrollment.

During the Annual Benefits Enrollment period, you will be sent an enrollment packet detailing your Medical, Dental and Vision plan options. Access FedEx Benefits Online at [https://fedex.ehr.com](https://fedex.ehr.com) to make your elections. Select ENROLL at the main menu and follow the instructions. Your Medical, Dental and/or Vision elections 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 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. See “If You Move to a New Location” on page H-9 for more information. 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 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 and make your election to opt out within 31 days following the gain of other coverage. If you choose to opt out of FedEx Medical coverage, you will
not have Medical 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 FedEx Benefits Online. To opt out of Medical coverage, you will be required to complete an affidavit stating you have other group medical coverage. You can elect to opt out of FedEx Express Medical coverage on the FedEx Benefits Enrollment Website, FedEx Benefits Online. You will be required to complete an online affidavit stating you have other group medical coverage.

If you choose to opt out, you may re-enroll in FedEx Medical, Dental and/or Vision coverage only:

- if you lose your other group health coverage (Change in Family Status/Employment event), or
- during the next Annual Benefits Enrollment period.

Access FedEx Benefits Online at https://fedex.ehr.com to make your elections. If you lose your other group medical, dental and/or vision coverage, you must access FedEx 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:

- Domestically Based – Pilot Only in Base Medical Plan, Base Dental Plan and Vision
- Live in Hawaii – Pilot Only in HMSA, Base Dental Plan and Vision
- Internationally Based – Pilot Only in the International Plan, Base Dental Plan and Vision

The Medical plan option you are enrolled in is based on your home address in PRISM, unless internationally based. You will be sent an enrollment packet detailing your available options, associated costs and deadline to make your elections. Access FedEx Benefits Online at https://fedex.ehr.com to make your elections. Select ENROLL at the main menu and follow the instructions. If you make no elections by your deadline, you will remain in the Medical, Dental and Vision plan options and coverage tier in which you were automatically enrolled.

You will have at least 31 days from the date indicated in your Personalized Letter in your New Hire packet to make any change.

HMSA in Hawaii is considered the Base plan option in Hawaii and is priced at the Base Plan rate.

**If You Are an Expatriate or an Internationally based Pilot**

You are automatically covered by the International Plan upon activation into a foreign base. If you want to opt out of Medical coverage, contact Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area. The International Plan is fully insured and administered by GeoBlue, effective January 1,
2013. You will receive a certificate from GeoBlue outlining the coverage details. The International Plan provides coverage for you and your covered dependents wherever you are, both internationally and in the United States. See page H-22 for Medical, Dental and Vision information.

**Enrolling Your Eligible Dependents**

You can elect to enroll your eligible dependents for Medical, Dental and/or Vision coverage during your New Hire enrollment, Annual Benefits Enrollment or when you experience an Employment or Change in Family Status event that allows 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 FedEx Benefits Online (https://fedex.ehr.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.

<table>
<thead>
<tr>
<th>New Hire</th>
<th>Your request for Pilot &amp; Child(ren), Pilot &amp; Spouse or Pilot &amp; Family coverage must be made by the date indicated in your New Hire Packet. 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 &amp; Child(ren), Pilot &amp; Spouse or Pilot &amp; Family – 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” on page H-8.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Benefits Enrollment</td>
<td>Your request for Pilot &amp; Child(ren), Pilot &amp; Spouse or Pilot &amp; 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” on page H-8.</td>
</tr>
<tr>
<td>Employment or Change in Family Status Event</td>
<td>Access FedEx Benefits Online within 31 days of 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 Employment or Change in Family Status event.</td>
</tr>
</tbody>
</table>

**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) are pilots/or non-pilot permanent full-time or permanent part-time employees at a FedEx Company and are eligible to enroll in the Federal Express Corporation Group Health Plan for Pilots or the Federal Express Corporation Group Health Plan, review the following to help you make your enrollment elections:

- **If you and your spouse have no dependent children**, each of you must elect your own Medical, Dental and/or Vision coverage. Your payroll deductions will depend on the Medical, Dental and/or Vision coverage you each elect and the plan your spouse is eligible to enroll in.

- **If you and your spouse have children you wish to cover and you each elect your own Medical, Dental and Vision elections**, one of you must elect Employee & Child(ren) coverage for Medical, Dental and/or Vision.
• If your spouse is a non-pilot employee and you have children you wish to cover, and you wish to cover the entire family unit (spouse and children) under your Medical, Dental and/or Vision coverage, you and your non-pilot spouse must call Pilot Benefits Administration to make your election. You cannot be covered as a dependent under your spouse's coverage.

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. If any of your dependent children are eligible for FedEx Express benefits as a pilot/permanent full-time or permanent part-time employee, they cannot be covered as a dependent under your 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 a participating Anthem PPO provider in the area where they live. For a list of participating 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 a Provider, follow the instructions: when prompted, enter FXF in the Identification Prefix Number box. You can also link to the directory from the EDUCATE module on FedEx Benefits Online, or call Anthem Customer Service at 1-866-406-0982.

If you enroll in a local HMO, your dependents living outside the HMO’s service area will not be covered except in emergencies. If you want more than emergency coverage for them, you should not choose an HMO 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 the HTH Worldwide.

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 FedEx Benefits Online (https://fedex.ehr.com), select ENROLL from the main menu and follow the instructions.

• 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 enrollment packet. Otherwise, you will be enrolled in Pilot Only Medical, Dental and Vision coverage as indicated in your enrollment packet.

• When you have a Change in Family Status or Employment 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 or Employment Event” on page H-9. Any changes you make to your benefits must be consistent with the Change in Family Status event.

During the 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 on the HOME screen in PRISM or 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 in Prism, contact Flight Operations Administration.

You will be sent an enrollment packet with information about your new Medical plan options. You may access FedEx Benefits Online at https://fedex.ehr.com within 31 days of the date of your address change in PRISM to review your options and make your elections. Select ENROLL from the main menu and follow the instructions. 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 or Employment Event

If you have a Change in Family Status event (for example, marriage, divorce, birth of a child, spouse gains or loses other coverage, etc.) or Employment event (for example, begin or return from a leave of absence), 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. Select the applicable Change in Family Status or Employment event from the ENROLL module menu on FedEx Benefits Online. 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, 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 or Employment 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 and Employment 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 begin or return from a leave of absence
- You or your spouse change from permanent full-time to permanent part-time or from permanent part-time to permanent full-time
- 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 Pilot Benefits Administration sends you an enrollment packet which describes the elections you can make and your deadline:

• Annual Benefits Enrollment (each year during the fall)
• New Hire or newly eligible employee
• Change of address
• Change in employment status for you, your spouse or children
• 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 FedEx Benefits Online within 31 days of the event to update your dependents’ information and make benefit changes associated with the event:

• Marriage or divorce
• Change in 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

### Change in Family Status or Employment Event/Special Enrollment Periods

<table>
<thead>
<tr>
<th>Event</th>
<th>To Add or Change Dependent Medical, Dental and/or Vision Coverage</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Within 31 days following your date of marriage or commencement of domestic partnership:</td>
<td>Date of marriage</td>
</tr>
<tr>
<td>Commencement of Domestic Partnership* (California residents only)</td>
<td>• Access FedEx Benefits Online at <a href="https://fedex.ehr.com">https://fedex.ehr.com</a>.</td>
<td>Date of Domestic Partnership registry in the state of California</td>
</tr>
<tr>
<td></td>
<td>• From the ENROLL menu, select Change in Family Status.</td>
<td></td>
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<tr>
<td></td>
<td>• Select the “I Got Married” or “I Began a Domestic Partnership” event.</td>
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<tr>
<td></td>
<td>• Follow the instructions to add your spouse, domestic partner and eligible children (or eligible domestic partner’s children) and make your benefit elections.</td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td>Within 31 days following your date of divorce or termination of domestic partnership:</td>
<td>Date of divorce</td>
</tr>
<tr>
<td>Termination of Domestic Partnership (California residents only)</td>
<td>• Access FedEx Benefits Online at <a href="https://fedex.ehr.com">https://fedex.ehr.com</a>.</td>
<td>Date of termination of Domestic Partnership</td>
</tr>
<tr>
<td></td>
<td>• From the ENROLL menu, select Change in Family Status.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Select the “I Got Divorced” or “I Ended a Domestic Partnership” event.</td>
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<tr>
<td></td>
<td>• Follow the instructions to make your benefit elections.</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> Your stepchildren and children of your domestic partner are no longer eligible for coverage on the date of divorce or termination of domestic partnership.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Change in Family Status or Employment Event/Special Enrollment Periods  (Continued)

<table>
<thead>
<tr>
<th>Event</th>
<th>To Add or Change Dependent Medical, Dental and/or Vision Coverage</th>
<th>Effective Date</th>
</tr>
</thead>
</table>
| **Newborn natural child**                                            | Within 31 days following your child’s date of birth:  
• From the ENROLL menu, select Change in Family Status.  
• Select the “I Had a Baby” event.  
• Follow the instructions to add your newborn and other eligible dependents and make your benefit elections.  
**NOTE:** If you currently have Pilot & Dependent(s) coverage, you must still add your newborn child for access to health benefits. | Date of birth                                                                                                                                   |
| **Adoption/ legal guardianship or placement in home for purpose of adoption** | Within 31 days following the date of legal adoption or guardianship or date the child is placed in your home for the purpose of adoption:  
• From the ENROLL menu, select Change in Family Status.  
• Select the “I Adopted a Child” or “I Gained Legal Guardianship of a Child” event.  
• Follow the instructions to add your adopted or legal guardianship child and other eligible dependents and make your benefit elections.  
**NOTE:** If you currently have Pilot & Dependent(s) coverage, you must still add the child for access to health benefits. | Date of court decree of adoption, legal guardianship or document for placement for adoption |
| **Change of employment status for pilot**                             | Within 31 days following the date of change of employment status:  
• From the ENROLL menu, select the Change in Employment.  
• Follow the instructions to make your benefit elections. | Date of change in employment status                                                               |
| **Pilot begins a suspension without pay**                             | Within 31 days following the date of the suspension without pay, contact Pilot Benefits Administration.                                             | First day of going to suspension without pay status                                                |
| **Pilot/Spouse/Domestic Partner Begins a Leave of Absence (LOA)**     | Within 31 days following the date the leave of absence begins:  
• If a pilot, select the “Begin Leave of Absence” event from the ENROLL main menu.  
• If a Spouse/Domestic Partner, select Change in Family Status, then the appropriate event.  
• Follow the instructions to make your benefit elections. | Date pilot/spouse/domestic partner goes on LOA                                                    |
| **Pilot/Spouse/Domestic Partner Returns from Leave of Absence (LOA)** | Within 31 days following the date of return from the leave of absence:  
• If a pilot, select the “Return from Leave of Absence” event from the ENROLL main menu.  
• If a Spouse/Domestic Partner, select Change in Family Status, then the appropriate event.  
• Follow the instructions to make your benefit elections. | Date pilot/spouse/domestic partner returned from LOA                                              |
<table>
<thead>
<tr>
<th>Event</th>
<th>To Add or Change Dependent Medical, Dental and/or Vision Coverage</th>
<th>Effective Date</th>
</tr>
</thead>
</table>
| Pilot/Spouse/Domestic Partner/Dependent Child Gains/Loses Employment or Medical, Dental and/or Vision coverage through Employer | Within 31 days following the date your dependent gains/loses employment or Medical, Dental and/or Vision coverage through employer or pilot gains/loses other employment or Medical, Dental and/or Vision coverage through another employer:  
  • From the ENROLL menu, select Change in Family Status.  
  • Select the appropriate “Gain or Loss of Other Coverage” event.  
  • Follow the instructions to make your benefit elections. | Date dependent gains/loses employment or Medical, Dental and/or Vision coverage through employer or pilot gains/loses other employment or Medical, Dental and/or Vision coverage through another employer. |
| Spouse or domestic partner becomes a FedEx pilot/employee triggering eligibility under the plan as a pilot/employee | Within 31 days following the date your dependent experiences a significant change in Medical, Dental and/or Vision coverage through the dependent’s employer:  
  • From the ENROLL menu, select Change in Family Status.  
  • Select the appropriate “Lost/Had Significant Change in Other Coverage” event.  
  • Follow the instructions to make your benefit elections. | Day after your dependent dropped Medical, Dental and/or Vision coverage as a result of the significant change in cost or Medical, Dental and/or Vision coverage. |
| Significant change in Medical, Dental and/or Vision coverage under spouse’s, domestic partner’s or dependent child’s employer’s plan  
(This could be due to significant changes in cost of coverage or benefits.) | Within 31 days following the date you or your dependent becomes entitled to or loses eligibility for Medicare or Medicaid:  
  • From the ENROLL menu, select Change in Family Status.  
  • Select the appropriate “Gain or Loss of Other Coverage” event.  
  • Follow the instructions to make your benefit elections. | Day after your dependent enrolls for coverage or loses coverage under Medicare or Medicaid. |
| Pilot, spouse, domestic partner or dependent child becomes entitled to Medicare or Medicaid  
Pilot, spouse, domestic partner or dependent child loses eligibility for Medicare or Medicaid | Within 31 days following the date you or your dependent becomes entitled to or loses eligibility for Medicare or Medicaid:  
  • From the ENROLL menu, select Change in Family Status.  
  • Select the appropriate “Gain or Loss of Other Coverage” event.  
  • Follow the instructions to make your benefit elections. | Day after your dependent enrolls for coverage or loses coverage under Medicare or Medicaid. |
| Dependent child loses eligibility for Medical, Dental and/or Vision coverage | Within 31 days following the date your dependent child loses eligibility for Medical, Dental and/or Vision coverage:  
  • From the ENROLL menu, select Change in Family Status.  
  • Select the appropriate Child event.  
  • Follow the instructions to make your benefit elections. | Date of election. |
| Death of covered spouse, domestic partner or dependent child | Within 31 days following death of spouse, domestic partner or child, call Pilot Benefits Administration to enter the date of death and make elections. | Date of death |
Change in Family Status or Employment Event/Special Enrollment Periods (Continued)

<table>
<thead>
<tr>
<th>Event</th>
<th>To Add or Change Dependent Medical, Dental and/or Vision Coverage</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent child is not incapacitated and becomes age 23 for Dental and/or Vision or 26 for Medical</td>
<td>Prior to your covered child’s 23rd or 26th birthday, as applicable, you will receive a letter advising your child is no longer eligible for benefits and instructions regarding how to change your coverage tier. Within 30 days of their 23rd or 26th birthday, as applicable, your child will receive a COBRA packet giving them the option to elect to continue benefits with instructions and a deadline to make their elections.</td>
<td>Day after the child’s 23rd/26th birthday</td>
</tr>
</tbody>
</table>

* Only pilots residing in California may elect Medical, Dental and/or Vision coverage for a domestic partner.

Your Cost for Coverage

FedEx Express pays the majority of the cost for Medical, Dental and/or Vision coverage. Since the Medical, Dental and/or Vision coverage cost the Company different amounts, your 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 available to you are listed in your personalized letter included in your enrollment material (i.e., Annual Benefits Enrollment, Change of Residence and New Hire).

The following chart shows monthly premiums for active pilots, **effective January 1, 2013**. The chart outlines the monthly pilot contributions for Pilot Only, Pilot & Child(ren), Pilot & Spouse and Pilot & Family Medical, Dental and/or Vision coverage.

1. For medical coverage in the Base & Buy Up Plans:

2013

<table>
<thead>
<tr>
<th>2013</th>
<th>Base Plan</th>
<th>Buy Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot</td>
<td>$20.64</td>
<td>$59.16</td>
</tr>
<tr>
<td>Pilot + Child(ren)</td>
<td>$88.04</td>
<td>$138.94</td>
</tr>
<tr>
<td>Pilot + Spouse</td>
<td>$107.30</td>
<td>$165.08</td>
</tr>
<tr>
<td>Pilot + Family</td>
<td>$137.57</td>
<td>$226.98</td>
</tr>
</tbody>
</table>

2. For dental coverage in the Dental Base and Buy Up Plans:

2013

<table>
<thead>
<tr>
<th>2013</th>
<th>Base Plan</th>
<th>Buy Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot</td>
<td>$4.13</td>
<td>$6.89</td>
</tr>
<tr>
<td>Pilot + Child(ren)</td>
<td>$16.50</td>
<td>$20.64</td>
</tr>
<tr>
<td>Pilot + Spouse</td>
<td>$17.89</td>
<td>$22.02</td>
</tr>
<tr>
<td>Pilot + Family</td>
<td>$19.26</td>
<td>$26.15</td>
</tr>
</tbody>
</table>
(3) For vision coverage only:

<table>
<thead>
<tr>
<th>Plan</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot</td>
<td>$2.76</td>
</tr>
<tr>
<td>Pilot + Child(ren)</td>
<td>$5.50</td>
</tr>
<tr>
<td>Pilot + Spouse</td>
<td>$5.50</td>
</tr>
<tr>
<td>Pilot + Family</td>
<td>$8.26</td>
</tr>
</tbody>
</table>

- As stated in the Collective Bargaining Agreement for 2011 and beyond, the monthly premiums may increase, but not by more than 6% over the monthly premiums payable for the immediately preceding year.

If you choose to enroll in a local HMO with monthly premiums greater than the Company's contribution to the FedEx Express Medical plan options, you will pay the difference in the cost. Please see page H-22 for additional information.

**Payroll Deductions for FedEx Express Medical, Dental and/or Vision Plan Options**

If you choose FedEx Express Medical, Dental and/or Vision coverage, the cost is automatically deducted from your paycheck on a pretax basis. You must notify Pilot Benefits Administration by calling 1-866-795-6353 or 1-901-434-6353 in the Memphis area 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.

**Health Care Contribution Plan**

The pretax deduction for Medical, Dental and/or Vision 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, Dental and/or Vision contributions to be made with pretax 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 pretax dollars increases your take-home pay and lowers your income tax liability. If you want your Medical, Dental and/or Vision contributions included in your taxable income, contact Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area.

**Important Note:** Future Social Security retirement benefits could be reduced slightly because pretax Medical, Dental and/or Vision 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 contributions will be deducted from your paycheck on an after tax basis.

**Your Coverage During a Leave of Absence—Medical, NonMedical or Military**

If you are on an approved leave of absence (LOA), 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, deductions will be taken.) 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 the following:

- Your dependents’ Medical, Dental and/or Vision coverage will end.

- You will be enrolled in the Base Plan and responsible for Medical premium payments. Your Dental and Vision coverage, if applicable, will be canceled. You will not be able to change your Medical plan option until the next Annual Benefits Enrollment period unless you move out of the service area and are not eligible for your current Medical plan option in your new location.

- During your LOA, 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/Employment event, which allows you to drop dependent Medical, Dental and/or Vision coverage within 31 days of the start of the leave. You can access FedEx Benefits Online within 31 days of beginning your LOA to make your coverage tier election. If you experience a Change in Family Status event while you are on LOA (for example, birth of a child, marriage, divorce, etc.), you have 31 days from the date of the event to add or drop dependent Medical, Dental and/or Vision coverage consistent with the Change in Family Status event. 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 of your return date.

### 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.

- A dependent spouse in active military service of any country is not an eligible dependent. If your covered spouse is on active duty, coverage for your spouse ends. If your spouse is your only covered dependent, you may want to drop spouse coverage. Make your elections on FedEx Benefits Online within 31 days of your spouse’s start of or return from active duty.

### 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/Employment event, which allows you to drop dependent Medical, Dental and/or Vision coverage within 31 days of the start of the suspension. To change your coverage tier, you must call Pilot Benefits Administration, 1-866-795-6353 or 434-6353 in the Memphis area, 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 from 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 the following:

- Medical, Dental and/or Vision coverage for you and your covered dependents will end.
- 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, 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 collective bargaining agreement
- You stop making the required contributions to participate in the Plan 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 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 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’s benefit plans is no longer provided under the terms of the Agreement
- You retire, unless you qualify for coverage after retirement as described on page W-6 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 Medical, Dental and/or Vision 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 are released or for 30 days, whichever occurs first.
If your coverage ends and your spouse is employed by FedEx Express or a participating employer in the Federal Express Corporation Group Health Plan and has coverage under that 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 1-901-434-6353 in the Memphis area within 31 days after your coverage ends to enroll you as a dependent of your spouse.

**When Dependents Lose Coverage**

You must notify Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area within 60 days of your dependent's loss of eligibility for your dependent to be eligible for COBRA and within 31 days of the event for you to be able to add or drop dependent coverage.

These dependents have the option to continue Medical, Dental and/or Vision coverage on their own under COBRA. If you do not notify Pilot Benefits Administration within 60 days following the date of the event, COBRA coverage will not be offered.

**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 or a local HMO on the day before any of these qualifying events occur:

- **Termination of employment for any reason other than gross misconduct or a reduction in the hours of employment**
- **Change from permanent to nonpermanent or restricted schedule**
- **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 FedEx Benefits Online at https://fedex.ehr.com, or you or your ex-spouse must call Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area. 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 FedEx Benefits Online at https://fedex.ehr.com, or you must call Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area. 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.
- **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 “COBRA Qualifying Events” on page H-20.

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 ADP, our COBRA administrator, at 1-800-522-6621. You can also write to ADP at:

ADP
P.O. Box 27478
Salt Lake City, UT 84127-0478

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 on page H-17 under “COBRA – Continuation of Coverage.” 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. ADP, our COBRA administrator, must be notified at 1-800-522-6621 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 ADP by telephone at 1-800-522-6621 within 30 days after the final determination.

Secondary Qualifying Events

If, during the 18 months of COBRA continuation Medical, Dental and/or Vision coverage, a second qualifying event occurs (e.g., divorce, legal separation, 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 ADP at 1-800-522-6621 within 60 days of that qualifying event. In no event, however, will COBRA continuation Medical, Dental and/or Vision coverage 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 which 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 which 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

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Qualifying Beneficiary</th>
<th>Notification</th>
<th>COBRA Period</th>
<th>COBRA Notification</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of pilot Covered spouse and/or dependent children</td>
<td>Pilot’s Assistant Chief Pilot must notify Pilot Benefits Administration within 30 days.*</td>
<td>36 months after the first 24 consecutive months of survivor coverage continuation</td>
<td>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.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Termination of employment or change from permanent status to temporary, nonpermanent or permanent restricted schedule</td>
<td>Covered pilot, spouse and dependent children</td>
<td>Pilot’s Assistant Chief Pilot must notify HRIS within 30 days of termination or status change.*</td>
<td>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 Administration)</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
<tr>
<td>Divorce</td>
<td>Covered spouse and/or stepchildren</td>
<td>Pilot must enter the divorce date on FedEx Benefits Online or pilot or qualified beneficiary must call Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area within 60 days of the event.</td>
<td>36 months</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
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## COBRA Qualifying Events

<table>
<thead>
<tr>
<th>Qualifying Event</th>
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<th>COBRA Period</th>
<th>COBRA Notification</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent child becomes ineligible for coverage (for example, age 23 for Dental and/or Vision or age 26 for Medical).</td>
<td>Covered dependent child</td>
<td>Qualified beneficiary or pilot must update the dependent child’s eligibility on the FedEx Benefits Online or notify Pilot Benefits Administration within 60 days of the event.</td>
<td>36 months</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
<tr>
<td>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.</td>
<td>Covered Spouse and Dependent Child(ren)</td>
<td>Pilot's Assistant Chief Pilot must notify FedEx Express Pilot Benefits Administration within 30 days.</td>
<td>36 months</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
</tbody>
</table>

** Submission of paperwork to HRIS is considered notification. If notification is made after 60 days from the date of the event, the rights to Medical, Dental and/or Vision continuation of coverage for such qualifying beneficiary will be lost.

COBRA-like coverage is also available for eligible domestic partners and their eligible dependent children. For details, call the Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area.

**Keep Your Plan Informed of Address Change** — In order to protect your family’s rights, you should keep ADP 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 ADP and Pilot Benefits Administration for your records.
Medical, Dental and Vision Information
Local HMOs and HMSA

In addition to the FedEx Express self-funded Medical plan options available to you, you may have the option to enroll in a local HMO, based on your home ZIP code as listed in PRISM if you live in California. Local HMOs (available only in specified regions) have their own guidelines and features, and are fully insured plans. In Hawaii, you can elect the local HMO—Health Plan Hawaii, or the fully insured PPO—HMSA.

These plans are fully insured benefit plans which means the local HMO 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 local HMOs or HMSA govern the plan provisions. The local HMO or HMSA, as applicable, is responsible for payment of the benefit.

If you choose to enroll in a local HMO or HMSA with monthly premiums greater than the Company’s contribution to the FedEx Express Medical plan options, you will pay the difference in the cost. This amount is communicated to you in your enrollment packet. Depending on your choice, monthly costs—or premiums—may be different. Continued availability of any local HMO is not guaranteed.

How the HMOs Work
Most local HMOs will require 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, pay only a small copayment for most services and then receive 100% coverage.

While most local HMOs offer the same level of benefits, individual local HMOs may differ slightly in the services they offer. You can get comprehensive benefits from each of the HMOs when you receive care within the network. If you go outside the local HMO network for care, the services are not covered and you are responsible for all medical charges. Keep in mind that local HMOs operate independently of FedEx—each has its own guidelines and features, and are fully insured rather than being self-funded like the FedEx Express Medical plan options.

HMO and HMSA Plan Descriptions
Benefits and services available from the local HMO options or HMSA are not described in this book. A general description of each local HMO option and HMSA is provided in the annual Health Enrollment Guide which is available on FedEx Benefits Online at https://fedex.ehr.com. If you need more specific information about a local HMO option or HMSA, you can call the local HMO or HMSA at the number listed under “Additional Information” in the local HMOs and HMSA chart in the Health Enrollment Guide, and detailed schedules of benefits and services will be provided, without charge, upon request. Also, the local HMO or HMSA will mail a complete packet to prospective enrollees, including a list of their participating providers and enrollment material, without charge, upon request. Detailed provider lists will be furnished automatically, without charge, to all plan participants.

If you enroll in a local HMO or HMSA, you will receive the appropriate ID card. You should contact the local HMO or HMSA directly for answers to your benefit questions. Eligibility and enrollment information described in this section applies to local HMO options and HMSA; however, the HMO Group Service Agreement or State law may establish different eligibility provisions. Please see the complete packet from the local HMO or HMSA for more information. FedEx will not be responsible for claim or appeal determinations when you choose a local HMO or HMSA. You should see your HMO or HMSA schedule of benefits and services for a description of the appeals process.
**Dental Coverage**

**MetLife** is the claims administrator for the FedEx Pilot dental plan options: Pilot Base Dental Plan and Pilot Buy Up Dental Plan.

Please call MetLife if you have any questions, to verify eligibility, to receive a list of in-network providers, or to request claim forms **1-800-540-5233**.

**To send dental claims to MetLife:**

<table>
<thead>
<tr>
<th>By Comail</th>
<th>Overnight Letter</th>
<th>Regular Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELP/TX</td>
<td>MetLife Dental</td>
<td>MetLife Dental</td>
</tr>
<tr>
<td>79906-0000</td>
<td>6 Founders Blvd., Ste. E</td>
<td>P. O. Box 981282</td>
</tr>
<tr>
<td></td>
<td>El Paso, TX 79906</td>
<td>El Paso, TX 79998-1282</td>
</tr>
</tbody>
</table>

**Website:**  [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)

**Vision Coverage**

**Davis Vision** is the claims administrator of the vision coverage. You can receive in-network benefits while in the U. S. through the Davis Vision in-network providers. Or, you may receive out-of-network benefits from a provider who does not participate in the Davis Vision network. There is no paperwork required to receive in-network benefits. When making your appointment with an in-network provider, identify yourself as a FedEx pilot and the provider will obtain the necessary authorization from Davis Vision.

Please call Davis Vision at 1-888-603-3339 if you have any questions, to verify eligibility, to receive a list of in-network providers, or to request claim forms. **To send vision claims to Davis Vision:**

<table>
<thead>
<tr>
<th>Overnight Letter</th>
<th>Regular Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis Vision</td>
<td>Davis Vision</td>
</tr>
<tr>
<td>Vision Processing Unit</td>
<td>Vision Processing Unit</td>
</tr>
<tr>
<td>711 Troy Schenectady Rd.</td>
<td>P. O. Box 1525</td>
</tr>
<tr>
<td>Suite 301</td>
<td>Latham, NY 12110</td>
</tr>
<tr>
<td>Latham, NY 12110-2488</td>
<td>Latham, NY 12110</td>
</tr>
</tbody>
</table>

**Website:**  [www.davisvision.com](http://www.davisvision.com)
Medical, Dental and Vision Information for Internationally Based FedEx Pilots

Medical Coverage

Effective January 1, 2013, GeoBlue is the administrator for the International Plan. 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.

The GeoBlue program will provide access to the BlueCard network in the U.S. You can access FedEx Benefits Online at https://fedex.ehr.com and download the Pilot Health Enrollment Guide and the GeoBlue Brochure on the EDUCATE module to review the summary of the International Plan. It can also be viewed on VIPS.

Before you receive your ID card, you can also obtain information about the plan online at the GeoBlue website: www.geo-blue.com.

- Click the Welcome, Sign in button in the right hand corner
- Generic User name FedEx@FedEx.com
- Generic Password 11FedEx
- The user may now begin using the site tools
- Note that 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, effective 1/1/2013:

Member Services
Collect outside the U.S. +1-610-254-5304
Toll Free Within the U.S. 1-855-282-3517
customerservice@geo-blue.com

24/7 Assistance – Provided by HTH Worldwide
Collect Calls Accepted +1-610-254-8771
globalhealth@hthworldwide.com
Prescription Coverage

Prescription coverage provided under the International Plan includes benefits for retail pharmacies and mail order (mail order is only available for members residing in the United States).

Retail Pharmacies

Members have access to over 44,000 participating pharmacies within the United States. Members are responsible for paying the copayment at retail pharmacies. Locate a participating pharmacy online at www.geo-blue.com. Present your medical and prescription ID card to the participating pharmacy.

Mail Order Program if residing in the United States

Provided by DrugSource.

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

Phone: Call DrugSource to order: 1-800-854-8764, (U.S.A). Hours: 8:30 a.m. – 7:00 p.m. CST, U.S.A.

Dental Coverage

MetLife is the claims administrator for the FedEx Pilot dental plan options: Pilot Base Dental Plan and Pilot Buy Up Dental Plan. MetLife has also agreed to accept faxed claims. When filing claims, be sure to include a note that identifies you as a “FedEx Pilot” and indicates the country’s currency.

To send dental claims to MetLife:

By Fax (315) 792-5706
Bekki Michik

By Comail 79906-0000

Overnight Letter MetLife Dental
6 Founders Blvd., Ste. E
El Paso, TX 79906

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

To telephone from outside the U.S.: 1-800-962-1401
(International toll free using AT&T access code)

To telephone from within the U.S.: 1-800-540-5233

Vision Coverage

Davis Vision is the claims administrator of the vision coverage. You can receive in-network benefits while in the U.S. through the Davis Vision in-network providers. Or, you may receive out-of-network benefits from a provider who does not participate in the Davis Vision network (offshore or in the U.S.). There is no paperwork required to receive in-network benefits. When making your appointment with an in-network provider, identify yourself as a FedEx pilot and the provider will obtain the necessary authorization from Davis Vision.

To receive reimbursement for out-of-network vision services, you must submit a completed claim form and an itemized bill. The itemized bill must give a breakdown of charges for each type of service or material (i.e. exam, frames, single vision lenses, bifocal, etc.). It would also be helpful, if possible, to provide a translation. Whenever you file a claim, attach a prominent note stating that you are a “FedEx Pilot.” Please call Davis Vision if you have any questions, to verify eligibility, to receive a list of in-
network providers, or to request claim forms. Appropriate addresses and phone numbers are:

<table>
<thead>
<tr>
<th>By Fax</th>
<th>By Comail</th>
<th>Overnight Letter</th>
<th>Regular Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>(518) 220-6023</td>
<td>Not Available</td>
<td>Davis Vision Vision Processing Unit</td>
<td>Davis Vision Vision Processing Unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>711 Troy Schenectady Rd., Suite 301</td>
<td>P. O. Box 1525</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Latham, NY 12110-2488</td>
<td>Latham, NY 12110</td>
</tr>
</tbody>
</table>

**Website:**

www.davisvision.com

**Collect from outside the U.S.:** 1-518-220-6000

**To telephone from within the U.S.:** 1-888-603-3339
Medical—Anthem PPO Plan Options
For Active Pilots & Covered Dependents
(Base Plan/Buy Up Plan)

The Federal Express Corporation Group Health Plan for Pilots (the “Plan”) is believed to be a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. However, grandfathered health plans must comply with certain provisions under the Affordable Care Act.

What this means to you:

• The medical lifetime maximum is eliminated for the Plan.

• Extension of medical coverage for children to age 26 with no restrictions on marital status, support, residency or full-time student status. You may not cover the dependents over age 23 if they are eligible for other group medical coverage through their own or their spouse’s employment.

If you have any additional questions, you can call Pilot Benefits Administration 1-866-795-6353 or 1-901-434-6353 in Memphis. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The Base Plan and Buy Up Plan, administered by Anthem Blue Cross Life & Health Insurance Company, Inc. (Anthem), provide access to the national Blue Cross/Blue Shield PPO network called BlueCard. These plans 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 Anthem PPO Plans:

• 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 a network provider, since the PPO 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

Whether you use in-network or out-of-network providers, you must meet an annual deductible before benefits are payable in the Base Plan, except for in-network expenses that require a copayment. Under the Buy Up Plan, you must meet an annual
deductible before benefits are payable if you use out-of-network providers. After the deductible is met, you pay a percentage of the covered expense—your coinsurance—up to a specified dollar amount annually. When you reach this annual limit—your out-of-pocket expense—the plan begins to pay 100% of covered expenses for the rest of the calendar year. Members will still be responsible for applicable copayments.

**Preventive Care**

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.

**How Covered Expense is Determined**

The PPO plans will pay for covered expenses you incur. A charge is incurred when the service or supply charge is rendered or received. 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.

**PPO (In-Network) Provider Charges**

The maximum covered expense for services provided by a participating provider will be the lesser of the billed charge or the negotiated rate. The negotiated rate is the amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by PPO Provider Agreements that Blue Cross/Blue Shield has with providers. When you choose a PPO provider, you will not be responsible for any amount in excess of the negotiated rate.

If you go to a hospital which is a PPO provider, you should not assume all providers in that hospital are also PPO providers. To receive the greater benefits afforded when covered services are provided by a PPO provider, you should request that all your provider services (such as services by an anesthesiologist) be performed by PPO 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 a PPO ambulatory surgical center provider before undergoing the surgery.

**How to Find an In-Network Provider**

For a list of participating providers, call Anthem Customer Service at 1-866-406-0982, or to access the online Provider Directory, go to www.anthem.com/ca and click on the Provider Finder and follow the instructions. When prompted, enter the Prefix Identification Number FXF. The network of providers is subject to change.

**Out-of-Network Charges**

**Out-of-Network Professional Charges**

Out-of-network claims for professional services will be determined using 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 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 Changes

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 and the claim is $1,000 or higher: 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 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 facility for the amount of the facility's bill above the Allowed Amount.

(3) If the out-of-network facility is not a Traditional facility and the claim is under $1,000: The amount the Plan will allow will be based on the local Blue Cross Blue Shield plan's out-of-network pricing (and will be applied when the claim is sent to Anthem). You will be liable for your share of the local Blue Cross Blue Shield pricing and will also be subject to balance billing by the facility for the amount of the facility's bill above the local Blue Cross Blue Shield pricing.

(4) 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.
What You Pay

Your monthly cost is based on the Medical, Dental and/or Vision plan options and coverage tier you elect. In addition to paying your monthly cost, you will also pay the copayments, deductibles and out-of-pocket maximums shown on the following chart.

For detailed information, see the following sections:

- Dental
- Vision
- Prescription Drugs

Anthem PPO Plan Options at a Glance
for Active Pilots & Covered Dependents

<table>
<thead>
<tr>
<th>Lifetime Maximum</th>
<th>BASE PLAN (Open Access PPO)</th>
<th>BUY UP PLAN (Open Access PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$250 individual</td>
<td>$250 individual</td>
</tr>
<tr>
<td></td>
<td>$750 family</td>
<td>$750 family</td>
</tr>
<tr>
<td>Out-of-Pocket maximum (including deductible)</td>
<td>$2,000 individual</td>
<td>$3,250 individual</td>
</tr>
<tr>
<td></td>
<td>$6,000 family</td>
<td>$9,750 family</td>
</tr>
<tr>
<td>Preventive Care (Based on Vendor Standard Guidelines)</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td></td>
<td>$20 copayment applies if PCP bills for an office visit.</td>
<td>$20 copayment applies if PCP bills for an office visit.</td>
</tr>
<tr>
<td></td>
<td>70% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 copayment per PCP/$40 copayment per specialist visit. No PCP referral required. OB/GYN is considered a PCP.</td>
<td>$20 copayment per PCP/$40 copayment per specialist visit. No PCP referral required. OB/GYN is considered a PCP.</td>
</tr>
<tr>
<td></td>
<td>70% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td>Inpatient Hospital Services (semiprivate room)</td>
<td>$150 copayment, then 90% coverage after deductible</td>
<td>$150 copayment, then 70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preauthorization.</td>
<td>Member responsible for preauthorization.</td>
</tr>
<tr>
<td></td>
<td>$150 copayment, then 100% coverage</td>
<td>$150 copayment, then 100% coverage</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preauthorization.</td>
<td>Member responsible for preauthorization.</td>
</tr>
<tr>
<td>Outpatient Lab, Radiology, Diagnostic and Pre-Admission Testing</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>If services performed in physician office, may be subject to office visit payment.</td>
<td>If services performed in physician office, may be subject to office visit payment.</td>
</tr>
<tr>
<td></td>
<td>100% coverage</td>
<td>70% coverage after deductible</td>
</tr>
</tbody>
</table>

Pilot Benefit Book
<table>
<thead>
<tr>
<th>Service</th>
<th>BASE PLAN (Open Access PPO)</th>
<th>BUY UP PLAN (Open Access PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity</strong></td>
<td>$20 copayment per visit</td>
<td>$20 copayment at first visit; then 100% coverage</td>
</tr>
<tr>
<td></td>
<td>70% coverage after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td>$75 copayment (waived if admitted) then 90% coverage after deductible if an emergency</td>
<td>$75 copayment (waived if admitted) then 100% coverage if an emergency</td>
</tr>
<tr>
<td></td>
<td>If not a true emergency, services are covered at the out-of-network level (70% coverage after deductible)</td>
<td>If not a true emergency, services are covered at the out-of-network level (70% coverage after deductible)</td>
</tr>
<tr>
<td></td>
<td>Ambulance: 90% coverage after deductible</td>
<td>Ambulance: Covered at the in-network level if an emergency. If not a true emergency, 70% coverage after deductible</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>$35 copayment, then 90% coverage after deductible</td>
<td>$35 copayment, then 70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>$35 copayment, then 100% coverage</td>
<td>$35 copayment, then 100% coverage</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>$50 copayment, then 90% coverage after deductible</td>
<td>$50 copayment, then 70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preauthorization.</td>
<td>Member responsible for preauthorization.</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>$1,750 annual maximum (In-network and out-of-network combined).</td>
<td>$1,750 annual maximum (In-network and out-of-network combined).</td>
</tr>
<tr>
<td><strong>Physical, Speech and Occupational Therapy</strong></td>
<td>Inpatient: 90% coverage after deductible</td>
<td>Inpatient: 100% coverage</td>
</tr>
<tr>
<td></td>
<td>Outpatient: $20 copayment</td>
<td>Outpatient: $20 copayment</td>
</tr>
<tr>
<td></td>
<td>Limits apply.</td>
<td>Limits apply.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preauthorization.</td>
<td>Member responsible for preauthorization.</td>
</tr>
</tbody>
</table>

**Anthem PPO Plan Options at a Glance**
for Active Pilots & Covered Dependents

**BASE PLAN**
(Open Access PPO)

**BUY UP PLAN**
(Open Access PPO)
<table>
<thead>
<tr>
<th></th>
<th>BASE PLAN (Open Access PPO)</th>
<th>BUY UP PLAN (Open Access PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preauthorization.</td>
<td>Member responsible for preauthorization.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preauthorization.</td>
<td>Member responsible for preauthorization.</td>
</tr>
<tr>
<td>Hospice</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for inpatient preauthorization.</td>
<td>Member responsible for inpatient preauthorization.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)/External Prosthetic Devices</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td>Prescription Drugs (Retail) For 1-month supply</td>
<td>• Generic: $10 copayment&lt;br&gt;• Preferred Brand: $41 copayment&lt;br&gt;• Non-Preferred Brand: $66 copayment&lt;br&gt;You pay the cost of the drug if less than the copayment.&lt;br&gt;Oral contraceptives are subject to the applicable prescription drug copayment. If administered in physician's office covered under the medical plan.&lt;br&gt;Oral contraceptives that are billed by the physician under the medical plan will be subject to the medical benefits. Oral contraceptives accessed at a pharmacy will be covered under the prescription drug benefit.</td>
<td>• Generic: $7.50 copayment&lt;br&gt;• Preferred Brand: $35 copayment&lt;br&gt;• Non-Preferred Brand: $55 copayment&lt;br&gt;You pay the cost of the drug if less than the copayment.&lt;br&gt;Oral contraceptives are subject to the applicable prescription drug copayment. If administered in physician's office, covered under the medical plan.&lt;br&gt;Oral contraceptives that are billed by the physician under the medical plan will be subject to the medical benefits. Oral contraceptives accessed at a pharmacy will be covered under the prescription drug benefit.</td>
</tr>
</tbody>
</table>
### Annual Medical Deductible

With the exception of the Buy Up Plan In-Network option, each year, you will have to meet your individual annual medical deductible before benefits are paid. 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 any enrolled dependent of that family. Refer to the “Anthem PPO Plan at a Glance for Active Pilots and Covered Dependents” chart on page H-30 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 PPO plan options pay, 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 “Anthem PPO Plan at a Glance for Active Pilots and Covered Dependents” chart on page H-30 for copayments and coinsurance amounts.

### Annual Medical Out-of-Pocket Maximum

Once you have met your annual medical deductible, you will pay your coinsurance and the inpatient hospital and/or outpatient surgery facility 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 for

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**Anthem PPO Plan Options at a Glance for Active Pilots & Covered Dependents**

<table>
<thead>
<tr>
<th>BASE PLAN (Open Access PPO)</th>
<th>BUY UP PLAN (Open Access PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Prescription Drugs (Mail Order) For 3-month supply</td>
<td></td>
</tr>
<tr>
<td>• Generic: $10 copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Preferred Brand: $68 copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Non-Preferred Brand: $118 copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td></td>
</tr>
<tr>
<td>100% covered for short-term counseling sessions up to 8 visits</td>
<td>Not covered</td>
</tr>
<tr>
<td>All services must be preauthorized.</td>
<td></td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Outpatient visit: $20 copayment</td>
<td>70% coverage for all services; no deductible or facility copayment. Member responsible for inpatient* preauthorization.</td>
</tr>
<tr>
<td>All other services 90% coverage; no deductible or facility copayment.</td>
<td></td>
</tr>
<tr>
<td>Member responsible for inpatient* preauthorization.</td>
<td></td>
</tr>
</tbody>
</table>

*Inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center and intensive outpatient program.

For preauthorization, call 1-800-274-7767. **Failure to obtain preauthorization for specific services will result in denial of benefits determined not medically necessary.**

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**Pilot Benefit Book**
any covered expense you incur during the remainder of that year. Refer to the “Anthem PPO Plan at a Glance for Active Pilots and Covered Dependents” chart on page H-30 for out-of-pocket amounts.

**How to File Claims**

If you go to a PPO provider, you will not have to file a claim. The PPO provider will file the claim for you. Once the claim is filed, you will receive an explanation of benefits (EOB) which 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 EOB if you have other insurance coverage that is secondary to your FedEx coverage.

If you go to a non-participating 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 time frame, 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 form 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. You will also receive an EOB explaining the covered expense and payments. Submit non-participating provider claims to the address below:

Anthem Blue Cross  
3179 Temple Avenue, Suite 200  
Pomona, CA  91768

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

**Coordination of Benefits 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**

<table>
<thead>
<tr>
<th>When You Have Medical Expenses for...</th>
<th>Your FedEx Express Medical Coverage Is...</th>
<th>Your Spouse’s Medical Plan Is...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>Primary*</td>
<td>Secondary</td>
</tr>
<tr>
<td>Spouse</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
<tr>
<td>Child</td>
<td>Primary if your birthday occurs first in the year. Secondary if your spouse’s birthday occurs first in the year.**</td>
<td>Primary if your spouse’s birthday occurs first in the year. Secondary if your birthday occurs first in the year.**</td>
</tr>
</tbody>
</table>

*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.
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 which 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 which has no Coordination of Benefits provision pays before a plan which 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 which covers you as an employee pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which 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, 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 which covers that child as a dependent of the parent with custody.

(c) The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

(d) The plan which 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 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 which 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, your human resources representative or the Workers’ Compensation Department.

Coordination of Benefits with TRICARE

If you and your covered dependents have coverage through one of the TRICARE programs, Anthem PPO 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 as a disabled person, 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:

- 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 enrolled in 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 payor.

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 payor 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’s Part A and Part B, benefits which otherwise may be payable by Anthem will be reduced by the amount Medicare would have paid. You will be responsible for any 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.

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 or access FedEx Benefits Online at https://fedex.ehr.com.

**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, MetLife, 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 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 is available upon request, subject to normal costs and restrictions as described in “Your Rights Under ERISA,” page I-14. Anthem provides medical policies on many procedures which are available online at www.anthem.com/ca. 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, it may not be covered by Anthem. Call Anthem Customer Service 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.”

**Utilization Review Preauthorization Requirements**

Preauthorization is recommended for inpatient mental health and substance abuse covered services (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center and intensive outpatient program). Preauthorization is not necessary for outpatient office visits for mental health and substance abuse services. Call 1-800-274-7767.

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 online at [www.anthem.com/ca](http://www.anthem.com/ca) and select Medical Policies and Clinical UM guidelines for
details before you schedule the surgery/procedure to see if preauthorization is required.

For preauthorization of the above services, call 1-800-274-7767. Failure to obtain any preauthorization as listed above 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 in the “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 one working day 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 which 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 5 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 2 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 disagree 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.

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.

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. FedEx and Anthem have 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 find 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, refer to the Appeal Section in Section I of this book. You may file a lawsuit in federal court.

**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.**

<table>
<thead>
<tr>
<th>Your Benefits</th>
<th>How To Receive Them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical emergency facility</td>
<td>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 network health care providers on staff at the hospital, you may request that all services be performed by network providers to incur less cost.</td>
</tr>
<tr>
<td>Emergency admission to a PPO network hospital</td>
<td>If you are admitted to a network hospital, your emergency room copayment will be waived. The hospital will notify Anthem of your admission. Anthem will then coordinate your care with your PPO network physician.</td>
</tr>
<tr>
<td>Emergency admission to an out-of-network hospital</td>
<td>If you are admitted to an out-of-network hospital, your emergency room copayment will be waived. 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.</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Your Benefits</th>
<th>How To Receive Them</th>
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</thead>
<tbody>
<tr>
<td>Urgent Care Centers</td>
<td>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.</td>
</tr>
</tbody>
</table>
When Traveling or Temporarily Residing Outside Your Home State

If you are traveling in the U.S., you and your enrolled dependents can access care from participating health care providers.

<table>
<thead>
<tr>
<th>Your Benefits</th>
<th>How To Receive Them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protection—when traveling or temporarily living outside your home state</td>
<td>To locate BlueCard PPO providers, just call toll-free 1-866-406-0982. Please note that the number is also printed on your ID card for handy reference.</td>
</tr>
<tr>
<td></td>
<td>You can also find BlueCard PPO providers at <a href="http://www.anthem.com/ca">www.anthem.com/ca</a>. Click on the Provider Finder and follow the instructions. When prompted, enter the Prefix Identification Number FXF.</td>
</tr>
<tr>
<td></td>
<td>• If you receive services from a provider in the national BlueCard PPO network, the provider will file the claim for you.</td>
</tr>
<tr>
<td></td>
<td>• If you receive services from an out-of-network provider, you may need to pay for the medical services when you receive them. You would then file a claim to the local Blue Cross/Blue Shield plan in the state where you received services. Addresses and details can be obtained by contacting Anthem Customer Service. Please save all relevant statements and attach to the claim form for reimbursement.</td>
</tr>
</tbody>
</table>

Access to HTH Worldwide Provider Network—When Traveling Outside the USA

<table>
<thead>
<tr>
<th>Your Benefits</th>
<th>How To Receive Them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services—when traveling outside the USA</td>
<td>Be prepared for the unexpected, call HTH Worldwide at the number printed on the back of your ID card before leaving the USA. You can call collect at 0+610-254-8769. An International Coordinator will provide you with a list of HTH Worldwide participating hospitals in several international cities. Or you can reach them online at <a href="http://www.hthbusiness.com">www.hthbusiness.com</a>.</td>
</tr>
<tr>
<td></td>
<td>For inpatient care at a network HTH 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.</td>
</tr>
<tr>
<td></td>
<td>To print a claim form, go to <a href="http://www.anthem.com/ca">www.anthem.com/ca</a>.</td>
</tr>
<tr>
<td>Inpatient care and all other medically necessary care that is not urgent or emergent will be covered subject to Anthem's PPO out-of-network benefits.</td>
<td></td>
</tr>
</tbody>
</table>
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.

### Your Benefits

<table>
<thead>
<tr>
<th>Outpatient urgent and emergency care—when outside the USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always carry your ID card when traveling outside the USA. You are covered 24 hours a day, seven days a week, regardless of your location.</td>
</tr>
<tr>
<td>How To Receive Them</td>
</tr>
<tr>
<td>If you need emergency medical care, go to the nearest hospital. Call HTH Worldwide at the number on the back of your ID card if you are admitted to the hospital. You can call collect at 0+610-254-8769.</td>
</tr>
<tr>
<td>If you are not admitted to the hospital, you may be asked to pay for emergency services when you receive care. Before leaving the emergency facility, please request an itemized bill, which you will need to include when filing the claim to Anthem. For all outpatient and professional medical care, you pay the provider and submit a claim. To print a claim form, go to <a href="http://www.anthem.com/ca">www.anthem.com/ca</a>.</td>
</tr>
</tbody>
</table>
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 federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's 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 means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under this Plan, including health care services which 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 federal 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 subject to a $1,750 annual maximum combined in and out of network.

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 which 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 are covered with a $500 lifetime maximum benefit. Hearing aids evaluations are limited based on Anthem's guidelines. Charges for ear mold(s), batteries, accessories or replacements are not covered.

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.

(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 which controls pain and relieves symptoms, but does not cure) which 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, ultra violet 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 which 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 which 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 eye glasses 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 MetLife (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. See “Skeletal Disorders of the Jaw” (Including TMJ) in the “Dental” section, page H-130.

Any outpatient TMJ surgery predetermination of benefits should be sent to MetLife. 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/Substance Abuse Benefits**

**Anthem EAP/Behavioral Health Resource Center**
Anthem EAP/Behavioral Health Resource Center offers access to:

- Employee Assistance Program (EAP) for short-term counseling,
- Mental Health/Substance Abuse for more complex or longer term care, and
- Trained behavioral health Customer Care representatives who can view all programs a member has available so that cross referrals to other beneficial programs can be offered.

**Employee Assistance Program (EAP)**
You are eligible for the EAP on your first day of active employment. All EAP services must be preauthorized through Anthem EAP/Behavioral Health Resource Center. In order to receive EAP services you must contact Anthem EAP/Behavioral Health Resource Center at 1-866-621-0130 to obtain a referral to an Anthem EAP network provider. The EAP is available 24 hours per day and is free to you, your eligible dependents and any member of your household—even if not covered by the Base Plan or Buy Up Plan. There is no need to file a claim form since this care is prepaid by FedEx. Your EAP services provide:

- Up to eight counseling sessions, prepaid by FedEx, for you, your eligible dependents or your household members, regardless of your FedEx Medical coverage (including HMOs, HMSA and the International Plan).
- In-network benefits only.
- Crisis counseling for urgent or emergency situations.
- Easy access to licensed psychologists and social workers located in your community.
- Confidential assistance 24 hours a day, every day of the year.

**Mental Health/Substance Abuse Services**
Under the Base Plan or Buy Up Plan, you are responsible for obtaining preauthorization for all inpatient mental health/substance abuse services and treatment (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center and intensive outpatient program) through the Anthem EAP/BH Resource Center. Mental health/substance abuse benefits are administered and claims are processed through Anthem Blue Cross.

**NOTE:** For local HMO participants, mental health/substance abuse treatment must be coordinated through your HMO, HMSA or International Plan.

Anthem Blue Cross provides:

- 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.
Your health coverage pays part of the cost of this type of care. See the “Benefits at a Glance” chart for details about mental health/substance abuse benefits. Since benefits are payable for this type of care, it is available only to you and eligible dependents covered by Anthem.

**Important:** You must preauthorize all EAP and it is recommended that you preauthorize inpatient mental health/substance abuse services and treatment (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center and intensive outpatient program) through the Anthem EAP/BH Resource Center by calling Anthem at **1-866-621-0130**.

### How It Works

To receive care, simply call Anthem EAP/Behavioral Health Resource Center anytime 24 hours a day at **1-866-621-0130**. When you call, an Anthem EAP/Behavioral Health Resource Center Customer Care representative will:

- Briefly review your concerns, assess whether your needs are best suited for the EAP or for mental health/substance abuse services and refer you to an Anthem EAP/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.

### In an Emergency

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

### 360° Health Programs

Anthem’s 360° Health Programs are available to assist enrolled pilots and their eligible dependents with health care information and support. These programs are discussed in detail below.

#### Condition Care

Condition Care programs are available for covered pilots and their covered dependents living with chronic conditions. The Condition Care programs include:

- Asthma (Pediatric or adult asthma).
- Diabetes (Pediatric or adult diabetes—Type I and II).
- Coronary artery disease.
- Heart failure.
- Chronic obstructive pulmonary disease.
- Low back pain.

When you participate in one of Anthem’s programs, participants living with a chronic condition can expect to receive:

- 24-hour toll-free access to registered nurses to answer your questions, provide support and education on how to better manage your condition.
- A health evaluation and consultation, as needed, to assist in managing your condition.
- Helpful educational materials on preventions, self-management and lifestyle factors that can help improve your health, including self-monitoring charts, self-care tips and more.
Participation in these programs is voluntary and will provide tools and information about living with chronic conditions to achieve optimal health.

To enroll in the Condition Care program call (866) 406-0982. Or to learn more about a particular chronic disease visit the Health and Benefit section of www.anthem.com/ca.

**My Health Coach Program**

MyHealthCoach 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.

The My Health Coaches 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, 24/7 NurseLine and other available care management programs.

My Health Coaches focus 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 (866) 406-0982.

**Future Moms**

Future Moms offers prenatal education and intervention, helping to make expectant mothers better informed about their pregnancy. Anthem provides mothers-to-be with toll-free access to a nurse 24/7. Program includes information on proper nutrition, diet and exercise during pregnancy. Participants receive prenatal and birth kits that include child-health and safety information.

To enroll in the Future Moms program, call (866) 406-0982 and ask to talk to a Future Moms Representative.

**24/7 Nurse Line**

This program provides access to a registered nurse 24 hours a day/7 days a week. The nurses provide free, confidential health information to assist in making informed health care decisions. To access a nurse, call (866) 406-0982.

In case of emergency, 911 should always be your first line of contact.

**Enrollment/Participation**

Participation in any of the 360° Health programs provided by Anthem Blue Cross 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 (866) 406-0982. Once enrolled, you have the option of discontinuing your participation by notifying Anthem at (866) 406-0982.

**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 Anthem PPO.
Limits for Base Plan and Buy Up Plan (In-Network and Out-of-Network)

- **Abortions**, either elective or non-elective, are limited based on Anthem’s guidelines.
- **Admission Kits** are limited based on Anthem’s guidelines.
- **Allergy Testing** is limited 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 a 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 $1,750 annual benefit limit (in-network and out-of-network combined) for you and each of your covered dependents.
- **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.
- **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 are covered with a $500 lifetime maximum benefit. Hearing aids evaluations are limited based on Anthem’s guidelines. Charges for ear molds, batteries, accessories or replacement are not covered.
- **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.
- **Lesion Removal** is limited based on Anthem’s guidelines.
- **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 and may result in a reduction of benefit.

• **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 limited based on Anthem's guidelines.

• **Oxygen** and rental of equipment for its administration is limited based on Anthem's guidelines.

• **Prenatal information, pregnancy risk assessment and consultation** are limited based on Anthem's guidelines.

• **Preventive care** is limited based on Anthem's guidelines.

• **Pediatric 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:
  – Surgical procedures or nail root removal
  – Lab and x-rays
  – Medical supplies
  – 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.

• **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.

• **Rental of durable medical equipment** is limited to the purchase price as determined by Anthem's guidelines.

• **Removal of Birthmarks** is limited based on Anthem's guidelines.

• **Skilled Nursing Facility.** Services provided by a Skilled Nursing Facility are limited based on Anthem's guidelines. Skilled Nursing Facility room and board (including regular daily services and supplies furnished by the Skilled Nursing Facility) are limited based on Anthem's guidelines. 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.
- 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.

Limits for Base Plan and Buy Up Plan (Out-of-Network)

- Hospital Room and Board. Up to the semiprivate room rate for inpatient hospital stays. The full cost of a private room is paid only when infectious disease precautions are required or when the patient has immunodeficiency resulting from an illness or treatment of an illness. If a hospital has only private rooms, benefits out-of-network are limited to the average semiprivate room rate for all other hospitals in the geographic area.

- Assistant surgeon charges are limited based on Anthem's guidelines.

- Co-surgeons are limited based on Anthem's guidelines.

Exclusions for Base Plan and Buy Up Plan (In-Network and Out-of-Network)

- 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.

- Acupuncture treatment. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

- 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 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 (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 or the lifetime maximum or the hearing aid lifetime maximum.

- **Exercise Equipment.** Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness.

- **Expenses incurred after the termination date of coverage.** See “When Coverage Ends” on page H-16 for more details.

- **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, eye glasses or for the purchase of eye glasses under the medical coverage.

- **Food or dietary supplements.**

- **Growth hormones.** These are not covered as a medical expense. See the Prescription Drug Benefit.

- **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, which 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 which 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.

See “Skeletal Disorders of the Jaw” (Including TMJ) in the “Dental” section, page H-130.

• **Natural childbirth education classes.**

• **Non-prescription nutritional formulas.** Nutritional formulas which can be purchased without a prescription and/or which are not medically necessary for the treatment of an illness.

• **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” section of this booklet.

- **Prescription drugs not administered in a doctor's office or facility**. See the “Prescription Drug Benefit” section beginning on page H-118.

- **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**.

- **Sex change**. Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex.

- **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 involve 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 MetLife (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. See “Skeletal Disorders of the Jaw” (Including TMJ) in the “Dental” section, page H-130.

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

- **Smoking cessation programs** or treatment of nicotine or tobacco use. Smoking cessation drugs.

- **Telephone and Electronic Consultation** charges incurred for consultations done outside of the office or facility setting.

- **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, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by Anthem guidelines.

- **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.
Limits for Base Plan and Buy Up Plan (In-Network Only)

- **Home births or home deliveries** are only excluded in-network.
- **Mammograms** are covered based on physician’s orders.
- **Participating midwife** must provide services under the direct supervision of an in-network physician at an authorized in-network facility.
- **Routine Pap smears** are limited based on Anthem’s guidelines.
- **Transplant travel & lodging expenses** are limited based on Anthem’s guidelines (only available when using a Network Transplant facility).

Exclusions for Base Plan and Buy Up Plan (Out-of-Network Only)

- **Expenses in excess of the Allowed Amount or Negotiated Amount** as described in “Out-of-Network Professional and Facility Charges” on page H-28.
- **No proof of charges.** Medical expenses for which you furnish no proof of charges.
- **Travel and lodging expenses** related to organ transplants.
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 “Retiree Health Coverage,” page H-65. 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 Medical, Dental and/or Vision 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 Medical, Dental and/or Vision coverage options.

<table>
<thead>
<tr>
<th>Spouse/Children under Medicare Age</th>
<th>If Spouse is Medicare Age at the time of Death</th>
<th>When Spouse Reaches Medicare Age Following the Pilot’s Death</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Pilot is Not Retiree Health Eligible</strong></td>
<td></td>
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</tr>
<tr>
<td>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 &amp; 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 in the Active Pilot Plan (i.e., Spouse Only, Child Only, Spouse &amp; Children or 2 or more Children).</td>
<td>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 &amp; 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 in the Active Pilot Plan (i.e., Spouse Only, Child Only, Spouse &amp; Children, or 2 or more Children).</td>
<td>When Spouse reaches Medicare Age during the:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1st 24 months, coverage continues for the 24-month period and the Spouse is then eligible to elect COBRA at active pilot COBRA rate for 36 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 36-month COBRA period, coverage ends the first of the month in which eligible for Medicare due to turning Medicare Age.</td>
</tr>
</tbody>
</table>
## Medical, Dental and/or Vision Coverage for Your Surviving Spouse/Children

<table>
<thead>
<tr>
<th>Spouse/Children under Medicare Age</th>
<th>If Spouse is Medicare Age at the time of Death</th>
<th>When Spouse Reaches Medicare Age Following the Pilot's Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
<td>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 &amp; Children if surviving spouse and children). The 1st 24 months 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 in the active Pilot Plan (i.e., Spouse Only, Child Only, Spouse &amp; 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).</td>
<td>When Spouse reaches Medicare age during the:</td>
</tr>
<tr>
<td>- For 1st 24 months, 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 &amp; Children if surviving spouse and children).</td>
<td>• 1st 24 months, coverage continues for the 24-month period and the Spouse is then eligible to elect COBRA at active pilot COBRA rate for 36 months.</td>
<td>• 1st 24 months, coverage continues for the 24-month period and the Spouse is then eligible to elect COBRA at active pilot COBRA rate for 36 months.</td>
</tr>
<tr>
<td>- For 1st 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).</td>
<td>After 24 months at active pilot rate, Spouse can elect up to 36 months at active pilot COBRA rate in the Active Pilot Plan (i.e., Spouse Only, Child Only, Spouse &amp; Children, or 2 or more Children), or Spouse can elect coverage in ALPA's Post Medicare Premium Reimbursement Plan (PRP) (Spouse can also elect coverage in the PRP at any time during the COBRA coverage period).</td>
<td>• 36-month COBRA period, coverage ends the first of the month in which eligible for Medicare due to turning Medicare Age.</td>
</tr>
<tr>
<td>or</td>
<td>• When Spouse reaches Medicare Age during Retiree Health, coverage ends the first of the month in which eligible for Medicare due to turning Medicare Age. Spouse can then elect Retiree COBRA for 36 months at the Pilot Retiree COBRA rate (i.e., Spouse Only), or can elect coverage in ALPA’s PRP.</td>
<td>• When Spouse reaches Medicare Age during Retiree Health, coverage ends the first of the month in which eligible for Medicare due to turning Medicare Age. Spouse can then elect Retiree COBRA for 36 months at the Pilot Retiree COBRA rate (i.e., Spouse Only), or can elect coverage in ALPA’s PRP.</td>
</tr>
</tbody>
</table>

Dependents referenced above are the same as described in the “Health Care – General Information” section.

**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” in the “Health Care – General Information” 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 Coverage for Your Surviving Spouse/Children chart above.
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 on page H-17.

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,” on page H-68 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 for all retirees, regardless of which Medical, Dental and/or Vision plan option is selected.

Eligibility

Eligible employees are any pilots of Federal Express Corporation who are subject to the Collective Bargaining Agreement between the Company and the Air Line Pilots Association, International and meet the eligibility requirements for Retiree Health.

As a retired pilot, you may enroll 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.

<table>
<thead>
<tr>
<th>Age and Service Requirements</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Were hired into a Permanent Full-Time or Permanent Part-Time position by FedEx Express before January 1, 1988</td>
<td>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.</td>
</tr>
<tr>
<td>Were hired into a permanent position by FedEx Express or another FedEx Corporation Controlled Group member on or after January 1, 1988</td>
<td>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.</td>
</tr>
<tr>
<td>Were a Flying Tiger pilot on August 6, 1989, and began to work for FedEx Express on August 7, 1989</td>
<td>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).</td>
</tr>
<tr>
<td>Are age 60 or older</td>
<td>Retire or terminate with at least 5 years of permanent part-time or permanent full-time continuous service immediately prior to age 60.</td>
</tr>
</tbody>
</table>
Continuous Service

Continuous service is service that begins on the most recent hire date at FedEx as reflected in PRISM, 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 PRISM to retired or terminated, Pilot Benefits Administration will determine your eligibility for Retiree Health Coverage. You will automatically be sent a COBRA packet to continue coverage under the Federal Express Corporation Group Health Plan and, if you meet the age and service requirements, 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.

Your Assistant Chief Pilot is responsible for submitting a PRISM authorization form to HRIS. 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 H-1 and only as permitted by the terms of the Collective Bargaining Agreement.

If, at the time of retirement, you were not participating in the FedEx Express group health coverage because you opted out for other group health coverage, you are still eligible to enroll in Retiree Health Coverage, 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,” page H-68, 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 a Medical Plan 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. The Base Plan and Buy Up Plan are the same as you had as an active pilot. You will also be eligible for the High Deductible Plan also administered by Anthem.

If you are Medicare Age on your retirement date, see “When You or Your Spouse Become Medicare Age” on page H-70.

If, at the time of your retirement, you were covered by either the Base Plan or the Buy Up Plan, you will be assigned to that same Medical plan option as a retired pilot. If you participated in a local HMO prior to your retirement, you will be enrolled in the local HMO, if it covers retirees. If the local HMO does not cover retirees, you will be enrolled in the Base Plan. If you were in the International Plan, you will be assigned the Base Plan. You will be assigned Medical, Dental and/or Vision coverage with the same coverage tier you were enrolled in prior to your retirement. If you were not participating in the FedEx group Medical, Dental and/or Vision coverage because you opted out for other group medical, dental and/or vision coverage, you are still
assigned Medical, Dental and/or Vision coverage in the Base Plan (HMSA in Hawaii) in the Retiree Only coverage tier and you are eligible to enroll in Retiree Health Coverage, as long as you meet the age and service requirements. You may elect to add your eligible dependents to your Retiree Health Coverage as long as they are eligible for Medical, Dental and/or Vision coverage on the date you commence Retiree Health Coverage.

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:

- Base Plan
- Buy Up Plan
- High Deductible Plan, or
- Local HMOs, if applicable
- HMSA

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 1-901-434-6353 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, but you send in your Medical, Dental and/or Vision payment, you will continue in the assigned Medical, Dental and/or Vision coverage and coverage tier.
- 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” on page H-68 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 Become Medicare Age” on page H-70. 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 beginning on page H-2.

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 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 of 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 of 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 reenroll 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 resume when you are no longer eligible for active health coverage. You must notify Pilot Benefits Administration that you wish to resume Retiree Health Coverage at 1-866-795-6353 or 1-901-434-6353 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 ADP, 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 1-901-434-6353 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 of 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. Your first payment must include costs retroactive to your date of retirement and must be submitted to Pilot Benefits Administration with your Medical, Dental and/or Vision plan option and coverage level 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 deductions begin. The Pension deduction election form will be included in your Retiree Health Coverage enrollment packet. Call Pilot Benefits Administration at 1-866-795-6353 or in the Memphis area at 901-434-6353 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 from pension deduction is that you do not have to remember to mail in your payment each month.

**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 a local HMO, generally Medicare will be considered primary. If you or one of your covered dependents becomes Medicare eligible prior to Medicare Age, you should notify Pilot Benefits Administration at 1-866-795-6353 or in the Memphis area at 901-434-6353.

**If You and/or Your Spouse 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 Health Plan sponsored by the Air Line Pilots Association, International (ALPA).

**When You or Your Spouse Become Medicare Age**

Effective the first of the month you or your spouse become Medicare Age, FedEx Retiree Health Coverage will end for that individual. Pursuant to the Collective Bargaining Agreement between Federal Express Corporation (FedEx) and ALPA, upon attainment of Medicare Age, you or your spouse are eligible for the ALPA-sponsored FedEx Pilots Post Medicare Retiree Health Plan, also referred to as the Premium Reimbursement Plan (PRP) provided you met the eligibility requirements for coverage under the Federal Express Retiree Health Plan for Pilots and you or your spouse participated in the Federal Express Retiree Health Plan for Pilots or the Federal Express Group Health Plan for Pilots upon the attainment of Medicare Age or, if later, on your retirement or termination date.

ALPA will mail you information on the FedEx Pilots Post Medicare Retiree Health Plan several months prior to your or your spouse attaining Medicare Age. For more information on the benefits offered under the ALPA-sponsored FedEx Pilots Post Medicare Retiree Health Plan, 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, HMSA, or a local HMO, 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 Health Plan.

If you have questions about your dependents’ eligibility, call Pilot Benefits Administration at 1-866-795-6353 or in the Memphis area at 901-434-6353. 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 1-901-434-6353 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 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 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 retire, unless you qualify for coverage after retirement as described on page H-65 or you elect to continue health coverage through COBRA
- You are on furlough and no longer receiving furlough pay
- You opt out of FedEx Express Retiree Health coverage
- The first of the month you or your covered spouse attain 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 a participating employer and has coverage, 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 1-901-434-6353 in the Memphis area within 31 days after your coverage ends to enroll you as a dependent of your spouse.
Anthem PPO Plan Options For Pre-Medicare Retired Pilots & Covered Dependents
(Base Plan/Buy Up Plan/High Deductible Plan)

In the Federal Express Corporation Retiree Group Health Plan for Pilots (the “Plan”) the Base and Buy Up Plan are believed to be “grandfathered health plans” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. However, grandfathered health plans must comply with certain provisions under the Affordable Care Act.

What this means to you is that under the Base and Buy Up Plan:

- The medical lifetime maximum is eliminated.
- Extension of medical coverage for children to age 26 with no restrictions on marital status, support, residency or full-time student status. You may not cover the dependents over age 23 if they are eligible for other group medical coverage through their own or their spouse’s employment.*

*Extension of medical coverage for children to age 26 as stated above was also applied to the High Deductible Plan.*

If you have any additional questions, you can call Pilot Benefits Administration 1-866-795-6353 or 1-901-434-6353 in Memphis. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The Base Plan, Buy Up Plan and High Deductible Plan, administered by Anthem Blue Cross Life & Health Insurance Company, Inc. (Anthem), provide access to the national Blue Cross/Blue Shield PPO network called BlueCard. These plans 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 Anthem PPO Plans:

- 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 a network provider, since the PPO 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

**Whether you use in-network or out-of-network providers**, you must meet an annual deductible before benefits are payable in the Base Plan and High Deductible Plan, except for in-network expenses that require a copayment. Under the Buy Up Plan, you must meet an annual deductible before benefits are payable if you use out-of-network providers. After the deductible is met, you pay a percentage of the covered expense—your coinsurance—up to a specified dollar amount annually. When you reach this annual limit—your out-of-pocket expense—the plan begins to pay 100% of covered expenses for the rest of the calendar year. Members will still be responsible for applicable copayments.

**Preventive Care**
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.

**How Covered Expense is Determined**
The PPO plans will pay for covered expenses you incur. A charge is incurred when the service or supply charge is rendered or received. 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.

**PPO (In-Network) Provider Charges**
The maximum covered expense for services provided by a participating provider will be the lesser of the billed charge or the negotiated rate. The negotiated rate is the amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by PPO Provider Agreements that Blue Cross/Blue Shield has with providers. When you choose a PPO provider, you will not be responsible for any amount in excess of the negotiated rate.

If you go to a hospital which is a PPO provider, you should not assume all providers in that hospital are also PPO providers. To receive the greater benefits afforded when covered services are provided by a PPO provider, you should request that all your provider services (such as services by an anesthesiologist) be performed by PPO 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 a PPO ambulatory surgical center provider before undergoing the surgery.

**How to Find an In-Network Provider**
For a list of participating providers, call Anthem Customer Service at 1-866-406-0982, or to access the online Provider Directory, go to www.anthem.com/ca and click on the Provider Finder and follow the instruction. When prompted, enter the Prefix Identification Number FXF. The network of providers is subject to change.
Out-of-Network Charges

Out-of-Network Professional Charges

Out-of-network claims for professional services will be determined using 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 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 Changes

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 and the claim is $1,000 or higher: 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, 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 the out-of-network facility is not a Traditional facility and the claim is under $1,000: The amount the Plan will allow will be based on the local Blue Cross Blue Shield plan’s out-of-network pricing (and will be applied when the claim is sent to Anthem). You will be liable for your share of the local Blue Cross Blue Shield...
prating and will also be subject to balance billing by the facility for the amount of the facility’s bill above the local Blue Cross Blue Shield pricing.

(4) 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.

What You Pay

Your monthly cost is based on the Medical, Dental and/or Vision plan options and coverage tier you elect. In addition to paying your monthly cost, you will also pay the copayments, deductibles and out-of-pocket maximums shown on the following chart.

For detailed information, see the following sections:
- Dental
- Vision
- Prescription Drugs

Anthem PPO Plan Options at a Glance
for Pre-Medicare Retired Pilots & Covered Dependents

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<tr>
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<th>PILOT HIGH DEDUCTIBLE PLAN (Open Access PPO)</th>
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<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>N/A for Base and Buy Up Plan; $3 million lifetime maximum for High Deductible Plan</td>
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<tr>
<td>Annual Deductible</td>
<td>• $250 individual</td>
<td>$250 individual</td>
<td>• $250 individual</td>
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<tr>
<td></td>
<td>• $750 family</td>
<td>$750 family</td>
<td>• $750 family</td>
</tr>
<tr>
<td>Out-of-Pocket</td>
<td>• $2,000 individual</td>
<td>$3,250 individual</td>
<td>• $3,250 individual</td>
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<td>maximum (including</td>
<td>• $6,000 family</td>
<td>$9,750 individual</td>
<td>• $9,750 family</td>
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<td>deductible)</td>
<td>Inpatient Hospital/Outpatient</td>
<td>Inpatient Hospital/Outpatient</td>
<td>Inpatient Hospital/Outpatient</td>
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<td></td>
<td>Surgery Facility copayments and</td>
<td>Surgery Facility copayments and</td>
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<td>all coinsurance, excluding</td>
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<td>prescription drug, apply to</td>
<td>prescription drug, apply to</td>
<td>prescription drug, apply to</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% coverage</td>
<td>100% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td>(Based on Vendor</td>
<td>$20 copayment applies if the PCP</td>
<td>for PCP visits for an office visit.</td>
<td>$70 copayment</td>
</tr>
<tr>
<td>Standard Guidelines)</td>
<td>for PCP visits for an office visit.</td>
<td>for PCP visits for an office visit.</td>
<td>$70 copayment</td>
</tr>
<tr>
<td></td>
<td>70% coverage after deductible</td>
<td>70% coverage after deductible</td>
<td>Not covered</td>
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</table>
## Anthem PPO Plan Options at a Glance
### for Pre-Medicare Retired Pilots & Covered Dependents

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<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 copayment per PCP/$40 copayment per specialist visit. No PCP referral required. OB/GYN is considered a PCP.</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td>Inpatient Hospital Services (semiprivate room)</td>
<td>$150 copayment, then 90% coverage after deductible</td>
<td>$150 copayment, then 70% coverage after deductible</td>
</tr>
<tr>
<td>Outpatient Lab, Radiology, Diagnostic and Pre-Admission Testing</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td>Maternity</td>
<td>$20 copayment per visit</td>
<td>70% coverage after deductible</td>
</tr>
</tbody>
</table>

*Anthem PPO Plan Options at a Glance for Pre-Medicare Retired Pilots & Covered Dependents*
### Anthem PPO Plan Options at a Glance
for Pre-Medicare Retired Pilots & Covered Dependents

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
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<tbody>
<tr>
<td><strong>Pilot Base Plan</strong></td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Pilot Buy Up Plan</strong></td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Pilot High Deductible Plan</strong></td>
<td>$150</td>
<td>$150</td>
</tr>
</tbody>
</table>

#### Emergency Services
- In-Network: $75 copayment (waived if admitted) then 90% coverage after deductible if an emergency.
- Out-of-Network: $75 copayment (waived if admitted) then 100% coverage if an emergency.
- In-Network: $75 copayment (waived if admitted) then 100% coverage after deductible if an emergency.
- Out-of-Network: $75 copayment (waived if admitted) then 100% coverage if an emergency.

#### Urgent Care Facility
- $35 copayment, then 90% coverage after deductible.
- $35 copayment, then 70% coverage after deductible.
- $35 copayment, then 100% coverage after deductible.
- $35 copayment, then 70% coverage after deductible.
- $35 copayment, then 100% coverage after deductible.
- $70 copayment, then 80% coverage after deductible.

#### Outpatient Surgery
- $250 copayment, then 80% coverage after deductible.
- $250 copayment, then 80% coverage after deductible.
- $250 copayment, then 80% coverage after deductible.
- $250 copayment, then 80% coverage after deductible.
- $250 copayment, then 80% coverage after deductible.
- $250 copayment, then 80% coverage after deductible.
- Member responsible for preauthorization.
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<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
<td>80% coverage after deductible</td>
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<tr>
<td></td>
<td>$1,750 annual maximum (In-network and out-of-network combined).</td>
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<td>$1,750 annual maximum (In-network and out-of-network combined).</td>
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<td></td>
<td>$20 copayment each visit</td>
<td>$20 copayment each visit</td>
<td>60% coverage after deductible</td>
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<td>Limits apply.</td>
<td>Limits apply.</td>
<td>Limits apply.</td>
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<tr>
<td></td>
<td></td>
<td>70% coverage after deductible</td>
<td>60% coverage after deductible</td>
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<tr>
<td></td>
<td>Limits apply.</td>
<td>Limits apply.</td>
<td>Limits apply.</td>
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<tr>
<td>Physical, Speech and</td>
<td>Inpatient: 90% coverage after</td>
<td>70% coverage after deductible</td>
<td>80% coverage after deductible</td>
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<tr>
<td>Occupational Therapy</td>
<td>deductible</td>
<td>70% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Outpatient: $20 copayment Limits apply.</td>
<td>Limits apply.</td>
<td>Limits apply.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>90% coverage after deductible</td>
<td>100% coverage</td>
<td>$250 copayment, then 80% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preautho-</td>
<td>Member responsible for preautho-</td>
<td>Member responsible for preautho-</td>
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<tr>
<td></td>
<td>rization.</td>
<td>rization.</td>
<td>rization.</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
<td>80% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preautho-</td>
<td>70% coverage after deductible</td>
<td>60% coverage after deductible</td>
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<tr>
<td></td>
<td>rization.</td>
<td>Member responsible for preautho-</td>
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<td></td>
<td></td>
<td>rization.</td>
<td>rization.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
<td>80% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preautho-</td>
<td>70% coverage after deductible</td>
<td>60% coverage after deductible</td>
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<td></td>
<td>rization.</td>
<td>Member responsible for preautho-</td>
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<td>rization.</td>
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</tbody>
</table>
# Anthem PPO Plan Options at a Glance

for Pre-Medicare Retired Pilots & Covered Dependents

<table>
<thead>
<tr>
<th></th>
<th>PILOT BASE PLAN (Open Access PPO)</th>
<th>PILOT BUY UP PLAN (Open Access PPO)</th>
<th>PILOT HIGH DEDUCTIBLE PLAN (Open Access PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
<td>70% coverage after deductible</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td>Member responsible for preautho-</td>
<td>Member responsible for preautho-</td>
<td>Member responsible for preautho-</td>
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<tr>
<td></td>
<td>rization.</td>
<td>rization.</td>
<td>rization.</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td>100% coverage after deductible</td>
<td>80% coverage after deductible</td>
</tr>
<tr>
<td></td>
<td>Member responsible for preautho-</td>
<td>Member responsible for preautho-</td>
<td>Member responsible for preautho-</td>
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<tr>
<td></td>
<td>rization.</td>
<td>rization.</td>
<td>rization.</td>
</tr>
<tr>
<td></td>
<td>60% coverage after deductible</td>
<td>60% coverage after deductible</td>
<td></td>
</tr>
<tr>
<td>Durable Medical</td>
<td>90% coverage after deductible</td>
<td>70% coverage after deductible</td>
<td>80% coverage after deductible</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td></td>
<td>100% coverage after deductible</td>
<td>60% coverage after deductible</td>
</tr>
<tr>
<td>(DME)/External</td>
<td></td>
<td>70% coverage after deductible</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices</td>
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</tr>
</tbody>
</table>

## Anthem PPO Plan Options at a Glance for Pre-Medicare Retired Pilots & Covered Dependents

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</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Prescription Drugs (Retail) For 1-month supply</td>
<td>50% of cost of prescription. In no case can the 50% coinsurance be less than what would have been paid in-network.</td>
<td>50% of cost of prescription. In no case can the 50% coinsurance be less than what would have been paid in-network.</td>
</tr>
<tr>
<td>• Generic: $10 copayment</td>
<td>• Generic: $7.50 copayment</td>
<td>• Mandatory Generic: $10 copayment</td>
</tr>
<tr>
<td>• Preferred Brand: $41 copayment</td>
<td>• Preferred Brand: $35 copayment</td>
<td>• Preferred Brand: 50% coinsurance ($50 minimum/ $150 maximum)</td>
</tr>
<tr>
<td>• Non-Preferred Brand: $66 copayment</td>
<td>• Non-Preferred Brand: $55 copayment</td>
<td>• Non-Preferred Brand: 50% coinsurance ($75 minimum/ $175 maximum)</td>
</tr>
<tr>
<td>You pay the cost of the drug if less than the copayment. Oral contraceptives are subject to the applicable prescription drug copayment. If administered in physician’s office covered under the medical plan. Oral contraceptives that are billed by the physician under the medical plan will be subject to the medical benefits. Oral contraceptives accessed at a pharmacy will be covered under the prescription drug benefit.</td>
<td>You pay the cost of the drug if less than the copayment. Oral contraceptives are subject to the applicable prescription drug copayment, if administered in physician’s office, covered under the medical plan. Oral contraceptives that are billed by the physician under the medical plan will be subject to the medical benefits. Oral contraceptives accessed at a pharmacy will be covered under the prescription drug benefit.</td>
<td>You pay the cost of the drug if less than the copayment. Oral contraceptives are subject to the applicable prescription drug copayment, if administered in physician’s office, covered under the medical plan. Oral contraceptive that are billed by the physician under the medical plan will be subject to the medical benefits. Oral contraceptives accessed at a pharmacy will be covered under the prescription drug benefit.</td>
</tr>
</tbody>
</table>
## Anthem PPO Plan Options at a Glance
**for Pre-Medicare Retired Pilots & Covered Dependents**

<table>
<thead>
<tr>
<th></th>
<th><strong>PILOT BASE PLAN</strong></th>
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<th><strong>PILOT HIGH DEDUCTIBLE PLAN</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>(Open Access PPO)</td>
<td>(Open Access PPO)</td>
<td>(Open Access PPO)</td>
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<tr>
<td><strong>In-Network</strong></td>
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<tr>
<td><strong>Out-of-Network</strong></td>
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</tr>
<tr>
<td><strong>In-Network</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs (Mail Order) For 3-month supply</strong></td>
<td>• Generic: $10 copayment</td>
<td>• Generic: $7.50 copayment</td>
<td>• Mandatory Generic: $10 copayment</td>
</tr>
<tr>
<td></td>
<td>• Preferred Brand: $68 copayment</td>
<td>• Preferred Brand: $65 copayment</td>
<td>• Preferred Brand: 50% coinsurance ($100 minimum/$300 maximum)</td>
</tr>
<tr>
<td></td>
<td>• Non-Preferred Brand: $118 copayment</td>
<td>• Non-Preferred Brand: $115 copayment</td>
<td>• Non-Preferred Brand: 50% coinsurance ($150 minimum/$350 maximum)</td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP)</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>100% covered for short-term counseling sessions up to 8 visits</td>
<td>100% covered for short-term counseling sessions up to 8 visits</td>
<td>100% covered for short-term counseling sessions up to 8 visits</td>
</tr>
<tr>
<td></td>
<td>All services must be preauthorized.</td>
<td>All services must be preauthorized.</td>
<td>All services must be preauthorized.</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td>Outpatient visit: $20 copayment</td>
<td>Outpatient visit: $20</td>
<td>Outpatient visit: $70 copayment</td>
</tr>
<tr>
<td></td>
<td>All other services; 90% coverage or facility copayment.</td>
<td>All other services; 90% coverage or facility copayment.</td>
<td>All other services; 80% coverage; no deductible.</td>
</tr>
<tr>
<td></td>
<td>Member responsible for inpatient* preauthorization.</td>
<td>Member responsible for inpatient* preauthorization.</td>
<td>Member responsible for inpatient* preauthorization.</td>
</tr>
<tr>
<td></td>
<td>70% coverage for all services; no deductible or facility copayment.</td>
<td>70% coverage for all services; no deductible or facility copayment.</td>
<td>60% coverage for all services; no deductible.</td>
</tr>
</tbody>
</table>

*Inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center and intensive outpatient program.

For preauthorization, call 1-800-274-7767. **Failure to obtain required preauthorization for specific services will result in denial of benefits determined not medically necessary.**
**Annual Medical Deductible**

With the exception of the Buy Up Plan In-Network option, each year, you will have to meet your individual annual medical deductible before benefits are paid. 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 any enrolled dependent of that family. Refer to the “Anthem PPO Plan at a Glance for Active Pilots and Covered Dependents” chart on page H-30 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 PPO plan options pay, 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 “Anthem PPO Plan at a Glance for Active Pilots and Covered Dependents” chart on page H-30 for copayments and coinsurance amounts.

**Annual Medical Out-of-Pocket Maximum**

Once you have met your annual medical deductible, you will pay your coinsurance and the inpatient hospital and/or outpatient facility 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 for any covered expense you incur during the remainder of that year. Refer to the “Anthem PPO Plan at a Glance for Pre-Medicare Retired Pilots and Covered Dependents” chart on page H-75 for out-of-pocket amounts.

**Lifetime Maximum Benefits**

You should know that:

- The lifetime maximum benefit for the High Deductible Plan is $3 million. 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 in which you currently participate or participated in the past. This includes claims incurred under CIGNA POS, CIGNA Network, California PPO, Memphis PPO, FedEx Puerto Rico PPO, FedEx Basic, FedEx Basic Plus, FedEx Retiree Basic for pilots and the FedEx Advantage/FedEx Premier (including Memphis and Plus), FedEx California POS, FedEx Low Option, Catastrophic Medical or any self-funded Retiree Medical plan option for non-pilots.

- If you enroll in a local HMO option, you start over under the local HMO’s lifetime maximum. However, if you switch back to the High Deductible Plan in some future year, you will resume with the lifetime maximum amount you had accumulated under the FedEx Express self-funded Medical plan option before you switched to the local HMO.

**How to File Claims**

If you go to a PPO provider, you will not have to file a claim. The PPO provider will file the claim for you. Once the claim is filed, you will receive an explanation of benefits (EOB) which 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 EOB if you have other insurance coverage that is secondary to your FedEx coverage.

If you go to a non-participating 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 time frame, 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 form 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. You will also receive an EOB explaining the covered expense and payments. Submit non-participating provider claims to the address below:

Anthem Blue Cross
3179 Temple Avenue, Suite 200
Pomona, CA 91768

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

Coordination of Benefits 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.

<table>
<thead>
<tr>
<th>COB When You and Your Spouse Both Have Group Medical Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When You Have Medical Expenses for...</strong></td>
</tr>
<tr>
<td>You</td>
</tr>
<tr>
<td>Spouse</td>
</tr>
<tr>
<td>Child</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>COB Other Situations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation</strong></td>
</tr>
</tbody>
</table>
| You also have coverage through your spouse’s employer. | • If 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. |
COB Other Situations

<table>
<thead>
<tr>
<th>Situation</th>
<th>Primary Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are an active covered pilot and also have retiree coverage through a former employer</td>
<td>The Primary plan is always your coverage as an active employee.</td>
</tr>
<tr>
<td>You have FedEx retiree coverage and also have active coverage through another employer</td>
<td>The Primary Plan is your active coverage through your other employer.</td>
</tr>
<tr>
<td>You and your spouse are separated or divorced</td>
<td>The medical plan options pay in this order for dependent children:</td>
</tr>
<tr>
<td></td>
<td>(1) The plan offered by the employer of the parent appointed to provide coverage</td>
</tr>
<tr>
<td></td>
<td>(2) The plan of the parent who has custody, when no court order indicates the parent appointed to provide coverage</td>
</tr>
<tr>
<td></td>
<td>(3) The plan of the spouse of the parent with custody (stepparent)</td>
</tr>
<tr>
<td></td>
<td>(4) The plan of the parent without custody</td>
</tr>
</tbody>
</table>

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 expense which 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 which has no Coordination of Benefits provision pays before a plan which 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 which covers you as an employee pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which 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 which covers that child as a dependent of the parent with custody.

(c) The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

(d) The plan which 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 which 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, Anthem PPO 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 non-military-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 an Anthem PPO 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's Part A and Part B, benefits which otherwise may be payable by Anthem will be reduced by the amount Medicare would have paid. You will be responsible for any 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.

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 or access FedEx Benefits Online at https://fedex.ehr.com.

**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, MetLife, 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 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 is available upon request, subject to normal costs and restrictions as described in “Your Rights Under ERISA,” page I-14. Anthem provides medical policies on many procedures which are available online at www.anthem.com/ca. 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, it may not be covered by Anthem. Call Anthem Customer Service 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).

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.”
Utilization Review Preauthorization Requirements

Preauthorization is recommended for inpatient mental health and substance abuse covered services (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center and intensive outpatient program). Preauthorization is not necessary for outpatient office visits for mental health and substance abuse services. Call 1-800-274-7767.

Preauthorization is also recommended 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 online at www.anthem.com/ca and select Medical Policies and Clinical UM guidelines for details before you schedule the surgery/procedure to see if preauthorization is required.

For preauthorization of the above services, call 1-800-274-7767. Failure to obtain any preauthorization as listed above 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

**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 one working day 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 which have been retroactively determined to not be medically necessary and appropriate will be retrospectively denied authorization.

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 in the “Effect on Benefits.”
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 5 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 2 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 disagree 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.

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. FedEx and Anthem have 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 find 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, refer to the Appeal Section in Section I of this book. You may file a lawsuit in federal court under the Employee Retirement Income Security Act of 1974 or submit your appeal to the Pilot Benefit Review Board. Refer to the Pilot Benefit Review Board on page I-43 for more information.

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.

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<thead>
<tr>
<th>Your Benefits</th>
<th>How To Receive Them</th>
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<tbody>
<tr>
<td>Medical emergency facility</td>
<td>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 network health care providers on staff at the hospital, you may request that all services be performed by network providers to incur less cost.</td>
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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.

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<td>Emergency admission to a PPO network hospital</td>
<td>If you are admitted to a network hospital, your emergency room copayment will be waived. The hospital will notify Anthem of your admission. Anthem will then coordinate your care with your PPO network physician.</td>
</tr>
<tr>
<td>Emergency admission to an out-of-network hospital</td>
<td>If you are admitted to an out-of-network hospital, your emergency room copayment will be waived. 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.</td>
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</table>

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.

When Traveling or Temporarily Residing Outside Your Home State

If you are traveling in the U.S., you and your enrolled dependents can access care from participating health care providers.
### Access to HTH Worldwide Provider Network—When Traveling Outside the USA

#### Your Benefits

**Inpatient services—when traveling outside the USA**

You may access HTH Worldwide participating hospitals for inpatient services to receive in-network benefits.

Inpatient out-of-network and all other medically necessary care that is not urgent or emergent will be covered subject to Anthem’s PPO out-of-network benefits.

#### How To Receive Them

Be prepared for the unexpected, call HTH Worldwide at the number printed on the back of your ID card before leaving the USA. You can call collect at 0+610-254-8769. An International Coordinator will provide you with a list of HTH Worldwide participating hospitals in several international cities. Or you can reach them online at www.hthbusiness.com.

For inpatient care at a network HTH 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.
### 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.

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(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 federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran’s 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 means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under this Plan, including health care services which 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 federal 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 subject to a $1,750 annual maximum combined in and out of network.

**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 which 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 are covered with a $500 lifetime maximum benefit. Hearing aids evaluations are limited based on Anthem's guidelines. Charges for ear mold(s), batteries, accessories or replacements are not covered.

**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 which controls pain and relieves symptoms, but does not cure) which 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)**

**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, ultra violet 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 which 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 which 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 eye glasses 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 MetLife (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. See “Skeletal Disorders of the Jaw” (Including TMJ) in the “Dental” section, page H-130.

Any outpatient TMJ surgery predetermination of benefits should be sent to MetLife. 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/Substance Abuse Benefits**

**Anthem EAP/Behavioral Health Resource Center**

Anthem EAP/Behavioral Health Resource Center offers access to:

- Employee Assistance Program (EAP) for short-term counseling,
- Mental Health/Substance Abuse for more complex or longer term care, and
- Trained behavioral health Customer Care representatives who can view all programs a member has available so that cross referrals to other beneficial programs can be offered.

**Employee Assistance Program (EAP)**

You are eligible for the EAP if you participate in the Retiree Group Health Plan. All EAP services must be preauthorized through Anthem EAP/Behavioral Health Resource Center. In order to receive EAP services you must contact Anthem EAP/Behavioral Health Resource Center at 1-866-621-0130 to obtain a referral to an Anthem EAP network provider. The EAP is available 24 hours per day and is free to you, your eligible dependents and any member of your household—even if not covered by the Base Plan, Buy Up Plan or High Deductible Plan. There is no need to file a claim form since this care is prepaid by FedEx. Your EAP services provide:

- Up to eight counseling sessions, prepaid by FedEx, for you, your eligible dependents or your household members, regardless of your FedEx Medical coverage (including HMOs and HMSA).
- In-network benefits only.
- Crisis counseling for urgent or emergency situations.
- Easy access to licensed psychologists and social workers located in your community.
- Confidential assistance 24 hours a day, every day of the year.

**Mental Health/Substance Abuse Services**

Under the Base Plan, Buy Up Plan or High Deductible Plan, you are responsible for obtaining preauthorization for all inpatient mental health/substance abuse services and treatment (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center and intensive outpatient program) through the Anthem EAP/BH Resource Center. Mental health/substance abuse benefits are administered and claims are processed through Anthem Blue Cross.

**NOTE:** For local HMO participants, mental health/substance abuse treatment must be coordinated through your HMO or HMSA.

Anthem Blue Cross provides:

- 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.

Your health coverage pays part of the cost of this type of care. See the “Benefits at a Glance” chart for details about mental health/substance abuse benefits. Since benefits are payable for this type of care, it is available only to you and eligible dependents covered by Anthem.

**Important:** You must preauthorize all EAP and it is recommended that you preauthorize inpatient mental health/substance abuse services and treatment (inpatient includes inpatient hospitalization, partial hospitalization, residential
treatment center and intensive outpatient program) through the Anthem EAP/BH Resource Center by calling Anthem at 1-866-621-0130.

**How It Works**

To receive care, simply call Anthem EAP/Behavioral Health Resource Center anytime 24 hours a day at 1-866-621-0130. When you call, an Anthem EAP/Behavioral Health Resource Center Customer Care representative will:

- Briefly review your concerns, assess whether your needs are best suited for the EAP or for mental health/substance abuse services and refer you to an Anthem EAP/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.

**In an Emergency**

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

**360° Health Programs**

Anthem’s 360° Health Programs are available to assist enrolled pilots and their eligible dependents with health care information and support. These programs are discussed below.

**Condition Care**

Condition Care programs are available for covered pilots and their covered dependents living with chronic conditions. The Condition Care programs include:

- Asthma (Pediatric or adult asthma).
- Diabetes (Pediatric or adult diabetes—Type I and II).
- Coronary artery disease.
- Heart failure.
- Chronic obstructive pulmonary disease.
- Low back pain.

When participating in one of Anthem’s programs, participants living with a chronic condition can expect to receive:

- 24-hour toll-free access to registered nurses to answer your questions, provide support and education on how to better manage your condition.
- A health evaluation and consultation, as needed, to assist in managing your condition.
- Helpful educational materials on preventions, self-management and lifestyle factors that can help improve your health, including self-monitoring charts, self-care tips and more.

Participation in these programs is voluntary and will provide tools and information about living with chronic conditions to achieve optimal health.
To enroll in the Condition Care program call (866) 406-0982. Or to learn more about a particular chronic disease visit the Health and Benefits on www.anthem.com/ca.

My Health Coach Program

MyHealthCoach 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.

The MyHealth Coaches 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, 24/7 NurseLine and other available care management programs.

MyHealth Coaches focus 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 (866) 406-0982.

Future Moms

Future Moms offers prenatal education and intervention, helping to make expectant mothers better informed about their pregnancy. Anthem provides mothers-to-be with toll-free access to a nurse 24/7. Program includes information on proper nutrition, diet and exercise during pregnancy. Participants receive prenatal and birth kits that include child-health and safety information.

To enroll in the Future Moms program, call (866) 406-0982 and ask to talk to a Future Moms Representative.

24/7 Nurse Line

This program provides access to a registered nurse 24 hours a day/7 days a week. The nurses provide free, confidential health information to assist in making informed health care decisions. To access a nurse, call (866) 406-0982.

In case of emergency, 911 should always be your first line of contact.

Enrollment/Participation

Participation in any of the 360° Health programs provided by Anthem Blue Cross 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 (866) 406-0982. Once enrolled, you have the option of discontinuing your participation by notifying Anthem at (866) 406-0982.

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 Anthem PPO.
**Limits for Base Plan, Buy Up Plan and High Deductible Plan**

*(In-Network and Out-of-Network)*

- **Abortions**, either elective or non-elective, are limited based on Anthem's guidelines.

- **Admission Kits** are limited based on Anthem's guidelines.

- **Allergy Testing** is limited 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 a 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 $1,750 annual benefit limit (in-network and out-of-network combined) for you and each of your covered dependents.

- **Clinical Trials** are limited based on Anthem's guidelines.

- **Clomid Treatment** is limited based on Anthem's guidelines.

- **Condition or Nutrition Counseling** are limited based on Anthem's guidelines.

- **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 are covered with a $500 lifetime maximum benefit. Hearing aids evaluations are limited based on Anthem's guidelines. Charges for ear molds, batteries, accessories or replacement are not covered.

- **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.

- **Lesion Removal** is limited based on Anthem's guidelines.

- **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 and may result in a reduction of benefit.

• **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.

• **Prenatal information,** pregnancy risk assessment and consultation are limited based on Anthem’s guidelines.

• **Preventive care** is limited based on Anthem’s guidelines.

• **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:
  – Surgical procedures or nail root removal
  – Lab and x-rays
  – Medical supplies
  – 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.

• **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.

• **Rental of durable medical equipment** is limited to the purchase price as determined by Anthem’s guidelines.

• **Removal of Birthmarks** is limited based on Anthem’s guidelines.

• **Skilled Nursing Facility.** Services provided by a Skilled Nursing Facility are limited based on Anthem’s guidelines. Skilled Nursing Facility room and board (including regular daily services and supplies furnished by the Skilled Nursing Facility) are limited based on Anthem’s guidelines. 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.

- **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.

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**Limits for Base Plan, Buy Up Plan and High Deductible Plan**

**(Out-of-Network)**

- **Hospital Room and Board.** Up to the semiprivate room rate for inpatient hospital stays. The full cost of a private room is paid only when infectious disease precautions are required or when the patient has immunodeficiency resulting from an illness or treatment of an illness. If a hospital has only private rooms, benefits out-of-network are limited to the average semiprivate room rate for all other hospitals in the geographic area.

- **Assistant surgeon charges** are limited based on Anthem’s guidelines.

- **Co-surgeons** are limited based on Anthem’s guidelines.

Refer to page H-28 for more details on out-of-network charges.

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**Exclusions for Base Plan, Buy Up Plan and High Deductible Plan**

**(In-Network and Out-of-Network)**

- **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.

- **Acupuncture treatment.** Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

- **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 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 (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 or the lifetime maximum.

- **Exercise Equipment.** Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness.

- **Expenses incurred after the termination date of coverage.** See “When Coverage Ends” on page H-16 for more details.

- **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, eye glasses or for the purchase of eye glasses under the medical coverage.**

- **Food or dietary supplements.**
• **Growth hormones.** These are not covered as a medical expense. See the Prescription Drug Benefit.

• **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, which 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 which 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.

See “Skeletal Disorders of the Jaw” (Including TMJ) in the “Dental” section, page H-130.

• **Natural childbirth education classes.**

• **Non-prescription nutritional formulas.** Nutritional formulas which can be purchased without a prescription and/or which are not medically necessary for the treatment of an illness.

• **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” section of this booklet.

- **Prescription drugs not administered in a doctor’s office or facility.** See the “Prescription Drug Benefit” section beginning on page H-118.

- **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.**

- **Sex change.** Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex.

- **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 involve 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 MetLife (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. See “Skeletal Disorders of the Jaw” (including TMJ) in the “Dental” section, page H-130.

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

- **Smoking cessation programs** or treatment of nicotine or tobacco use. Smoking cessation drugs.

- **Telephone and Electronic Consultation** charges incurred for consultations done outside of the office or facility setting.

- **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, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by Anthem’s guidelines.
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.

Limits for Base Plan, Buy Up Plan and High Deductible Plan

(In-Network Only)

- Home births or home deliveries are only excluded in-network.
- Mammograms are covered based on physician’s orders.
- Participating midwife must provide services under the direct supervision of an in-network physician at an authorized in-network facility.
- Routine Pap smears are limited based on Anthem’s guidelines.
- Transplant travel & lodging expenses are limited based on Anthem’s guidelines (only available when using a Network Transplant facility).

Exclusions for Base Plan and Buy Up Plan

(Out-of-Network Only)

- Expenses in excess of the Allowed Amount or Negotiated Amount as described in “Out-of-Network Professional and Facility Charges” on page H-28.
- No proof of charges. Medical expenses for which you furnish no proof of charges.
- Travel and lodging expenses related to organ transplants.

Exclusions for High Deductible Plan

(Out-of-Network Only)

- Expenses in excess of the Allowed Amount or Negotiated Amount as described in “Out-of-Network Professional and Facility Charges” on page H-28.
- No proof of charges. Medical expenses for which you furnish no proof of charges.
- Routine checkups (including Pap smears and mammograms), physical examinations, immunizations, and other services and supplies that are preventive in nature.
- Travel and lodging expenses related to organ transplants.
- Well-baby care such as routine checkups and immunizations after discharge from the hospital.

The following applies to all Retiree Health coverage regardless of Medical plan option:

Spouse and Dependent Children

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), your enrolled spouse and dependents are eligible to pay for continued retiree group Medical, Dental and/or Vision coverage, if they lose Medical, Dental and/or Vision coverage because of a specific “qualifying event.”

Continuation of health coverage is available to any qualified beneficiary (pilot, spouse or dependent child) who is covered by any of the FedEx Express retiree Medical, Dental and/or Vision plan options or a local HMO on the day before any of these qualifying events occur:

- Death of a pilot.
- Divorce from the retired pilot. The Retiree must enter the divorce date on FedEx Benefits Online at https://fedex.ehr.com, or the retiree or ex-spouse must call Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area. 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 health plan option. You must enter the change in eligibility date on FedEx Benefits Online at https://fedex.ehr.com, or you must call Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area. If notification is made after 60 days following the date of the event, the rights to continuation of health coverage for such qualified beneficiary will be lost.

- The spouse becomes eligible for Medicare (Part A. Part B or both).
- Bankruptcy filing by FedEx Express under Chapter 11 of the United States Code.

 Except in the case where the spouse becomes eligible for Medicare, Medical, Dental and/or Vision coverage can be continued for 36 months and is subject to certain notice requirements and time limitations as outlined in the chart “COBRA Qualifying Events” on page H-114. In the event that your spouse loses coverage after becoming eligible for Medicare, your spouse may continue Medical, Dental and/or Vision coverage for 18 months.

Retired Pilot
You are eligible to pay for 18 months of continuation coverage at the time you become eligible for Medicare.

In addition, you are eligible to pay for continuation coverage if coverage under the retiree medical plan is substantially eliminated in the event that FedEx Express files for bankruptcy protection under Chapter 11 of the United States Code. In that case, you may continue coverage until the date of your death. Eligible dependents may continue COBRA coverage for up to 36 months following the bankruptcy.

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 collective bargaining agreement during which the cost of coverage does not increase from the amount paid prior to the qualifying event.

If You Have COBRA Questions
For questions about continuing Medical, Dental and/or Vision coverage under COBRA, contact ADP, our COBRA administrator, at 1-800-522-6621. You can also write to ADP at:

ADP
P.O. Box 27478
Salt Lake City, UT 84127-0478

Individual Election Rights to Continue Medical, Dental and/or Vision Coverage
Each individual who was covered by a FedEx Express retiree group Medical, Dental and/or Vision plan option 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 on page H-17 under “COBRA – Continuation of Coverage.”

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 health 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 coverage and the extension also applies to covered dependents. ADP, our COBRA administrator, must be notified at 1-800-522-6621 of the disability status before the end of the initial 18-month coverage period and within 60 days of your Social Security disability determination, or within the initial 60 days of COBRA if a qualified beneficiary have a Social Security Disability on the date health coverage is lost.
If the Social Security Administration determines that the qualified beneficiary is no longer disabled, the qualified beneficiary is required to notify ADP by telephone at 1-800-522-6621 within 30 days after the final determination.

**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 will not be processed and paid until you have elected COBRA continuation coverage and made the first payment. You should retain any receipts for 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 covered under any group Medical, Dental and/or Vision plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such qualified beneficiary.
- FedEx Express ceases to provide a group Medical, Dental and/or Vision plan which 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 continuation period. (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate.)

When COBRA continuation Medical, Dental and/or Vision coverage ends, there is no right to convert group Medical, Dental and/or Vision coverage to an individual policy.
## COBRA Qualifying Events

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
<th>Timeframe</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of Pilot Covered...</td>
<td>Pilot's Assistant Chief Pilot must notify Pilot Benefits Administration within 30 days**</td>
<td>36 months after the first 24 consecutive months of survivor coverage continuation</td>
<td>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 to elect Medical, Dental and/or Vision coverage from the date the COBRA notice is provided whichever is later, to elect Medical, Dental and/or Vision coverage.</td>
</tr>
<tr>
<td>Divorce</td>
<td>Pilot must enter the divorce date on FedEx Benefits Enrollment Online or pilot or qualified beneficiary must call Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area within 60 days of the event.</td>
<td>36 months</td>
<td>The qualified beneficiary will be notified of continuation rights, costs 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 the COBRA notice is provided whichever is later, to elect Medical, Dental and/or Vision coverage.</td>
</tr>
</tbody>
</table>

Qualified beneficiary has 45 days from date of selection to make payment; payment must be the full amount due from the date of the qualifying event to the current date. After that time, payments are due on the first day of the month.
**COBRA Qualifying Events**

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Dependent Child Status</th>
<th>Event Description</th>
<th>Qualifying Event Duration</th>
<th>Rights to Coverage Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent child becomes ineligible for coverage (for example, age 23 for Dental</td>
<td>Covered dependent</td>
<td>Qualified beneficiary or retired pilot must update the dependent child's eligibility on FedEx Benefits Online or notify Pilot Benefits Administration within <strong>60 days</strong> of the event.</td>
<td>36 months</td>
<td>Same as above</td>
</tr>
<tr>
<td>and/or Vision or age 26 for Medical)</td>
<td></td>
<td></td>
<td></td>
<td>Same as above</td>
</tr>
<tr>
<td>Retired pilot becomes entitled to Medicare (under Part A, Part B or both)</td>
<td>Retired pilot</td>
<td>FedEx will notify the retired pilot of the right to continue coverage within 14 days of the date coverage would otherwise terminate.</td>
<td>18 months measured from the date of enrollment in Medicare</td>
<td>Same as above</td>
</tr>
<tr>
<td>Spouse becomes entitled to Medicare (under Part A, Part B or both)</td>
<td>Spouse</td>
<td>FedEx will notify the spouse of the right to continue coverage within 14 days of the date coverage would otherwise terminate.</td>
<td>18 months measured from the date of enrollment in Medicare</td>
<td>Same as above</td>
</tr>
<tr>
<td>Filing for Bankruptcy by FedEx Express</td>
<td>Retiree, covered spouse and/or eligible dependent child(ren)</td>
<td>FedEx will notify the qualified beneficiaries of their right to continue coverage within 14 days of the date coverage would otherwise terminate.</td>
<td>Retiree: Until death Covered spouse and/or eligible dependent child(ren): 36 months from the date of the retiree's death</td>
<td>Same as above</td>
</tr>
</tbody>
</table>

**If notification is made after 60 days from the date of the event, the rights to continuation of health coverage for such qualifying beneficiary will be lost.**
*Keep Your Plan Informed of Address Change* — In order to protect your family’s rights, you should keep ADP 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 ADP and Pilot Benefits Administration for your records.

COBRA-like coverage is also available for eligible domestic partners and their eligible dependent children. For details, call the Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area.
Continuing Retiree Health 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. Some key provisions are mentioned below.

Retiree Group Health Plan

Your eligible dependents, who were covered at the time of your death and who continue to meet the eligibility requirements, may continue the Federal Express Corporation Retiree Group Health Plan coverage (medical, mental health/substance abuse, prescription drug, dental and vision) after your death provided they were covered by the Plan at the time of your death based on the chart below.

Retiree Health Coverage for Your Surviving Spouse/Children

<table>
<thead>
<tr>
<th>Spouse/Children under Medicare Age</th>
<th>When Spouse Reaches Medicare Age Following the Pilot's Death</th>
</tr>
</thead>
</table>
| Spouse/Children will have the following medical plan options from which to choose:  
- Base Plan  
- Buy Up Plan  
- High Deductible Plan,  
- HMSA or  
- A local HMO, if available | Spouse coverage in the Pre-Medicare FedEx plan ends. Spouse will be eligible for ALPA's Post-Medicare Retiree Health Plan or spouse can also elect Retiree COBRA for 36 months. Any covered dependent child(ren) will remain eligible for the Pre-Medicare medical options administered by Anthem, HMSA or a local HMO, if available. Upon reaching the age limitations, dependent children can elect COBRA for 36 months. |

For 24 months from date of retiree’s death, surviving dependents are charged the applicable spouse/child(ren) Retiree Health rate in the Retiree Group Health Plan.

After 24 months, spouse and/or child(ren) pay 100% of the cost in the Retiree Group Health Plan. When spouse turns Medicare Age, coverage ends for the spouse. When child(ren) reach the age limitations, coverage ends. Upon reaching the age limitations, dependent children can elect COBRA for 36 months.

Dependents eligible to be covered for Retiree Health Coverage and/or Retiree COBRA are the same as described in the “Health Care – General Information” section on page H-2.

For Retiree COBRA information, see “COBRA Continuation of Retiree Coverage” on page H-111.
Prescription Drug Benefit for Active and Pre-Medicare Retired Pilots
(Pre-Medicare Retired Pilot must be participating in Retiree Health Coverage)

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

Anthem Pharmacy Services, administered by Express Scripts, Inc. (ESI) provides prescription drug coverage.

Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted by the Plan for each different type of pharmacy. It is not necessarily the amount a pharmacy bills for the service.

You may avoid higher out-of-pocket expenses by choosing a participating 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.

Prescription drug covered expense will always be the lesser of the billed charge or the amount shown below. Expense is incurred on the date you receive the drug for which the charge is made.

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Maximum Prescription Drug Covered Expense is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating pharmacies and mail service program</td>
<td>Prescription drug negotiated rate</td>
</tr>
<tr>
<td>Non-participating pharmacies</td>
<td>Drug limit fee schedule amount</td>
</tr>
</tbody>
</table>

When you choose a participating pharmacy, any expense which is not covered under your prescription drug benefits will be subtracted. The remainder is the amount of prescription drug covered expense for that claim. You will not be responsible for any amount in excess of the prescription drug negotiated rate for the covered services of a participating pharmacy.

When Anthem Pharmacy Services receives a claim for drugs supplied by a non-participating pharmacy, any expense which is not covered under your prescription drug benefits will be first subtracted, and then any expense exceeding the drug limited fee schedule is also subtracted. The remainder is the amount of prescription drug covered expense for that claim.

You will always be responsible for expense incurred which is not covered under this Plan.

Prescription Drug Copayments

After prescription drug covered expense is determined, your Prescription Drug Copayment for each prescription will be subtracted.

If your Prescription Drug Copayment includes a percentage of prescription drug covered expense, then that percentage will be applied to such expense. This will determine the dollar amount of your Prescription Drug Copayment. Refer to the following chart for a list of your drug copayments.
Pharmacy Benefit Definitions

**Generic** – Generic drug is a pharmaceutical equivalent of one or more brand name drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand name drug.

**Brand** – Brand drug is a prescription drug that has been patented and is only produced by one manufacturer.

**Preferred Drug** – Preferred Drug is a drug listed on the preferred drug program.

**Specialty Medication** – Specialty drugs are high cost, biotech drugs, usually injected or infused and used for the treatment of acute or chronic conditions like rheumatoid arthritis, multiple sclerosis, hepatitis C, HIV/AIDS, infertility, cancer, asthma and psoriasis, among others. Due to the nature of the conditions and the special handling of these types of medications, Anthem Pharmacy Services collaborates with the prescribing physician, pharmacist and participant to more effectively manage the participant’s medication and condition to improve outcomes. Nurses assist the participant with management of medication side effects to help improve adherence and continuation of therapy. A personal care coordinator provides one-on-one service to the participant to schedule refills and encourage therapy adherence.

**Preferred Drug Program** – Preferred drug program is a list which Anthem Pharmacy Services has developed of outpatient prescription drugs which may be cost-effective,
therapeutic choices. Any participating pharmacy can assist you in purchasing drugs listed on the preferred drug program.

**Non-Preferred Drug** – Non-preferred drugs are drugs not listed on the preferred drug program.

**How to Use Your Anthem Pharmacy Services Drug Plan**

**When you go to a Participating Pharmacy**

To identify you as a member covered for prescription drug benefits, you will be issued an identification card. You must present this card to participating pharmacies when you have a prescription filled. Provided you have properly identified yourself as a member, a participating pharmacy will only charge your copayment. For information on how to locate a participating pharmacy in your area, call 1-866-406-0982.

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 a participating pharmacy, and the participating pharmacy indicates your prescription cannot be filled, or requires an additional Copayment, this is not considered an adverse claim decision. If you want the prescription filled, you will have to pay either the full cost, or the additional copayment, for the prescription drug. If you believe you are entitled to some plan benefits in connection with the prescription drug, submit a claim for reimbursement to ESI at the address shown below:

Express Scripts, Inc. (ESI)
P.O. Box 66558
St. Louis, MO  63166-6558

Or

Express Scripts, Inc.
4600 N. Hanley
St. Louis, MO  63134

Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms and customer service are available by calling 1-866-406-0982. Mail your claim, with the appropriate portion completed by the pharmacist, to ESI within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 9-month filing limit will be allowed (a total of 12 months from date incurred).

**When you go to a Non-Participating Pharmacy**

If you purchase a prescription drug from a non-participating pharmacy, you will have to pay the full cost of the drug and submit a claim to ESI, at the address below:

Express Scripts, Inc. (ESI)
P.O. Box 66583
St. Louis, MO  63166-6583

Non-participating pharmacies do not have the necessary prescription drug claim forms. You must take a claim form with you to a non-participating pharmacy. The pharmacist must complete the pharmacy’s portion of the form and sign it.

Claim forms and customer service are available by calling 1-866-406-0982. Mail your claim with the appropriate portion completed by the pharmacist to ESI within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.
When you order your prescription through the Mail

You can order your prescription through the mail service prescription drug program. Not all medications are available through the mail service pharmacy.

The prescription must state the drug name, dosage, directions for use, quantity, the physician's name and phone number, the patient's name and address, and be signed by a physician. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need only pay the cost of your copayment.

Your first mail service prescription must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent mail service prescriptions, or call the toll-free number. Copayments can be paid by check, money order or credit card. Submit mail service prescription claims to ESI, at the address below:

Express Scripts, Inc. (ESI)
P.O. Box 66558
St. Louis, MO  63166-6558

Mail order form can be obtained by logging onto www.anthem.com/ca and selecting pharmacy link; this will direct you to Express Scripts site. Select “Fill a New Prescription.” 1) Print a prescription order form, 2) mail prescription to

Express Scripts, Inc. (ESI)
Mail Order
P.O. Box 66558
St. Louis, MO  63166-6558

Send your written prescription for up to a 90-day supply of medication (or the maximum allowed by your plan) and your completed order form. After you’ve completed the patient sections of the order form, ask your doctor to fill out the rest and fax to: 1-866-272-8856.

NOTE:  Faxes must be sent from a doctor's office, not your home or work.
Prescriptions for Class II medications cannot be accepted by fax.

Once you are a registered member of www.anthem.com/ca, you may view all of your retail and mail order pharmacy claims by clicking on the MyPharmacy tab located on the MyAnthem member portal homepage.

Prescription Drug Utilization Review

Your prescription drug benefits include utilization review of prescription drug usage for your health and safety. Certain drugs may require prior authorization. If there are patterns of over-utilization or misuse of drugs, ESI's medical consultant will notify your personal physician and your pharmacist. Anthem Pharmacy Services reserves the right to limit benefits to prevent over-utilization of drugs.

Preferred Drug Program

Anthem Pharmacy Services uses a list of preferred drugs, which is sometimes called a formulary, to help your physician make prescribing decisions. The presence of a drug on the Plan’s preferred drug list does not guarantee that you will be prescribed that drug by your physician. These medications, which include both generic and brand name drugs, are listed in the preferred drug list. The preferred drug list is updated quarterly to ensure that the list includes drugs that are safe and effective.

NOTE:  The preferred drug list may change from time to time.
Some drugs may require prior authorization. If you have a question regarding whether a particular drug is on Anthem Pharmacy Services preferred drug list or requires prior authorization please call 1-866-406-0982.

Your Medical plan is committed to helping you manage your prescription benefits. Prior Authorization, and Quantity Limits, are requirements recommended by your Medical Plan’s Pharmacy and Therapeutics Committee and approved by your Medical plan. These requirements, which help ensure you have access to safe, appropriate and effective prescription medications, are defined as follows:

- **Prior Authorization**: medications which require pharmacy benefit manager or Plan approval before you may receive benefits (see below for additional information)
- **Quantity Limit**: affects the frequency or dosage of certain medications for which you receive benefits

**Prior Authorization**

Certain drugs require written prior authorization of benefits in order for you to receive benefits. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a drug other than the one originally prescribed if Anthem Pharmacy Services determines that it should be clinically effective for you. The prior authorization process is normally used to monitor the prescribing of certain drugs, to help promote utilization of prescription benefits that are safe and cost effective. The Prior Authorization program focuses mainly on drugs that

- May have a high potential for serious side effects or adverse interaction with other drugs.
- May have the potential to be frequently used incorrectly.
- May have better alternatives.
- May have high potential for abuse.
- Should be used only for very specific conditions.

The prior authorization review process allows confirmation of medical necessity before providing benefits for these drugs thereby helping to ensure that they are delivered in only the most appropriate cases and in safe and appropriate dosages as recommended by the Food and Drug Administration (FDA).

However, if Anthem Pharmacy Services determines through prior authorization that the drug originally prescribed is medically necessary, you will be provided the drug originally requested at the applicable copayment. (If, when you first become a beneficiary, you are already being treated for a medical condition by a drug that has been appropriately prescribed and is considered safe and effective for your medical condition, Anthem Pharmacy Services will not require you to try a drug other than the one you are currently taking.) If approved, drugs requiring prior authorization for benefits will be provided to you after you make the required copayment.

In order for you to get a drug that requires prior authorization, your physician must make a written request to ESI for you using an Outpatient Prescription Drug Prior Authorization of Benefits form. The form can be facsimiled or mailed to ESI. If your physician needs a copy of the form, he or she may call 1-866-406-0982 to request one. The form is also available online at www.anthem.com/ca. If the request is for urgently needed drugs, after ESI receives the Outpatient Prescription Drug Prior Authorization of Benefits form:

- ESI will review it and decide if benefits will be approved within 72-hours. (As soon as ESI can, based on your medical condition, as medically necessary. ESI may take
less than 72-hours to decide if benefits will be approved.) ESI will tell you and your physician what has been decided in writing—by fax to your physician and by mail to you.

- If more information is needed to make a decision, or a decision cannot be made for any reason, ESI will tell your physician, within 24-hours after the form is received, what information is missing and why a decision cannot be made. If, for reasons beyond ESI's control, they cannot tell your physician what information is missing within 24-hours, ESI will tell your physician that there is a problem as soon as they know that they cannot respond within 24-hours. In either event, ESI will tell you and your physician that there is a problem—always in writing by facsimile and, when appropriate, by telephone to your physician and in writing by mail to you.

- As soon as ESI can, based on your medical condition, as medically necessary, but, not more than 48-hours after all the information required to decide if benefits will be approved is received, ESI will tell you and your physician what has been decided in writing—by fax to the physician and by mail to you.

If the request is not for urgently needed drugs, after ESI receives the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on your medical condition, as medically necessary, ESI will review it and decide if benefits will be approved within 5-business days. ESI will tell you and your physician what has been decided in writing—by fax to your physician, and by mail, to you.

- If more information is needed to make a decision, ESI will tell your physician in writing within 5-business days after the request is received, what information is missing and why a decision cannot be made. If, for reasons beyond ESI control, they cannot tell your physician what information is missing within 5-business days, ESI will tell your physician that there is a problem as soon as they know that they cannot respond within 5-business days. In any event, ESI will tell you and your physician that there is a problem in writing by facsimile, and when appropriate, by telephone to your physician, and in writing to you by mail.

- As soon as ESI can, based on your medical condition, as medically necessary, within 5-business days after all the information required to decide if benefits will be approved is received, ESI will tell you and your physician what has been decided in writing—by fax to your physician and by mail to you.

While ESI is reviewing the Outpatient Prescription Drug Prior Authorization of Benefits form, a 72-hour emergency supply of medication may be dispensed to you if your physician or pharmacist determines that it is appropriate and medically necessary. You may have to pay the applicable copayment for the 72-hour supply of your drug. If ESI approves the request for the specialty pharmacy drug after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the drug with no additional copayment.

If you have any questions regarding whether a drug is on Anthem Pharmacy Services preferred drug list, or requires prior authorization, please call 1-866-406-0982.

If ESI denies a request for prior authorization of a drug, you or your prescribing physician may appeal their decision by calling 1-866-406-0982.

New drugs and changes in the prescription drugs covered by the plan.

The outpatient prescription drugs included on the list of formulary drugs covered by the plan is decided by Anthem Pharmacy Services Pharmacy and Therapeutics Committee which is comprised of independent physicians and pharmacists. The Pharmacy and Therapeutics Committee meets quarterly and decides on changes to make in the formulary drug list based on recommendations from Anthem Pharmacy Services and a review of relevant information, including current medical literature.
What’s Not Covered – Limits and Exclusions for Anthem 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.
- Generics, when available, are mandatory for the High Deductible Plan 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 which 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, sanatorium, convalescent hospital or similar facility, may be purchased at a pharmacy by the beneficiary, or a friend, relative or care giver 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. Any drugs or medications prescribed for experimental indications. If you are denied a drug because ESI determines that the drug is experimental or investigational, you may appeal the decision by calling Anthem Pharmacy Services at 1-866-406-0982.
- Any expense incurred for a drug or medication in excess of: (a) the drug limited fee schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate, for drugs dispensed by participating pharmacies or through the mail service program.
- Drugs which 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 Anthem Pharmacy Services 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 Anthem Pharmacy Services guidelines.
Dental Benefits
for
Active and Pre-Medicare Retired Pilots
(Pre-Medicare Retired Pilot must be participating in Retiree Health Coverage)

IMPORTANT: Participation in FedEx Dental Coverage requires an enrollment election separate from your Medical enrollment election.

Your FedEx Express Pilot Base and Buy Up Dental Plans provide you and your family with valuable help in paying for preventive dental care and care to treat dental problems. MetLife is the claims paying administrator for this benefit for all the self-funded Medical plan options, i.e., Base Plan and, Buy Up Plan for Active and Pre-Medicare retired pilots, High Deductible Plan for Pre-Medicare retired pilots. MetLife is also the claim paying administrator for the International Plan for internationally based pilots, HMSA and all local HMOs. Dental benefits are self-funded meaning all claims are paid by FedEx. 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.

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. Covered dental expenses are the reasonable and customary (R&C) charges for necessary services and supplies, which must be ordered by a dentist for dental care and treatment of dental diseases or injuries. See “Reasonable and Customary (R&C) Limits” on page H-127 for more information.

Charges for eligible services are allowed only when deemed necessary for treatment of dental disease or injuries. It is strongly recommended you obtain a predetermination of benefits before incurring significant dental expenses.

Your dental benefits will coordinate with benefits you may be eligible for under another plan. See “Coordination of Benefits When There Is Another Plan” beginning on page H-130 for more information.

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.

In addition, you can take advantage of the MetLife PDP (Preferred Dental Program) for greater savings on dental care. See “MetLife PDP (Preferred Dental Program)” on page H-128 for more information.

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 $100 deductible in the Base Plan/$50 in the Buy Up Plan, but there is an overall maximum deductible amount of $300 per family in the Base Plan/$100 in the Buy Up Plan. Each covered individual cannot have more than the individual deductible amount count toward the maximum family deductible. Two preventive dental care checkups each year are not subject to the annual deductible.
A Look at Dental Benefits

<table>
<thead>
<tr>
<th>Covered Dental Services</th>
<th>Base Plan</th>
<th>Buy Up Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>• $100 individual</td>
<td>• $50 individual</td>
</tr>
<tr>
<td></td>
<td>• $300 family</td>
<td>• $100 family</td>
</tr>
<tr>
<td>Annual Maximum Benefit After Deductible</td>
<td>$2,750 individual</td>
<td>$2,750 individual</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>$30,000 individual</td>
<td>$30,000 individual</td>
</tr>
</tbody>
</table>

Class I Services:
- Dental X-rays
- Sealants (permanent molars only)
- Preventive care (first two checkups in calendar year are not subject to deductible)

Class II Services:
- Restorations (fillings), including amalgam, silicate, plastic and composite restoration
- Endodontics
- Oral surgery
- Extractions
- Other services

Class III Services:
- Crowns and/or replacement crowns (when medically necessary)

Class IV Services:
- Orthodontics
- Full or partial denture or bridgework if it:
  - Replaces natural teeth extracted while individual is covered by the plan; or
  - Replaces another denture or bridge that is at least five years old when individual has been covered under the plan for at least six months.

Reasonable and customary (R&C) limits apply only when you see a Non PDP Dentist. Benefit payments for all eligible covered dental expenses are based on R&C limits. The R&C charge is the lower of the usual charge by the provider for a service or supply and the usual amount charged by most health care providers in the same geographic area charge for the same service or supply. The Plan does not cover charges above the R&C limits. Charges that exceed the R&C limit do not apply to the deductible.

The R&C tables maintained by MetLife are under continuous review and are updated on a regular basis to keep pace with the constant change in dental costs. Contact MetLife, 1-800-540-5233, if you have questions about the R&C limit for a specific dental service or supply.

Steps to Take if Part of Your Claim Is Denied for R&C Limits

1. **Contact the health care provider** who submitted the charge. Explain MetLife finds the charge to be in excess of the R&C limit. If there is no special reason that the charge is high, ask the health care provider to reduce the charge to the allowable amount.

2. **Resubmit the claim** if the health care provider can submit additional information, itemize each charge or report unusual procedures that justify the higher charge. You or your health care provider should send an appeal directly to MetLife, at the address shown on your dental ID card. This request must include information explaining the higher charge. The claim will be reviewed with the additional information.

3. If the claim is denied on the final appeal, **you pay any charges** in excess of the R&C limits.
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.

MetLife PDP (Preferred Dental Program)

The MetLife PDP comprises a network of dentists who have contracted with MetLife to provide dental care at specially negotiated rates. There are over 100,000 dentists in the PDP nationwide network. You will be able to take advantage of receiving dental care at lower, negotiated fees with no additional charges associated with fees over reasonable and customary limits.

How It Works

Locate a participating dentist by calling 1-800-474-PDP1 (1-800-474-7371), and enter the requested information as prompted, including the ZIP code for the location in which you wish to locate a dentist. A customized directory will be mailed to you the following business day. The provider directory is also available on the Internet at www.metlife.com/mybenefits.

Call one of the participating dentists, identify yourself as a pilot, confirm that the dentist is a PDP participant and schedule an appointment. At the time of your appointment, confirm again the dentist is a PDP participant before services are rendered. Benefit is based on network participation at time of service.

Take a claim form when you go to the dentist. The claim form can be obtained by calling MetLife, 1-800-540-5233 or downloading from the FedEx Intranet, keyword: benefits forms. Either you or the dentist mails the claim to MetLife. You will be required to pay any deductible and coinsurance amount (the same as you do under the current program; see the chart “A Look at Dental Benefits” on page H-134). Due to some dentists’ billing practices, you may be required to pay for services in advance.

There is no penalty if you decide not to use a participating dentist but charges will be subject to R&C limits. If you have questions, call MetLife Customer Service at 1-800-540-5233.

Preventive Dental Care

This Plan is designed to encourage you to take care of your teeth on a regular basis. Preventive dental care is payable at 80% in the Base Dental Plan and 90% in the Buy Up Dental Plan and is not subject to the deductible. Preventive dental care includes:

- Checkups, bitewing x-rays and cleanings twice each year and
- Two fluoride treatments for dependents until age 19.

Additional preventive dental care in the same calendar year is payable at 80% in the Base Dental Plan and 90% in the Buy-Up Dental Plan, but is subject to the deductible.

Predetermination of Benefits

Predetermination of benefits is a process that allows you, your dentist and MetLife, the claims paying administrator, 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 by MetLife 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 MetLife, 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, of course, entirely between you and your dentist. Charges for eligible services are allowed only
when deemed 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
- Partial
- 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 provider** to submit a written request for a predetermination of benefits. Your health care provider should send a written request to MetLife that clearly indicates that it is a request for predetermination of benefits.

   - MetLife Dental Claims
   - P.O. Box 981282
   - El Paso, TX 79998-1282
   - COMAIL: ELP/TX/79906-0000

   The request should include a complete description of the proposed course of treatment, appropriate medical code, anticipated dates of services, expected charges and tax identification number of the service provider.

2. **MetLife reviews** the predetermination request for medical 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 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. MetLife, the claims paying administrator for Dental benefits determines medical necessity. See Medically Necessary Care on page H-39 for more information.

**Orthodontic Charges**

Orthodontic charges that result from orthodontia treatment are payable at 50%. Benefits for orthodontia treatment are paid in monthly installments. The first payment begins when the orthodontia appliance is inserted. Monthly installments are made thereafter for the duration of the orthodontia treatment.
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 and lifetime maximums, and patient’s eligibility.

**Skeletal Disorders of the Jaw (Including TMJ)**

Treatment of all skeletal disorders of the jaw, including myofacial 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 MetLife 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 MetLife. Inpatient TMJ claims should be preauthorized by Anthem. See “What’s Not Covered – Limits and Exclusions,” page H-131.

**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 that 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 MetLife’s guidelines.

**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 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 or access FedEx Benefits Online at https://fedex.ehr.com.

**Coordination of Benefits**

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.

**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.

**What’s Not Covered – Limits and Exclusions**

**Limits**

- Benefits for x-rays include:
  - Panoramic x-rays – once a year; and
  - Full mouth x-rays – once every three years.
- 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 payable at 75% in the Base Plan/80% in the Buy Up Plan. Charges for crowns used in abutments to a fixed bridge are payable 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. Local HMO participants should check their particular HMO 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 five years old.
- Crowns, bridges, dentures and partials for treatment of temporomandibular joint syndrome (TMJ).
- Fluoride treatment after 19th birthday.
- Replacement of lost, stolen or broken appliances.
- 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.
- Charges for cosmetic services.
- Charges for unnecessary services or supplies.
- Expenses in excess of reasonable and customary charges.
- Charges for injuries caused by a third party. See “Reimbursement, Subrogation and Third-Party Liability for Medical, Dental and Disability Claims Administered by Vengroff Williams, Inc. (VWA)” on page H-130.
- Experimental procedures or treatment.
- Dental implants, dental implants for certain conditions qualify as an eligible expense under the medical plan, see page H-59.
- 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.
Vision Benefits for Active and Pre-Medicare Retired Pilots

(Pre-Medicare Retired Pilot must be participating in Retiree Health Coverage)

Your FedEx Express Vision coverage provides benefits for active and retired pilots and their covered dependents for vision examinations and eyewear. In addition, even if not enrolled for Vision coverage, all active and retired pilots and their covered dependents are eligible to receive discounts provided under the Advantage Eye Care Program. Davis Vision is the claims paying administrator for this benefit for all the self-funded Medical plan options, i.e., Base Plan, Buy Up Plan for Active and Pre-Medicare retired pilots, and the High Deductible Plan for Pre-Medicare retired pilots. Davis Vision is also the claim paying administrator for the International Plan for internationally based pilots, HMSA and all local HMOs. 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. There is no vision coverage for you and your covered dependents if you Opt Out of FedEx Express Vision coverage. You must be enrolled in vision coverage in order to receive benefits.

IMPORTANT: Participation in FedEx Vision Coverage requires an enrollment election separate from your Medical enrollment election.

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, 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.

Areas Without In-Network Providers

Steps to Take to Receive In-Network Benefits in Areas Without In-Network Providers (NPP)

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 at levels shown in the chart below. 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:

   Davis Vision  
   VisionCare Processing Unit  
   P.O. Box 1525  
   Latham, NY 12110

A Look at Vision Benefits

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage</th>
<th>Reimbursement Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>One routine eye examination, including dilation when indicated by your provider, once every 12 months</td>
<td>100% coverage</td>
<td>Up to $50 reimbursed</td>
</tr>
<tr>
<td>One pair of frames every 24 months</td>
<td>100% coverage for selection from the Davis Vision’s Designer Frame collection** or 100% coverage up to $115 “retail value” after $15 copayment. You pay charges in excess of $115 value. Some retail locations may offer a different retail credit which equates to the FedEx Express retail value. The retailer will provide additional information.</td>
<td>Up to $120 reimbursed</td>
</tr>
</tbody>
</table>
| One pair of standard glass, plastic or safety lenses every 12 months (single vision, bifocals, trifocals and lenticular lenses) | 100% coverage after $15 copayment | Single vision: Up to $35 reimbursed  
Bifocal: Up to $50 reimbursed  
Trifocal: Up to $65 reimbursed  
Lenticular: Up to $90 reimbursed |

**NOTE:** You cannot receive benefits for contact lenses and spectacle lenses during the same 12-month period.
## A Look at Vision Benefits

<table>
<thead>
<tr>
<th>Lens options for spectacle lenses</th>
<th>100% coverage after pilot’s $15 copayment.</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oversized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PGX (sun-sensitive glass)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progressive addition multifocal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blended bifocal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polycarbonate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solid, gradient or sun-tinted plastic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV and scratch-resistant coatings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quadrifocal (safety glasses only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faceted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ski-type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low power aspheric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Conventional bifocals will be supplied for anyone who is unable to adapt to Progressive addition multifocal lenses, up to 60 days from the date the eyewear is dispensed.

- One pair of contact lenses every 12 months
  - **NOTE:** You cannot receive benefits for contact lenses and spectacle lenses during the same 12-month period.
  
  You may choose from a special collection of standard soft daily wear, planned replacement and disposable lenses which are available for most prescription lenses or 100% of coverage up to $110. Your benefit includes a care kit for proper cleaning and sterilization, and related expenses (e.g., fitting fee). First time wearers must pay $10 fee toward the cost of professional fitting. You must pay costs in excess of $110.

  Contact lenses are dispensed subject to Davis Vision requirements, including but not limited to separate fitting exam and follow-up care from the routine eye exam for new (to the provider or first time) wearers.

  A maximum of $135 for exam, fitting, follow-up and exam, fitting, follow-up and materials. Up to $55 reimbursed for materials only.

** Available at most in-network offices.

*** Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. You cannot receive benefits for contact lenses and spectacle lenses during the same 12-month period.

** **NOTE:** Davis Vision will repair or replace any damaged or destroyed frame or spectacle lens (totally provided by Davis) for a period of one (1) year from the delivery date regardless of the cause of such damage. Such frame or lens shall be repaired/replaced and shipped within five (5) days following receipt by Davis Vision of the damaged or destroyed frame or lens. You must return the damaged or destroyed frame and/or lens to Davis Vision in order to take advantage of this warranty.
Optional Features—
In-Network Only

When you use an in-network provider, the following optional features are covered after you pay the $15 copayment and the corresponding copayments. These features are not covered when you use out-of-network providers.

Your Copayment for Optional Features

<table>
<thead>
<tr>
<th>Optional Feature</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiere (blue tag) frames from the “Tower Collection”</td>
<td>$ 15</td>
</tr>
<tr>
<td>Blended myodisc</td>
<td>$ 25</td>
</tr>
<tr>
<td>Double segment bifocals</td>
<td>$ 75</td>
</tr>
<tr>
<td>Edge coating (painted groove)</td>
<td>$ 9</td>
</tr>
<tr>
<td>Edge polish</td>
<td>$ 9</td>
</tr>
<tr>
<td>Executive multifocals</td>
<td>$ 10</td>
</tr>
<tr>
<td>High-index lenses</td>
<td>$ 55</td>
</tr>
<tr>
<td>Mirror coating</td>
<td>$ 15</td>
</tr>
<tr>
<td>Near variable focus lenses</td>
<td>$ 0</td>
</tr>
<tr>
<td>Premium reflection-free</td>
<td>$ 48</td>
</tr>
<tr>
<td>Polaroid lenses</td>
<td>$ 65</td>
</tr>
<tr>
<td>Reflection-free coating</td>
<td>$ 35</td>
</tr>
<tr>
<td>Transitions® single vision lenses</td>
<td>$ 65</td>
</tr>
<tr>
<td>Transitions® multifocal lenses</td>
<td>$ 60</td>
</tr>
<tr>
<td>Quadrifocals</td>
<td>$100</td>
</tr>
</tbody>
</table>

Sunglasses

Discounts can be obtained from the Advantage Eyecare Program. Nonprescription sunglasses are also available for purchase at a discount at some in-network provider locations.

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 12-month period
- 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 the schedule in the “A Look at the Benefits” chart on page H-134

• 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. A 24-hour messaging service is also available, or you can write to:

Davis Vision  
Vision Care Program  
P.O. Box 1501  
Latham, NY 12110  
Attn: Quality Management Team

All inquiries will be reviewed and responded to within 48 hours of receipt.

**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 for vision coverage to utilize the Advantage Eye Care Program. However, dependents must be listed on FedEx Benefits Online at [https://fedex.ehr.com](https://fedex.ehr.com).

Pilots and dependents enrolled for vision coverage may also take advantage of these prices to purchase additional services, such as a second pair of eyeglasses or sunglasses. These services must be received from an in-network provider.

**NOTE:** There is no coverage in the Advantage Eye Care Program for you and your dependents if you Opt Out of FedEx Express health coverage.

**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.

**Advantage Eye Care Program: A Look at the Costs**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye examination</td>
<td>$50 – $78 based on the area of the country</td>
</tr>
<tr>
<td>Single vision lenses and frames</td>
<td>$121.70</td>
</tr>
<tr>
<td>Bifocal lenses and frames</td>
<td>$134.76</td>
</tr>
<tr>
<td>Trifocal lenses and frames</td>
<td>$147.82</td>
</tr>
<tr>
<td>Single vision lenses only</td>
<td>$64.18</td>
</tr>
<tr>
<td>Bifocal lenses only</td>
<td>$77.24</td>
</tr>
<tr>
<td>Trifocal lenses only</td>
<td>$90.30</td>
</tr>
<tr>
<td>Frames only</td>
<td>$71.88</td>
</tr>
<tr>
<td>Contact lenses (new wearers)</td>
<td>$142.60</td>
</tr>
</tbody>
</table>

* In addition to your cost above, you will pay a $15 materials fee at the provider's office.
Health Section 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 services or prescription drugs. The percentage varies by Medical plan option. See the active and Pre-Medicare retiree Medical plan option “Benefits at a Glance” chart for coinsurance amounts.

Copayment
The flat fee you pay for certain services in Base Plan, Buy Up Plan, High Deductible Plan (for Retiree only) or a local HMO. Typically, you pay a copayment for each office visit, emergency room visit and for generic prescription drugs. Copayments are paid at the time of service and do not apply to out-of-pocket maximums.

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 & Children
- Pilot & Spouse
- Pilot & Family

Please note that Benefit communications may sometimes refer to you as “employee” rather than “pilot.” For example, FedEx Benefits Online refers to health coverage tiers as “Employee Only,” etc.

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 Medical Base Plan and Medical High Deductible Plan (in and out-of-network) and Medical Buy Up Plan (out-of-network only). See the active and Pre-Medicare retiree Medical plan option “Benefits at a Glance” chart for annual deductible amounts.

Both Dental Plans – Base and Buy Up – require satisfaction of a deductible before benefits are payable. See the “A Look at Dental Benefits” chart 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 which 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.
H-K

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.

HTH Worldwide
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 enrolled in the Medical Base Plan, Buy Up Plan or High Deductible Plan (for Retirees only). HTH Worldwide also administers the International Plan for pilots based in Subic Bay and other Foreign Bases.

In-Network Provider (Participating Provider)
A physician, hospital, lab, pharmacy or other health professional or facility that participates in a Medical plan option’s provider network.

L-N

Lifetime Maximum Benefit
The most you can receive in benefits from the Plan for the High Deductible Plan 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, pharmacy, mental health/substance abuse and utilization management, MetLife, 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 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 is available upon request, subject to normal costs and restrictions as described in “Your Rights Under ERISA,” page I-14. Anthem provides medical policies on many procedures which are available online at www.anthem.com/ca.
If a health care provider orders a particular service or supply, it may not be covered by Anthem. Call Anthem Customer Service 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**
  - Base Plan
  - Buy Up Plan
  - International Plan
  - HMSA
  - Local HMO

- **Retiree Medical Plan Options**
  - Base Plan
  - Buy Up Plan
  - High Deductible Plan
  - HMSA
  - Local HMO

Internationally based pilots are eligible for the International Plan only.

**O–Q**

**Opt Out**
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 “Out-of-Network Professional and Facility Charges” on page H-28 are not considered covered expenses and do not apply to the maximum out-of-pocket. See the active and Pre-Medicare retiree Medical plan option “Benefits at a Glance” chart for out-of-pocket maximum amounts.

**Outpatient Care**
Tests, treatments and surgeries performed in a physician’s office or outpatient department of a hospital or other health care facility.
Preauthorization
A review for medical appropriateness before a medical service is rendered. Preauthorization is your responsibility. See the active and Pre-Medicare retiree Medical plan option “Benefits at a Glance” chart for information regarding when preauthorization is required and who is responsible for the preauthorization.

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, coinsurance and are responsible for charges above Allowed Amount or Negotiated Amount as described in “Out-of-Network Professional and Facility Charges” on page H-28.

Predetermination of Benefits
A written determination from MetLife 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.

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.

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

Reasonable and Customary (R&C) for Dental
The amount considered a typical charge made by a dentist for a service, based on similar ranges of services of comparable complexity, in the same or similar geographic region as determined by the claims paying administrator’s guidelines. If you enroll in the Base Dental Plan, Buy Up Dental Plan and go outside the network, you’ll be responsible for charges that exceed the R&C limit.

Self-funded Medical Plan Options
The Base Plan, Buy Up Plan and High Deductible Plan (for Retirees only) are self-funded. This means that claims are paid by FedEx out of its general assets and contributions made by employees for Medical coverage. Local HMOs, HMSA and the International Plan are insured.

Sterilization Vasectomies and Tubal Ligations
Vasectomies and tubal ligations.

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.
Disability

About Your Disability Coverage

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 Plan (LTD) for Pilots. Aetna Life Insurance Company (Aetna) is the claims paying administrator and the appeals administrator.

The information you need... begins on page...

Workers’ Compensation D-2
Long Term Disability (LTD) Plan for Pilots D-3
Supplementary Disability Benefit D-12

If your disability commenced prior to May 31, 1999, please refer to the 1998 Your Employee Benefits Book and 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 Section I page 24.

Important
You are required to file a claim for LTD benefits within 60 days following exhaustion of your sick bank period. If you do not file a LTD claim for benefits, you will 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 shall be eligible for up to 168 credit hours (CH) 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 CH.

Here’s how it works in a typical situation:

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 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 this 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 this 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” on page D-8.

Enrollment

Enrollment in the Plan is automatic.

When Coverage Begins

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 banks and your claim is approved by Aetna.

Your Cost for Coverage

LTD is provided at no cost to you. FedEx pays the full cost to provide this Plan. Benefits are paid from a trust which is funded by the Company. Pilots working in certain states may be required to contribute for statutory coverage. Contact your Flight Manager or state disability program for details.

For Information to File a Claim

See Section I, page 25.

Important

You are required to file a claim with Aetna for LTD benefits within 60 days following exhaustion of your sick banks. 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 (excluding overtime)
  - Volunteer (excluding overtime)
  - Trip make-up for which you receive pay
  - International Override
  - Passover Pay

- 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
  - FAA Designee (FAA)

- Sick leave hours drawn from your sick bank 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 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 and 2007

**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, 2012 (first day of the Plan year), the compensation limit is $250,000; therefore, until the next adjustment to the compensation limit, the maximum monthly benefit amount for disabilities is $12,500.

**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 $20,833.33 or more, then your maximum monthly benefit would be $12,500 because $20,833.33 x 60% = $12,500.
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.

LTD benefit checks are paid monthly and are mailed to your home address as reflected in PRISM unless you elect direct deposit for your LTD benefits. You are responsible for ensuring that changes to your home address are in PRISM. Aetna will send all correspondence to the address listed on the HOME screen in PRISM. Please notify Aetna and your Assistant Chief Pilot 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 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” in this section, page D-5

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, Aetna 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” on page D-10.

**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 a pilot’s disability shall be applicable to a pilot only after the disability payments plus
the outside income earned by the pilot exceed the pilot’s pre-disability income. For purposes of this provision, a pilot’s pre-disability income shall be measured as the average earnings (Company + outside earned income) over the 12 months immediately preceding the pilot’s disability.

For example, a pilot programs software as a side business in addition to flying. He breaks his arm on July 1, 2011, and goes on LTD disability after his sick leave runs out on September 1, 2011. Between July 1, 2010, and July 1, 2011, 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. In this situation, a monthly disability reduction of 50% of the $1,583.34, or $791.67 per month would be required.

Social Security — Aetna or its designee will ask you to apply for Social Security Disability Income (SSDI). You are responsible for applying for this benefit and providing proof that you applied. If you do not provide this information, your disability benefits could 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 Aetna or its designee instructs you to do so, you are required to appeal any denial of benefits to the fullest extent permitted by law.

Aetna 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 Aetna immediately and to reimburse the LTD Plan for any overpaid amounts.

You are also required to notify Aetna 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 Aetna 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 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. Aetna may request proof from your health care professional that you still disabled. If your health care professional does not provide this information, Aetna will ask for your help in obtaining the medical data. If you fail to submit the information Aetna 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 Aetna. If the information from your health care professional does not prove that you are disabled, Aetna may ask you to submit to an independent medical exam (“IME”) or functional capacity exam (“FCE”) by a health care professional of Aetna's choosing. Aetna may also ask you to submit to a FAA exam. If you refuse the exam or fail to fully participate, your LTD benefits will end.

A health care professional for Aetna is involved in reviewing your medical information and Aetna 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 provisions. Your disability must be due to illness, disease or injury.

If you have an occupational disability and all Plan provisions are met, LTD payments will continue until the end of your occupational disability or for a maximum of 24 months. 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 D-12.

If your disability commenced prior to October 30, 2006, and you have a total disability, provided you meet all Plan provisions, 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 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 needed. 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 your Assistant Chief Pilot.

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 a 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 Aetna 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 Aetna 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 a 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 Aetna 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 permanent full-time employee 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, 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.
- Gender change treatment.
- 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 administrator determines, in its sole and exclusive discretion, would be a felony.

You also 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 Aetna
- You fail to report your LTD claim to Aetna within 60 days after exhaustion of your sick banks or your return to seat change position, whichever is earlier
- You fail to report your recurring disability to Aetna within 60 days following your relapse
- You or your treating provider fails to respond to Aetna’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 Pilot Supplementary Disability Benefit for more information)
- You reach age 65 if your disability commenced prior to 10/30/06 and you are deemed to be totally disabled. If your disability commenced prior to October 30, 2006, began at age 60 or older, and you are deemed to be totally disabled, disability benefits end after 5 years.
- You fail to provide or approve the release of requested medical information within the time specified by Aetna
- You refuse or don’t participate fully in an independent medical exam, functional capacity exam or FAA exam requested by Aetna
- 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-crewmember position
- You fail to seek restoration of required FAA license or certification to return to work or fail to do anything requested by Aetna
- The LTD Plan is discontinued pursuant to the terms of the Collective Bargaining Agreement or any successor collective bargaining agreement

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 Aetna. 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 Aetna. Aetna 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 and Group Long-Term Care Insurance are not withheld from LTD benefits.

Refer to “Coverage During a Paid Leave of Absence (Disability or Workers’ Compensation)” on page W-13 for information on how a disability leave of absence affects your health, life and other benefits.

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.

**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 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 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 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 Plan’s rights apply to any funds recovered from another party by or on behalf of you 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 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 FedEx Benefits Online at fedex.ehr.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, as outlined on pages D-3 thru D-11 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 10/30/06
When you attain the Regulated Age and, if you are unable to hold a second class medical certificate, Supplementary Disability benefits will be equal to the lesser of (1) 50% of your projected monthly compensation as a Second Officer, or (2) your disability benefit immediately prior to your obtainment of Regulated Age. Your projected monthly compensation as a Second Officer will be determined by multiplying the credit hours used in calculating your basic monthly compensation by the rate of pay in effect for the highest Second Officer position you could hold at the time you attained the Regulated Age (provided FedEx still employs Second Officers). When you attain the Regulated Age, if FedEx no longer employs Second Officers, your LTD benefits will end and there will be no need to recalculate your earnings.
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, 2012, (first day of the plan year) the compensation limit is $250,000; therefore, until the next adjustment to the compensation limit, the maximum monthly benefit amount is $10,416.67.

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 $20,833.33 or more, then your monthly benefit would be $10,416.67 because $20,833.33 x 50% = $10,416.67.

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.

Seat Change or Non-Pilot Position

If you choose to return to work in a medically required seat change or return in a non-pilot position (covered by the Collective Bargaining Agreement), benefits are calculated as follows:

- **Medically required seat change** – If benefits are payable because of a seat change wage loss, your benefit equals 50% of the difference between your hourly pay rate before and after the seat change, multiplied by your monthly credit hours earned. Your hourly pay rate before the seat change remains unchanged regardless of any future hourly rate increases. Earnings paid on a monthly or semi-monthly basis are not included in the calculation of seat change benefits. For seat change only, monthly credit hours will include vacation buyback hours.

- **Return as non-pilot** – If you return to FedEx in a non-pilot position (covered by the Collective Bargaining Agreement), your monthly disability benefit is offset only if your monthly disability benefit plus the earnings in your new position would cause you to have greater income than you earned before your disability.

Benefit Offsets

Refer to page D-5 for detailed information regarding Benefit Offsets.

When Benefits Begin

If your claim is approved, Supplementary LTD benefits begin when you have exhausted the 24-month LTD occupational benefit period.

For seat change or return to work in a non-pilot position (covered by the Collective Bargaining Agreement), if your claim is approved, Supplementary LTD benefits begin the day the status change takes place as reflected in PRISM. You are not required to exhaust your sick banks or 24 months of occupational disability LTD benefits; however, you must call Aetna to file a LTD claim within 60 days following your seat change or return to work in a non-pilot position.

Proof of Disability

Refer to page D-6 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 the later of age 65 or five years from your LTD date if your LTD benefits began after you reached age 60 (provided FedEx still employs Second Officers), for disabilities commencing on or after October 30, 2006
- 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 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 Aetna
• 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 Aetna
• 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 Aetna
• FedEx no longer employs Second Officers and you are over the Regulated Age

**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 the later of age 65 or five years from your LTD date if your LTD benefits began after age 60 (provided FedEx still employs Second Officers), for disabilities commencing on or after October 30, 2006
• 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
• FedEx no longer employs Second Officers and you are over the Regulated Age
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 accident 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 the insurance company govern the plan provisions. The master policy governs in the case of any discrepancy between the policy and this summary.

The Company is responsible only for the payment of premiums either from corporate funds or as collected from payroll deductions. The appropriate insurance company is responsible for payment of the benefit.

Life Insurance

Enrollment and Beneficiary Designation on the FedEx Benefits Enrollment Website

To make your Life Insurance enrollment elections and beneficiary designations, log in to the FedEx Benefits Enrollment Website at https://fedex.ehr.com. Enter your Employee Number and your password, then click [LOGIN].

If you are accessing the Website for the first time or you have forgotten your password, you can create a new password – just “Click here.” After creating your password, you’ll return to this screen to enter your Employee Number and password. Click [LOGIN].

NOTE: Your password is not automatically set with your Enterprise, LDAP or Web Single Sign-On (WSSO) password. You must complete the authentication process and create a strong password to access the FedEx Benefits Enrollment Website.

After you log into the FedEx Benefits Enrollment Website, you can access the EDUCATE, EVALUATE and ENROLL modules from the ENGAGE main menu.

- EDUCATE module for additional information about your options.
- EVALUATE module for the Life Insurance Needs Estimator, an online tool to help you estimate how much life insurance coverage you need.
- ENROLL module to view your current life insurance coverage, make changes to your life insurance coverage, and access the Beneficiary Maintenance 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.

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, the Pilots’ Money Purchase Pension 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:

(a) Your surviving spouse
(b) Your surviving child(ren) in equal shares
(c) Your surviving parents in equal shares
(d) Your surviving siblings in equal shares
(e) Your estate

If the designated beneficiary dies within 15 days of the pilot’s death and before the insurance company(ies) receive proof of the pilot’s death, then payment will be made as if the pilot had survived the beneficiary unless other provisions have been made.

Designate or Change a Beneficiary for All Insurance Plans
You may change your beneficiary(ies) AT ANY TIME through the FedEx Benefits Enrollment Website. Access the FedEx Benefits Enrollment Website at https://fedex.ehr.com. Select ENROLL from the main menu, then click on Beneficiary Maintenance to enter or update your beneficiary information for your Company-provided and employee-paid insurance coverage. You should periodically review your beneficiary designations. Certain events may dictate a change in your beneficiary designations (for example, 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. A confirmation of your beneficiary designations will also be mailed to your home address for your records.

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 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 benefit 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. Primary beneficiary(ies) will share the benefits payable from your insurance in the event of your death. Secondary beneficiary(ies) will receive benefits only if the 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.

For each insurance plan in which you are enrolled, you can either enter a percentage amount for each primary or secondary beneficiary or you can designate all the beneficiaries you list as your primary or secondary beneficiaries and assign an equal percentage of benefits to each beneficiary.

Continuation of Insurance Coverage
Optional Life Participants: If you terminate your FedEx employment or downgrade to a non-permanent status prior to age 55 and are actively at work during the entire last week of your employment, you can enroll in the Optional Life Portability Insurance Plan offered by Prudential. Your coverage is not portable 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 are receiving Workers Compensation benefits immediately prior to your termination. The Optional Life Insurance Portability Plan allows you to continue your Optional Life Insurance coverage under a separate Prudential group contract. Coverage is also available for your covered spouse (under age 80) and eligible dependent children (under age 19 or 23 if students) provided they are not hospital or home confined on the day of your termination. You must port at least $20,000 to enroll in the Optional Life Insurance Portability Plan. See Option Life Portability Insurance Plan for more specifics on page L-20.
Retiree Optional Life (Term) Insurance: If you retire or terminate your FedEx employment at age 55 or older and are actively at work during the entire last week of your employment and you were an Optional Life participant, you can enroll in the Retiree Optional Life Insurance Plan offered through Prudential. Your coverage is not portable 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 are receiving Workers Compensation benefits immediately prior to your termination. Coverage is also available for your covered spouse under age 80 who was covered under Optional Life Insurance provided they are not hospital or home confined on the day of your retirement/termination. See “Retiree Optional Life Insurance Plan” for more details on page L-22.

Portability or Conversion to Individual Policy: The Basic Life, Optional Life, Basic AD&D, and Optional AD&D Insurance coverage are provided through group policies.

You can convert your Basic Life Insurance policy in which you were enrolled to an individual policy of permanent universal life insurance (conversion policy). If you do not elect or are not eligible for Optional Life Portability Insurance or Retiree Optional Life Insurance coverage, you and your dependents may convert your Optional Life Insurance coverage to an individual policy of permanent whole life insurance.

When Pilot Benefits Administration is notified of your loss of coverage, you and/or your dependents enrolled in Basic Life, Optional Life, Basic AD&D, and Optional AD&D Insurance coverage will be sent instructions to obtain a conversion policy included in the COBRA and/or Retiree Health Coverage packet, or, in the case of Optional Life Insurance, information from Prudential about the option to enroll in the Optional Life Insurance Portability Plan or in the Retiree Optional Life Insurance Plan.

For Optional Life Insurance Portability or Retiree Optional Life Insurance coverage as well as a Basic Life Insurance and Optional Life Insurance conversion policy, you will have 31 days from the notice date to submit the proper application and your first premium to the appropriate insurance company.

- The notice date for Basic Life Insurance is the date indicated in your COBRA or Retiree Health Coverage packet.
- The notice date for Optional Life Insurance is the date on the letter sent by Prudential.

For Basic AD&D and Optional AD&D Insurance, you will have 31 days from your coverage termination date to submit a conversion application and your first premium to the appropriate insurance company. Coverage begins upon receipt of premium and application within 31 days after coverage ends. If you want to obtain an individual AD&D policy, contact Pilot Benefits Administration to obtain an application.

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 Optional Life coverage or to convert Basic Life or Optional Life.

Any such extension of the portability or conversion period will expire on the earliest of:

- 31 days after the Insured Person is given notice, or
- 91 days after the life insurance is terminated, even if the Insured Person is never given such notice.
If an individual dies within 31 days after coverage ended, a death benefit is payable. If an individual dies more than 31 days after coverage ended (even though the right to convert or elect Portability was extended), no death benefit is payable.

With respect to the Optional Life Insurance Plan, an individual may elect either to convert coverage or to port coverage (to the Optional Life Portability Plan or the Retiree Optional Life Insurance Plan, as applicable), but may not elect both conversion and portability.

For Leave of Absence: If you are on a medical leave of absence, FedEx will continue to pay the full cost of your:

- Basic Life Insurance Plan
- Basic Accidental Death and Dismemberment (AD&D) Plan

The cost of Optional Life and Optional AD&D coverage for you and your eligible dependents (if applicable) accumulates for the first 90 days and is deducted from your paycheck on a percentage basis when you return to work. Pilot Benefits Administration notifies you of the cost to continue coverage beyond the 90-day period. If you make the required payments during your leave, regular payroll deductions resume when you return to work.

Failing to make required insurance payments, making partial payments, or having checks returned due to insufficient funds will result in cancellation of coverage. If you want to reenroll when you return to work, you and your spouse must provide Evidence of Insurability for Optional Life coverage. Coverage will resume once you have been approved. This Evidence of Insurability is subject to review for approval or denial. Optional AD&D coverage does not require Evidence of Insurability; coverage will resume on the first of the month following your request.

For Military Leave of Absence (MLOA):

Basic Life Insurance—Coverage continues at no cost. No exclusions.

Optional Life Insurance—Coverage continues with no exclusions 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 billing notification will be sent to your home address 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. If monthly premiums are not received, your and your dependents’ coverage, if applicable, will end. If you want to reenroll when you return to active work, you must enroll within 31 days after you return to active work or Evidence of Insurability forms and evidence satisfactory to Prudential will be required.

If you are not presently enrolled in Optional Life and want to enroll, you must enroll prior to beginning your leave. There will be no prejudice due to your activation status. However, the approval process, which could take up to six weeks, could require a request for medical records and a physical exam, and 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, 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. Losses resulting from declared or undeclared war or an act of either within the geographic limits, territorial waters or the airspace above the United States are excluded. 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. Dependent coverage continues as long as the required Pilot & Dependent 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 billing notification will be sent to your home address as listed in PRISM 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. If monthly premiums are not received, your and your dependents’ coverage will end. 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.

The following exclusions along with other policy exclusions apply to continuation of Optional AD&D dependent coverage:

- 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, notify Pilot Benefits Administration.

- Losses resulting from declared or undeclared war or an act of either within the geographic limits, territorial waters or the airspace above the United States are excluded.

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 work.

For Suspension

If you are on an unpaid suspension and are participating in any of the following plans, you must pay the full cost of these plans in advance if you want to continue coverage:

- Basic Life Insurance Plan
- Basic Accidental Death and Dismemberment Plan (Basic AD&D)
- Optional Life Insurance Plan
- Optional Accidental Death and Dismemberment Plan (Optional AD&D)

Failing to make required insurance payments, making partial payments, or having checks returned due to insufficient funds will result in cancellation of coverage. Basic Life and Basic AD&D will automatically resume when you return to work. If you want to reenroll in Optional Life Insurance when you return to work, you must provide Evidence of Insurability satisfactory to Prudential. If coverage is denied, you will not be eligible to reenroll until you satisfactorily provide Evidence of Insurability as approved by the insurance company. Optional AD&D coverage does not require Evidence of Insurability; coverage will resume on the first of the month following your request. Contact Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area for information.

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 Life and Optional 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 insurance company. The notice date is the date on the letter sent by Prudential.

- For Optional AD&D, your dependents will have 31 days from their coverage termination date to submit a conversion application and the first premium to the
appropriate insurance company. Coverage begins upon receipt of premium and application within 31 days after coverage ends.

If you die accidentally and your family is enrolled in Optional AD&D, family coverage continues for eighteen months at no cost. The dependent can call after the 18 months and ask to get an individual policy.

Your dependents are responsible for paying all premiums.

If an Insured Person covered under Optional 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 earliest of:

- 31 days after the Insured Person is given notice, or
- 91 days after the life insurance is terminated, even if the Insured Person is never given such notice.

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 Optional Life Insurance Plan, an individual may elect either to convert coverage or to port coverage (to the Optional Life Portability Plan or the Retiree Optional Life Insurance Plan, as applicable), but may not elect both conversion and portability.

**Continuation of Coverage For Surviving Spouse of Pilot Who Dies as a Retired Pilot**

If the retired pilot had Retiree Optional Life Insurance, the spouse is eligible to elect to continue their spousal coverage. The spouse should contact Prudential for information.

**Payment of Death Benefits**

Pilot Benefits Administration contacts the designated beneficiary or beneficiaries and provides written instructions to designated beneficiaries on procedures for payment of applicable life insurance benefits. Certified death certificates and other appropriate documents must be sent to the address listed in the Pilot Benefits Administration written instructions. Four to five weeks’ processing time is required from the date the documentation is received.

**Additional Conversion Right under Basic Life and/or Optional Life Plan**

If the Basic Life and/or Optional Life plan is terminated or is changed so that the insurance for the specific plan to which you belong ends, and if you have been insured for at least five years prior to such termination; you may convert, within 31 days after your life insurance ends, the smaller of $2,000 or the difference between your coverage under the canceled policy and the coverage for which you become eligible under any other new, enhanced or replacement group plan offered by the Company.
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, you can receive an advance payment before your death. The Basic Life Insurance Plan is insured by Lincoln National Life Insurance Company.

Eligibility

Eligible employees are any pilots covered by the collective bargaining agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective February 28, 2011. Deaths occurring prior to February 28, 2011, will be governed by the previous contract.

Enrollment

Participation in the plan is automatic. However, you must designate your beneficiary(ies). Refer to “Life Insurance Enrollment and Beneficiary Designation on the FedEx Benefits Enrollment Website” on page L-2.

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. New Hires can elect to decrease the coverage amount to $300,000, $400,000 or $500,000 during their new hire eligibility period. Otherwise, you can increase or decrease your Basic Life Insurance coverage only during the Annual Benefits Enrollment period. Evidence of Insurability is required to increase the coverage amount.

Your life insurance is reduced by 8 percent each year you work from age 65 until you reach 70, after which there are no further reductions. The reduction is effective on the date your birthday occurs.

Accelerated Benefit Option

If your life expectancy is 6 months or less, as certified by your physician, you may receive up to 50 percent (maximum $200,000) of your Basic Life Insurance benefit once during your lifetime and will be paid to you in a lump sum, subject to the 8 percent reduction per year if you are 65 or older, or if you attain age 65 within the six months you are expected to live.

To be eligible, the following conditions apply:

• Benefits may be paid only to you.

• The Accelerated Benefit Option (also known as a Living Needs Benefit) is requested in writing in a form satisfying the requirements of the insurance company.

• You provide the insurance company with satisfactory proof of your terminal condition, including certification by a health care professional acceptable to the insurance company.

• If your Basic Life Insurance has been assigned, written acknowledgment of consent by the assignee must be provided to the insurance company for this benefit. If you have named an irrevocable beneficiary(ies) for your Basic Life Insurance, written consent of the beneficiary(ies) must be provided to the insurance company for this benefit.

• Your request is voluntary, meaning that you are not required by law to use this option to pay creditors or to use this option to become entitled to government assistance. If you have filed for bankruptcy, written approval of the bankruptcy court is required.
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, also known as Living Needs Benefit. When you leave the Company, you may convert to an individual contract any amount that was not paid to you under the Accelerated Benefit Option and that was eligible to be converted. Contact Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area for further information.

### Imputed Income for Basic Life Insurance Coverage

IIRS regulations require that the value of Company-paid Basic Life Insurance coverage in excess of $50,000 be subject to Federal income taxes and FICA (Social Security and Medicare) taxes. 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.

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<td>55-59</td>
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<tr>
<td>60-64</td>
</tr>
<tr>
<td>65-69</td>
</tr>
<tr>
<td>70 and above</td>
</tr>
</tbody>
</table>

The imputed income is provided on the FedEx Benefits Enrollment Website. The imputed income amount is also reflected on your paycheck stub under the code IMPINCLIFE and on the W-2 at year end in Box 12c. 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 earns $163,000 per year. The taxable life insurance benefit is calculated as follows:

<table>
<thead>
<tr>
<th>Basic Life Insurance Value</th>
<th>$800,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Tax-Free Amount</td>
<td>$50,000</td>
</tr>
</tbody>
</table>
### Filing a Claim

For information on filing claims, refer to “Basic and Optional Life Insurance” on page I-32.

### When Coverage Ends

Your coverage ends on the earliest of:

- The day you cease to be in a class of pilots 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
- 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

A conversion period extends coverage for 31 days. See the “Rules Applicable to All Insurance Plans” on page L-2 for details on conversion and for details on how certain events, such as termination, retirement or leaves of absence, affect your coverage under this Plan.

| Amount of Life Insurance Beyond Tax-Free Amount | $750,000 |
| $750,000/$1,000 | 750 |
| IRS Specified Premium for a 40-year old individual per $1,000 coverage | \(750 \times \$0.10\) |
| Monthly amount subject to taxation | $75.00 |
| Amount reported as IMPINCLIFE on paycheck stub each pay period | $37.50 |
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 **for any cause**. 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. The Optional Life Insurance Plan is insured by The Prudential Insurance Company of America.

**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 February 28, 2011. In addition to FedEx Express, participating employers in the Optional Life Insurance Plan include FedEx Corporation; FedEx Trade Networks Transport & Brokerage, Inc.; FedEx Trade Networks Trade Services, Inc.; World Tariff, Limited; FedEx TechConnect Inc. and holding company employees only of FedEx Corporate Services, Inc., FedEx Freight Corporation, and FedEx Trade Networks, Inc.

**Dependent Coverage**

If you are an active pilot with Optional Life Insurance, you may purchase additional coverage for your eligible spouse. You must elect coverage as a pilot in order to elect dependent coverage for an eligible spouse. Your eligible dependent children are automatically enrolled for dependent coverage at no additional cost to you when you enroll for Optional Life Insurance. Contact Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area.

Dependents eligible to be covered under your Optional Life Insurance include your:

- Spouse: Legally married spouse (as defined by Federal law).
- Common-Law Spouse (as defined by the state where Common-Law status is established).
- Child who is unmarried and receives more than half of his or her support from the pilot and meets any of the following criteria:
  - Your child is under age 19 or, if a full time student, to the 23rd birthday.
  - If a stepchild, either your stepchild resides with you at least six months of the year or your spouse is required to cover your stepchild because of a court decree.
  - Your child is adopted, placed in the home for the purpose of adoption or is a child for whom you have legal guardianship. Legal documents must be provided to Pilot Benefits Administration.
  - Your child of any age is unmarried and becomes mentally or physically incapacitated (incapable of self-support) before reaching age 23. If your child...
becomes incapacitated before age 19, proof of the child’s disability must be provided to Pilot Benefits Administration within 31 days of the child’s 19th birthday to continue coverage for the 19th birthday and thereafter. If your child becomes incapacitated between age 19 and the 23rd birthday, proof of the child’s disability must be provided to Pilot Benefits Administration no later than 31 days after the child’s 23rd birthday to continue coverage for the 23rd birthday and thereafter. For details, contact Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area.

NOTE: The FedEx definition of an eligible dependent is consistent with the definition of dependent under the Internal Revenue Code. If you claim the child as a dependent for federal tax purposes, the child can continue to be covered under the Plan. The child must also meet the other criteria listed above.

If your spouse is added to your Optional Life coverage within 31 days of your date of marriage, Evidence of Insurability is not required.

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 Express or a participating employer in the Plan;
- On active duty in the armed forces of any country; or
- Your coverage has ended, except during the conversion grace period. (Generally, this is a 31-day period.)

Coverage ends automatically on a child’s 23rd birthday unless incapacitated as previously described.

Dependents listed on the FedEx Benefits Enrollment Website are not necessarily eligible for or enrolled in coverage under the life insurance plans. Pilot Benefits Administration may request proof of eligibility, such as a birth certificate or marriage license, 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 permanent full-time pilot/employee of FedEx Express or any other FedEx company that is a participating employer in the Plan, your spouse cannot be covered as an eligible dependent but may elect to participate in the Optional Life Insurance Plan as a pilot or employee.

Dependent children may not be covered as eligible dependents of more than one pilot/employee. If both you and your spouse or you and another pilot/employee have the same dependents and are permanent full-time pilot/employees with Optional Life Insurance coverage, benefits are payable to only one pilot/employee. Absent any written agreement designating the pilot/employee who will cover the children, the pilot/employee who first enrolled in the Optional Life Insurance Plan will be the beneficiary of dependent coverage.

**Enrollment**

See “Life Insurance Enrollment and Beneficiary Designation on the FedEx Benefits Enrollment Website.”

You must enroll within 31 days of your hire date or date of notification. If you enroll past that date, you must provide Evidence of Insurability to the insurance company. Evidence of Insurability 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, Evidence of Insurability 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). Refer to “Designate or Change a Beneficiary for All Insurance Plans” on page L-3.

Evidence of Insurability (EOI)

In some situations, documentation is required by the insurance company substantiating that you are in good medical condition. Evidence of Insurability is required if:

- You enroll beyond 31 days following eligibility;
- Your coverage ends due to nonpayment of required premiums (to reinstate coverage, you would need to reenroll and provide Evidence of Insurability);
- 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 Evidence of Insurability 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 after your date of marriage or date of initial eligibility;
- He or she was previously denied Optional Life Insurance coverage;
- 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 (the pilot) will be asked to complete a “short” online questionnaire. You will either be approved immediately or asked to complete the full EOI form to submit to Prudential for review. When enrolling in Optional Life for your spouse, your spouse will also complete a “short” questionnaire and submit (mail or fax) to Prudential for review. (There is no immediate approval of coverage for your spouse.) Prudential will either approve the coverage or ask for the full EOI form or additional medical records. The EOI forms are available at https://fedex.ehr.com.

Approval of coverage is made by the insurance company after reviewing your completed application and the required additional information. It may take at least six weeks before you receive their written decision to approve or deny coverage. If the insurance company requires a physical exam, you are responsible for the expense.

When Coverage Begins

If you enroll within 31 days of your eligibility, your coverage begins on your first day of eligibility. 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, your coverage (or change in coverage) will start on the next active workday in which you meet these requirements.

If you do not enroll within the 31 days of your eligibility, your coverage (or change in coverage) will begin on the date the insurance company deems the Evidence of Insurability requirements have been satisfied.

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 Evidence of Insurability to the insurance company. Contact Pilot Benefits Administration for details.

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 February 28, 2011, Optional Life Insurance coverage is available in increments of $100,000 to a maximum of $1,000,000 of coverage but no more than ten (10) times your basic annual salary. This amount shall be reduced by 8% a year for pilots beginning on their 65th birthday and ending at age 70, after which there are no further reductions.

Optional Life Insurance

<table>
<thead>
<tr>
<th>Coverage Amount Available to Pilots</th>
<th>You may elect coverage in increments of $100,000 up to a maximum of $1,000,000—but not to exceed 10 times basic annual salary.</th>
</tr>
</thead>
</table>
| Coverage Amount Available to Eligible Dependents | • $25,000 for eligible spouse  
• $1,000 for eligible children from live birth to 6 months  
• $5,000 for eligible children 6 months and older* |
| Enrollment | You can newly elect, increase or decrease coverage any time throughout the year. To newly elect coverage or increase the coverage amount, you must submit an Evidence of Insurability form and evidence satisfactory to Prudential. You must be actively at work for coverage to become effective or to increase Optional Life Insurance coverage. |
| Effective Date of Coverage | • If your election is made within your new hire eligibility period, coverage is effective on your date of hire.  
• 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 Prudential.  
• If on Leave of Absence, coverage will not become effective until you return to active work. |

* Children must meet all eligibility criteria including age, relationship, student status and support.

Important: Coverage amounts for pilots age 65 to 70 will be reduced by 8% each year beginning on the 65th birthday and ending at age 70, after which there are no further reductions. There is no reduction in the $25,000 spousal coverage.

Monthly Premiums for Optional Life Insurance

<table>
<thead>
<tr>
<th>Pilot's Age</th>
<th>Monthly Premium Per $1,000 of Coverage</th>
<th>Spouse's Age</th>
<th>Monthly Premium for Spouse $25,000 Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through age 24</td>
<td>$.032</td>
<td>Through age 39</td>
<td>$ 2.49</td>
</tr>
<tr>
<td>25-29</td>
<td>$.035</td>
<td>40-49</td>
<td>$ 3.08</td>
</tr>
<tr>
<td>30-34</td>
<td>$.047</td>
<td>50-54</td>
<td>$ 6.05</td>
</tr>
</tbody>
</table>
### Monthly Premiums for Optional Life Insurance

The monthly premium is based on the elected coverage amount and age.

<table>
<thead>
<tr>
<th>Pilot's Age</th>
<th>Monthly Premium Per $1,000 of Coverage</th>
<th>Spouse's Age</th>
<th>Monthly Premium for Spouse $25,000 Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-39</td>
<td>$.053</td>
<td>55-59</td>
<td>$ 7.95</td>
</tr>
<tr>
<td>40-44</td>
<td>$.078</td>
<td>60-64</td>
<td>$15.46</td>
</tr>
<tr>
<td>45-49</td>
<td>$.11</td>
<td>65-69</td>
<td>$23.20</td>
</tr>
<tr>
<td>50-54</td>
<td>$.17</td>
<td>70 or older</td>
<td>$38.66</td>
</tr>
<tr>
<td>55-59</td>
<td>$.315</td>
<td>As your spouse ages, the monthly premium will adjust accordingly.</td>
<td></td>
</tr>
<tr>
<td>60-64</td>
<td>$.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-69</td>
<td>$.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70 or older</td>
<td>$1.65</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As you age, your monthly premium will adjust accordingly.

**IMPORTANT**

Pilot coverage amounts will reduce 8% each year you work beginning the 65th birthday and ending on the 70th birthday, after which there are no further reductions. Also note that coverage terminates at retirement. There is no reduction in spousal benefits.

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**Imputed Income for Optional Life Insurance**

Effective January 1, 2012, there was a premium increase for the Optional Life Plan. Section 27.C.1 of the February 28, 2011, CBA states “Except for routine and scheduled premium adjustments caused by a pilot’s moving between age categories, a non-retired pilot’s premium payments for equal amounts of coverage shall not be increased.” Therefore, the Pilots did not experience a premium rate increase to cover this premium adjustment.

As a result of the rate increase, the pilot Optional Life participants (both Pilot and/or Pilot’s spouse) will incur imputed income based on the difference between the full premium charged by the insurance company and the premium paid. This imputed income amount will be reported on the paycheck stub under the “EXCPIIL” and reported on the Pilot’s W-2 starting in 2012. The tables below show how the imputed income is determined for Pilot coverage and Spouse coverage starting January 1, 2012.

**Table A — Imputed Income for Pilot Coverage**

<table>
<thead>
<tr>
<th>Pilot’s Age</th>
<th>Monthly Premium Rate Paid by Pilot per $1,000 of Coverage</th>
<th>Full Monthly Premium Rate Charged by Insurer per $1,000 of Coverage</th>
<th>Difference in Premium Rate Paid by FedEx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.032</td>
<td>$0.035</td>
<td>$0.003</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.035</td>
<td>$0.038</td>
<td>$0.003</td>
</tr>
</tbody>
</table>

---

---
### Table A — Imputed Income for Pilot Coverage

<table>
<thead>
<tr>
<th>Pilot's Age</th>
<th>Monthly Premium Rate Paid by Pilot per $1,000 of Coverage</th>
<th>Full Monthly Premium Rate Charged by Insurer per $1,000 of Coverage</th>
<th>Difference in Premium Rate Paid by FedEx</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-34</td>
<td>$0.047</td>
<td>$0.051</td>
<td>$0.004</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.053</td>
<td>$0.058</td>
<td>$0.005</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.078</td>
<td>$0.085</td>
<td>$0.007</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.110</td>
<td>$0.120</td>
<td>$0.010</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.170</td>
<td>$0.185</td>
<td>$0.015</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.315</td>
<td>$0.344</td>
<td>$0.029</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.480</td>
<td>$0.524</td>
<td>$0.044</td>
</tr>
<tr>
<td>65-69</td>
<td>$0.950</td>
<td>$1.036</td>
<td>$0.086</td>
</tr>
<tr>
<td>70 and older</td>
<td>$1.650</td>
<td>$1.800</td>
<td>$0.150</td>
</tr>
</tbody>
</table>

### Table B — Imputed Income for Spouse Coverage

<table>
<thead>
<tr>
<th>Spouse's Age</th>
<th>Monthly Premium Rate Paid by Pilot for $25,000 Spouse Coverage</th>
<th>Full Monthly Premium Rate Charged by Insurer for $25,000 Spouse Coverage</th>
<th>Difference in Premium Rate Paid by FedEx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$2.49</td>
<td>$2.63</td>
<td>$0.14</td>
</tr>
<tr>
<td>25-29</td>
<td>$2.49</td>
<td>$2.63</td>
<td>$0.14</td>
</tr>
<tr>
<td>30-34</td>
<td>$2.49</td>
<td>$2.63</td>
<td>$0.14</td>
</tr>
<tr>
<td>35-39</td>
<td>$2.49</td>
<td>$2.63</td>
<td>$0.14</td>
</tr>
<tr>
<td>40-44</td>
<td>$3.08</td>
<td>$3.25</td>
<td>$0.17</td>
</tr>
<tr>
<td>45-49</td>
<td>$3.08</td>
<td>$3.25</td>
<td>$0.17</td>
</tr>
<tr>
<td>50-54</td>
<td>$6.05</td>
<td>$6.38</td>
<td>$0.33</td>
</tr>
<tr>
<td>55-59</td>
<td>$7.95</td>
<td>$8.39</td>
<td>$0.44</td>
</tr>
<tr>
<td>60-64</td>
<td>$15.46</td>
<td>$16.31</td>
<td>$0.85</td>
</tr>
<tr>
<td>65-69</td>
<td>$23.20</td>
<td>$24.48</td>
<td>$1.28</td>
</tr>
<tr>
<td>70 and older</td>
<td>$38.66</td>
<td>$40.79</td>
<td>$2.13</td>
</tr>
</tbody>
</table>
Basic Annual Salary

You may elect coverage in increments of $100,000 up to a maximum of $1,000,000—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, e.g. 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.

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
- PMPPP contributions
- Excess Life Premiums (Imputed income for Life Insurance coverage)
- Reimbursed expenses

Accelerated Benefit Option (Living Needs Benefit)

If your life expectancy is six months or less as certified by your physician, you may receive up to 50 percent of your Optional Life Insurance benefit (maximum $250,000) once during your lifetime. This amount is subject to the 8 percent reduction per year if you are 65 or older, or if you reach age 65 within the six-month period you are expected to live.

To be eligible, the following conditions apply:

- Benefits may be paid only to you.
- The Accelerated Benefit Option must be requested in writing in a form satisfying the requirements of the insurance company.
• You provide the insurance company with satisfactory proof that your life expectancy is six months or less, including certification by a health care professional acceptable to the insurance company.

• Your Optional Life Insurance is not assigned.

• Your request is voluntary, meaning that you are not required by law to use this option to pay creditors or to use this option to become entitled to government assistance.

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 Optional Life Insurance that is ordinarily paid upon your death is reduced by the amount already paid as an Accelerated Benefit Option, also known as Living Needs Benefit. When you leave the Company, you may convert to an individual policy any amount that was not paid to you under the Accelerated Benefit Option and that was eligible to be converted. Call Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area, for more information.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 55900.

Filing a Claim

For information on filing claims, refer to “Basic and Optional Life Insurance” on page I-32.

When Coverage Ends

Your coverage ends on the earliest of:

• The day you cease to be in a class of pilots eligible for coverage.

• The day you no longer work for the Company.

• The last day for which you have paid premiums for Optional Life Insurance.

• 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.

• 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, this 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.

A conversion period extends your coverage 31 days. See “Rules Applicable to All Insurance Plans” on page L-2, for details on conversion.

If your coverage ends, and your spouse is a permanent full-time employee and participates in the Optional Life Insurance Plan, you may be eligible for coverage as a dependent. Contact Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area, within 31 days of the end of your coverage.
Refer to “Rules Applicable to All Insurance Plans” on page L-2 for details on how certain events, such as termination, retirement or leaves of absence affect your coverage under this plan and conversion options available.

If you no longer have an eligible spouse, it is your responsibility to change your Optional Life coverage to Pilot Only and pay the corresponding premium for Pilot Only coverage.

It is your responsibility to ensure that payroll deductions end. If they do not end within two pay periods, notify Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 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.
Optional Life Portability Insurance Plan

Pursuant to the terms of the collective bargaining agreement between Federal Express Corporation and the Air Line Pilots Association, International effective February 28, 2011, FedEx offers “portability” of Optional Life coverage issued by Prudential when you or your covered dependent(s) are no longer eligible for coverage under the Federal Express Corporation Optional Life Insurance Plan. Portability will be offered if:

- The pilot is under age 55 and terminates employment, downgrades to a non-permanent status, or transfers to a FedEx company not covered by the FedEx Optional Life Insurance on or after February 28, 2011.
- The dependent(s) ceases to be eligible due to divorce or death of a pilot.

Your coverage is not portable 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 are receiving Workers Compensation benefits immediately prior to your termination. If your covered dependents want to apply for portability, Prudential will request verification that your dependents were not home or hospital confined on the day of pilot termination.

If the pilot dies, then to port Optional Dependents Term Life coverage the spouse must be less than age 80, the spouse must be covered for Optional Dependents Term Life on the day the Optional Employee Term Life ends and the spouse must not be confined for medical care or treatment. If the pilot dies, the spouse has the right to port a child’s coverage if the child is under age 19 or 23 (if full-time student), the child must be covered for Optional Dependents Term Life on the day the Optional Employee Term Life ends and the dependent child must not be confined for medical care or treatment. In the case of a divorce, the spouse has the right to apply for Portability if the Optional Dependents Term Life coverage on the spouse ends due to divorce, the spouse is less than 80 and the spouse is not confined for medical care or treatment.

If your spouse is under age 80 and/or children are enrolled in the Optional Life Insurance plan, you can port their coverage. Dependent coverage may be ported only if pilot coverage is ported except in the event of pilot death or divorce. The monthly portability premium for spouse and children is in addition to the pilot’s portability premium.

How much coverage can be ported and for how long?

For pilot coverage, you can elect a coverage amount up to or less than your Optional Life Insurance coverage amount as an active pilot. The minimum amount of coverage that you can port is $20,000 and the maximum is the lesser of your pre-termination coverage or $1 million not to exceed 5 times your pre-termination basic monthly salary. Benefits will reduce to 60% 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 Policy coinciding with or next following the attainment of that age.

For Spouse and Child coverage

The maximum amount of dependent term life insurance under the Portability Plan is up to or less than amount of insurance on the dependent under the Optional Dependents Term Life Coverage when that insurance ends. Though there are no age reductions in spousal coverage, the coverage will terminate at age 80. Child portability ends at age 19 or 23 if a full-time student.
How do I elect Portability of my Optional Life Insurance?

If you are actively at work during the entire last week of your employment and are an Optional Life Insurance participant under age 55 when you terminate employment, you will receive notification from Prudential regarding your eligibility for Optional Life portability and enrollment instructions. You will have 31 days from the later of your termination date or the eligibility notice date to contact Prudential to enroll yourself and your eligible dependents. If an individual dies within 31 days after coverage ended, a death benefit is payable. If an individual dies more than 31 days after coverage ended (even though the right to convert or elect Portability was extended), no death benefit is payable.

Prudential will send a letter on spouse or child eligibility in the event of death or divorce.

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 layoff; 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.

Premiums for Portability Life Insurance

The monthly Standard premium per $1,000 for Portability is shown in this table. Also, you may qualify for the lower Preferred cost by submitting satisfactory Evidence of Insurability (EOI) to Prudential. The EOI option is not available for children.

<table>
<thead>
<tr>
<th>Pilot/Spouse Age</th>
<th>Monthly Premium per $1,000</th>
<th>Monthly Premium per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25</td>
<td>$0.134</td>
<td>$0.099</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.134</td>
<td>$0.099</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.149</td>
<td>$0.111</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.185</td>
<td>$0.137</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.269</td>
<td>$0.20</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.406</td>
<td>$0.30</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.675</td>
<td>$0.50</td>
</tr>
<tr>
<td>55-59*</td>
<td>$1.150</td>
<td>$0.852</td>
</tr>
<tr>
<td>60-64*</td>
<td>$1.896</td>
<td>$1.405</td>
</tr>
<tr>
<td>65-69*</td>
<td>$3.226</td>
<td>$2.389</td>
</tr>
<tr>
<td>70-74*</td>
<td>$5.224</td>
<td>$3.869</td>
</tr>
<tr>
<td>75-79*</td>
<td>$8.708</td>
<td>$6.451</td>
</tr>
<tr>
<td>Dependent Child</td>
<td>$0.22</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

*Available only to participants who elect Portability prior to age 55.

Ported lives will pay an additional administrative charge of $3 per bill for direct billing. This charge typically occurs quarterly. This charge will be waived when participants elect Electronic Funds Transfer (EFT).

The Portability policy is administered by Prudential. Premium rates are subject to change at any time.
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 February 28, 2011, 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 Prudential. 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). Any pilot who retired (or terminated) prior to October 30, 2006, is not eligible to elect Retiree Optional Life Insurance coverage.

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 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. Your spouse’s Retiree Optional Life Insurance coverage amount is $25,000. 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 $25,000 spouse 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, Prudential 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 during the entire last week of your employment prior to termination and an Optional Life Insurance participant age 55 or older when you retire or terminate on or after October 30, 2006, you will receive notification from Prudential 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 Prudential 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 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 Prudential regarding their 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 Prudential to enroll for Retiree Optional Life.
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.

**NOTE:** Your spouse is eligible for coverage only if you enroll for coverage.

### PILOT/SPOUSAL PREMIUMS

<table>
<thead>
<tr>
<th>AGE</th>
<th>Monthly Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>55-59</td>
<td>$0.618</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.080</td>
</tr>
<tr>
<td>65</td>
<td>$1.507</td>
</tr>
<tr>
<td>66</td>
<td>$1.650</td>
</tr>
<tr>
<td>67</td>
<td>$1.822</td>
</tr>
<tr>
<td>68</td>
<td>$2.143</td>
</tr>
<tr>
<td>69</td>
<td>$2.404</td>
</tr>
<tr>
<td>70</td>
<td>$2.555</td>
</tr>
<tr>
<td>71</td>
<td>$2.878</td>
</tr>
<tr>
<td>72</td>
<td>$3.241</td>
</tr>
<tr>
<td>73</td>
<td>$3.585</td>
</tr>
<tr>
<td>74</td>
<td>$3.826</td>
</tr>
<tr>
<td>75</td>
<td>$4.112</td>
</tr>
<tr>
<td>76</td>
<td>$4.760</td>
</tr>
<tr>
<td>77</td>
<td>$5.440</td>
</tr>
<tr>
<td>78</td>
<td>$5.945</td>
</tr>
<tr>
<td>79</td>
<td>$6.542</td>
</tr>
<tr>
<td>Spouse only, age 55 or less</td>
<td>$0.347</td>
</tr>
</tbody>
</table>

**Example:** The monthly premium for a 65-year-old to purchase $100,000 Retiree Optional Life Insurance is $150.70 ($100,000 divided by $1,000 x $1.507). To cover a 60-year-old spouse for $25,000 is an additional $27.00 per month ($25,000 divided by $1,000 x $1.08). The total monthly premium is $177.70.

Your monthly premium will increase as you age. Also, like the Optional Life Insurance Plan, Retiree Optional Life Insurance coverage will reduce 8% per year beginning on the pilot’s 65th birthday until age 70. There is no reduction in the $25,000 spouse coverage. All coverage (pilot and spouse) ends at age 80.
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. The Basic Accidental Death and Dismemberment Plan is insured through National Union Fire Insurance.

Eligibility


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 “Steps to Take to Designate or Change a Beneficiary for All Life Insurance Plans” on page L-2.

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 work day.

A Look at the Benefits and Cost

The Company pays the full cost of Basic AD&D.

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:

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Percentage of Pilot Death Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of both hands, both arms, both legs, both feet, both eyes, or any combination</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of speech and hearing in both ears</td>
<td></td>
</tr>
<tr>
<td>Loss of one arm or one leg</td>
<td>70%</td>
</tr>
<tr>
<td>Loss of speech, hearing in both ears, one hand, or one foot, or entire sight in one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of thumb and index finger of the same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>
Loss is defined as:

- Loss of an arm or leg – Actual and complete severance through 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 an eye – Irrecoverable loss of the entire sight in that eye.
- Loss of the thumb and index finger – Actual and complete severance through or above the joint closest to 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.

If an Insured Person as a result of the same covered accident sustains more than one Loss, only one amount, the largest, will be paid.

**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.

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Percentage of Pilot Death Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quadriplegia (total paralysis of both upper and both lower limbs)</td>
<td>100%</td>
</tr>
<tr>
<td>Triplegia (total paralysis of three limbs)</td>
<td>75%</td>
</tr>
<tr>
<td>Paraplegia (total paralysis of both lower limbs)</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia (total paralysis of upper and lower limbs on same side of body)</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia (total paralysis of a single limb)</td>
<td>25%</td>
</tr>
</tbody>
</table>

**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 percent 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

<table>
<thead>
<tr>
<th>This additional benefit…</th>
<th>Pays…</th>
<th>When…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coma</td>
<td>1% of the pilot's death benefit amount each month after the first 30 days of a coma; maximum 100 months. If death from this covered accident results within the first 365 days, any amount paid under this provision reduces any death benefit payable.</td>
<td>You sustain a covered injury that results in a coma within 30 days of a covered accident and the coma continues for 30 consecutive days.</td>
</tr>
<tr>
<td>Felonious Assault</td>
<td>Additional 10% of pilot's death benefit amount to a maximum of $25,000.</td>
<td>You suffer a loss as a result of a felonious assault while acting on behalf of the Company.</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>Reimbursement of reasonable and necessary expenses up to a maximum of $10,000/covered accident.</td>
<td>You incur expenses for medically necessary rehabilitative training within two years after a covered accident that results in a covered dismemberment or paralysis.</td>
</tr>
<tr>
<td>Seat Belt and Air Bag Usage</td>
<td>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.</td>
<td>Seat belt: You suffer loss of life as a result of a covered bodily injury from an automobile accident in which your use of an original factory installed, properly fastened seat belt is documented. Air bag: You suffer loss of life as a result of a covered bodily injury from an automobile accident and a seat belt benefit is payable and you are positioned in a seat protected by a properly functioning, original factory installed air bag that inflates on impact. No benefit is payable if the vehicle is used in race, speed or endurance test or for acrobatic or stunt driving.</td>
</tr>
<tr>
<td>Emergency Evacuation/ Repatriation</td>
<td>Reasonable expenses for emergency evacuation/repatriation, return of children/companion to Primary Home, visit of family member/friend to Insured that is alone and hospitalized.</td>
<td>Covered Injury or Emergency Sickness occurs while you are traveling more than 100 miles from your Primary Home and physician orders services. Travel Guard® must make all arrangements and must authorize all expenses in advance for benefit to be payable. Repatriation (return of remains) benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which you are entitled to benefits under any Workers’ Compensation Act or similar law. Primary Home is country of residence before expatriation. Policy exclusions do not apply to the Emergency Evacuation benefit. Sickness exclusion does not apply to the Repatriation benefit.</td>
</tr>
</tbody>
</table>
Additional Basic AD&D Benefits

<table>
<thead>
<tr>
<th>This additional benefit…</th>
<th>Pays…</th>
<th>When…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure &amp; Disappearance</td>
<td>Pilot’s death benefit amount.</td>
<td>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.</td>
</tr>
<tr>
<td>Hospital Confinement</td>
<td>An additional benefit equal to the lesser of 2% of the pilot’s death benefit amount or $3,000/month up to a maximum of 12 months per period of hospital confinement. Benefit payable from 1st day of confinement pro-rated daily.</td>
<td>After 7 consecutive days of hospital confinement due to a covered injury.</td>
</tr>
</tbody>
</table>

NOTE: Pilot is required to provide proof of incurred expenses to obtain applicable benefits as described in above chart.

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 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 one year after the date of the covered accident.

Travel Assistance Services

Travel Assistance Services are only provided through Travel Guard® and only while the Insured Person is traveling 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, 1-800-626-2427
- To call collect from anywhere outside the United States and Canada, contact an AT&T International Operator to place your call to Houston at 715-267-2525.

Travel Assistance Services (Travel Guard®)

<table>
<thead>
<tr>
<th>This additional benefit…</th>
<th>Applies when…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel Medical Emergency Services</td>
<td>Insured Person requires assistance to secure the availability of the services of a local physician and arrange hospital confinement.</td>
</tr>
<tr>
<td>Emergency Cash</td>
<td>Insured Person is caught in an emergency and needs cash. In coordination with insured’s finances, provides cash through banks, consulates, hotels, and Western Union.</td>
</tr>
<tr>
<td>General Assistance</td>
<td>Information is needed on transmission and retention of urgent messages, translations and communication during emergencies, advice on contacting and using services available from consulates, government agencies, translators, and other service providers that can help with travel-related problems.</td>
</tr>
</tbody>
</table>
Travel Assistance Services (Travel Guard®)

<table>
<thead>
<tr>
<th>This additional benefit…</th>
<th>Applies when…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-departure Services</td>
<td>Insured Person needs information on immunization requirements, medical exams and treatments, passport and visa requirements, weather, and travel hazards.</td>
</tr>
<tr>
<td>Lost Baggage/Passport</td>
<td>Insured Person whose baggage has been lost or delayed by a carrier and who needs assistance. Will provide advice regarding how to recover lost or delayed luggage. Insured Person loses passport, service notifies the appropriate authorities of lost passport and provides directions for replacement.</td>
</tr>
<tr>
<td>Insurance Coordination</td>
<td>Insured Person needs assistance with the completion of insurance and medical claim forms or verification of that person’s insurance coverage.</td>
</tr>
<tr>
<td>Legal Assistance</td>
<td>Insured Person is in need of legal assistance. Can arrange help from local attorney, embassies, and consulates. If insured person is arrested or in danger of being arrested, the service can provide that person with the name of an attorney who can provide representation.</td>
</tr>
<tr>
<td>Travel Agency</td>
<td>Insured Person needs to replace lost or stolen airline ticket by arranging payment through that person’s credit card. Hotel reservations can be arranged.</td>
</tr>
<tr>
<td>Evacuation and Repatriation</td>
<td>Covered Injury or Emergency Sickness occurs while you are traveling more than 100 miles from your Primary Home and physician orders services. Travel Guard® must make all arrangements and must authorize all expenses in advance for benefit to be payable. Repatriation (return of remains) benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which you are entitled to benefits under any Workers’ Compensation Act or similar law. Primary Home is country of residence before expatriation. Policy exclusions do not apply to the Emergency Evacuation benefit. Sickness exclusion does not apply to the Repatriation benefit. Reasonable expenses for emergency evacuation/repatriation, return of children/companion to Primary Home, visit of family member/friend to Insured that is alone and hospitalized.</td>
</tr>
</tbody>
</table>

What’s Not Covered – Exclusions

Basic AD&D benefits are not paid for losses having to do with:

- Sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning
- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury
- Declared or undeclared war or an act of declared or undeclared war either within the geographical limits, territorial waters or the airspace above the United States
- Loss caused by, contributed to or resulting from injury sustained while serving in the armed forces of any country (except service in the National Guard or a Reserve Unit that does not exceed 60 days)

Filing a Claim

For information on filing claims, refer to “Basic and Optional Accidental Death & Dismemberment (AD&D)” on page I-32.

When Coverage Ends

Your coverage ends on the earliest of:

- The day you cease to be in a class of pilots 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, this Collective Bargaining Agreement or a successor collective bargaining agreement no longer provides for this coverage

Option to Purchase Individual AD&D

When Basic AD&D coverage ends, an individual AD&D policy is available prior to age 80. Coverage begins upon receipt of premium and application within 31 days after coverage ends under Basic AD&D. No Evidence of Insurability is required. The amount of insurance converted cannot exceed $250,000 and not be less than $100,000.

For any questions, contact Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area.
Optional Accidental Death and Dismemberment (AD&D) Plan

Eligibility


Pilots continue to be eligible for coverage:

- When performing Civil Reserve Air Fleet (CRAF) missions or
- For a covered injury suffered by an Insured Person 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 & Dependent(s) coverage. You must list your dependents on the FedEx Benefits Enrollment Website (https://fedex.ehr.com) and validate their eligibility. You must elect coverage as a pilot in order to elect dependent coverage for eligible dependents. You may not purchase Optional AD&D coverage for your spouse/dependent child(ren) if they are a permanent full-time employee of a participating employer in the Plan.

Dependents eligible to be covered under your Optional AD&D include your:

- Spouse: Legally married spouse (as defined by Federal law).
- Common-Law Spouse (as defined by the state where Common-Law status is established).
- Child who is unmarried and receives more than half of his or her support from the pilot and meets any of the following criteria:
  - Your child is under age 19 or, if a full time student, to the 23rd birthday.
  
  **NOTE:** Your child is eligible for coverage if your child is currently enrolled as a full-time student in an educational institution’s normal school year and meets the educational institution’s full time student requirements. If your child is not currently a full time student, but meets the requirements at a later date, you have 31 days from the date your child becomes a full time student to enroll for benefits. If your child is currently a full time student but loses eligibility at a later date, you must drop your child from coverage within 31 days of that date.
  
  - If a stepchild, either your stepchild resides with you at least six months of the year or your spouse is required to cover your stepchild because of court decree.
  
  - Your child is adopted, placed in the home for the purpose of adoption or is a child for whom you have legal guardianship. Legal documents must be provided to Pilot Benefits Administration.
  
  - Your child of any age is unmarried and becomes mentally or physically unable to care for themselves (incapacitated) before reaching age 23. If your child becomes incapacitated before age 19, proof of the child’s disability must be provided to Pilot Benefits Administration within 31 days of the child’s 19th birthday to continue coverage for the 19th birthday and thereafter. If your child becomes
incapacitated between age 19 and the 23rd birthday, proof of the child's disability must be provided to Pilot Benefits Administration no later than 31 days after the child's 23rd birthday to continue coverage for the 23rd birthday and thereafter. For details, contact Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area.

NOTE: The FedEx definition of an eligible dependent is consistent with the definition of dependent under the Internal Revenue Code. If you claim the child as a dependent for federal tax purposes, the child can continue to be covered under the Plan. The child must also meet the other criteria listed above.

Eligibility ends automatically on a child's 23rd birthday unless incapacitated as previously described.

Your spouse/child(ren) cannot be covered as an eligible dependent if:

- He or she is also eligible as a permanent full-time employee of FedEx Express or a participating employer in the Plan

or

- On active duty in the armed forces of any country

Dependents listed on the FedEx Benefits Enrollment Website are not necessarily eligible for or enrolled in coverage in the Optional AD&D Plan. Pilot Benefits Administration may request proof of eligibility, such as a birth certificate or marriage license, for any dependent. Documentation may also be requested by the carrier for further proof of eligibility.

The pilot is the beneficiary for all dependent coverages. Refer to L-2 for the beneficiary rules.

**Married to Another Pilot/Employee Who Is Also Eligible to Participate in the Optional AD&D Plan**

If you are a pilot and you are married to another permanent full-time pilot/employee of FedEx Express or any other FedEx company that is a participating employer in the Plan, your spouse cannot be covered as an eligible dependent but may elect to participate in the Optional AD&D Plan as a pilot or employee. To cover eligible dependent children, you or your spouse must elect Pilot & Dependent coverage.

Dependent children may not be covered as eligible dependents of more than one pilot/employee. If both you and your spouse or you and another pilot/employee have the same dependents and are permanent full-time pilots/employees with Optional AD&D Insurance coverage, benefits are payable to only one pilot/employee. Absent any written agreement designating the pilot/employee who will cover the children, the pilot/employee who first enrolled in the Optional AD&D Insurance Plan will be the beneficiary of dependent coverage.

**Enrollment**

To enroll in Optional AD&D, refer to “Life Insurance Enrollment and Beneficiary Designation on the FedEx Benefits Enrollment Web Site.” You can enroll in Optional AD&D or increase coverage at any time during the year without Evidence of Insurability. You may drop or reduce the amount of coverage at any time.

**When Coverage Begins**

Coverage begins on the first day of the month following the date of your election. Any change in coverage amounts becomes effective on the first day of the month following the date of your 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.

**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.

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**

<table>
<thead>
<tr>
<th>Coverage Amount Available to Pilots</th>
<th>From $35,000 to $235,000 (in increments of $50,000)</th>
</tr>
</thead>
</table>
| Coverage Amount Available to Eligible Dependents | • 75% of pilot's coverage for Eligible Spouse  
• 30% of pilot's coverage for Eligible Children |
| 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. |
| Effective Date of Coverage | First day of the month following the date of your election |

**Monthly Premium for Optional AD&D Insurance**

<table>
<thead>
<tr>
<th>Coverage Amount</th>
<th>Pilot Only* Monthly Premium</th>
<th>Pilot &amp; Dependent(s)* Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$35,000</td>
<td>$.077</td>
<td>$1.37</td>
</tr>
<tr>
<td>$85,000</td>
<td>$1.87</td>
<td>$3.32</td>
</tr>
<tr>
<td>$135,000</td>
<td>$2.97</td>
<td>$5.27</td>
</tr>
<tr>
<td>$185,000</td>
<td>$4.07</td>
<td>$7.22</td>
</tr>
<tr>
<td>$235,000</td>
<td>$5.17</td>
<td>$9.17</td>
</tr>
</tbody>
</table>

*These coverage levels may also be referred to as Employee Only or Employee & Dependent(s) in other communications and/or the FedEx Benefits Enrollment Website.

**Dismemberment Benefit**

If you or a covered spouse suffers a covered loss within 365 days of a covered accident, you receive benefits as shown in the following chart:

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Percentage of Death Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of both hands, both arms, both legs, both feet, both eyes or any combination</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of speech and hearing in both ears</td>
<td></td>
</tr>
<tr>
<td>Loss of one arm or one leg</td>
<td>70%</td>
</tr>
</tbody>
</table>
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:

### Loss is defined as:
- Loss of an arm or leg – Actual and complete severance through 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 in an eye – Irrecoverable loss of the entire sight of that eye.
- Loss of the thumb and index finger – Actual and complete severance through or above the joint closest to 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.

If an Insured Person as a result of the same covered accident sustains more than one Loss, only one amount, the largest, will be paid. In no event will the benefits payable under the provision due to the same covered accident exceed the Insured Person’s applicable benefit amount.

### Paralysis Benefit
Optional AD&D pays a benefit equal to the percentage of the benefit amount shown in the prior chart for children and 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**
---|---
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%

### Child Dismemberment or Paralysis Benefit

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Percentage of Child Death Benefit Amount</th>
</tr>
</thead>
</table>
Loss of both arms, legs, hands, feet, eyes or any combination; or quadriplegia | 200%
Loss of speech and hearing in both ears | 150%
Triplegia | 140%
Loss of one arm or leg | 100%
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 | 50%

**NOTE:** Payment of benefit is subject to the terms and conditions of the Paralysis Benefit.
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.

For adults, Optional AD&D will not pay more than 100 percent 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

<table>
<thead>
<tr>
<th>This Additional Benefit...</th>
<th>Pays...</th>
<th>When...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catastrophic Accident Care/Home Health</td>
<td>$235,000 lifetime maximum for medically supervised assistance with covered activities of daily living performed by licensed home health agency.</td>
<td>Insured Person is confined to home because of covered injury resulting in severe brain or spinal cord damage and had been confined in a hospital for 30 consecutive days.</td>
</tr>
<tr>
<td>Home Alteration and Vehicle Modification</td>
<td>$10,000 maximum/covered accident provided modifications comply with applicable laws or standards.</td>
<td>If Insured Person suffers dismemberment or paralysis requiring a minimum hospital stay of 10 consecutive days due to a covered injury, benefit is paid for medically necessary alterations to the Insured Person's residence and modifications to his or her car. Benefit is reduced by the amount of benefits paid or payable by other group insurance.</td>
</tr>
<tr>
<td>Coma</td>
<td>1% of the Insured Person’s benefit amount each month after the first 30 days of a coma; maximum 100 months. If death from this covered accident results within the first 365 days, any amount paid under this provision reduces any death benefit payable.</td>
<td>Insured Person sustains a covered injury that results in a coma within 30 days of a covered accident and the coma continues for 30 consecutive days.</td>
</tr>
<tr>
<td>Common Disaster*</td>
<td>Spouse’s benefit is increased from 75% to 100% of the pilot’s death benefit amount.</td>
<td>Pilot and covered spouse die in the same covered accident or a separate covered accident within a 24-hour period.</td>
</tr>
<tr>
<td>Continued Medical Coverage*</td>
<td>Lesser of 5% of pilot’s death benefit amount or $5,000/year up to 3 consecutive years for family medical/dental coverage continuation.</td>
<td>Pilot death claim is payable. Benefit is payable monthly.</td>
</tr>
</tbody>
</table>
## Additional Optional AD&D Benefits

<table>
<thead>
<tr>
<th>This Additional Benefit...</th>
<th>Pays...</th>
<th>When...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day Care</strong>*</td>
<td>Lesser of 5% of the pilot or covered spouse’s death benefit amount or $5,000/year payable annually for 4 years or until the child reaches age 13, whichever is earlier. If no children under 13, pays $2,500 to designated beneficiary.</td>
<td>Pilot or covered spouse suffers loss of life as a result of a covered injury and is survived by dependent children under age 13 who are or will be attending an accredited day care center within 1 year of the death of the pilot or covered spouse.</td>
</tr>
<tr>
<td><strong>Family Coverage Extension</strong>*</td>
<td>Optional AD&amp;D coverage for dependents of pilot is continued for 18 months from death of insured pilot at no charge.</td>
<td>Pilot suffers loss of life as a result of a covered accident.</td>
</tr>
<tr>
<td><strong>Felonious Assault</strong></td>
<td>Additional 10% of the pilot’s death benefit amount to a maximum of $25,000.</td>
<td>Insured Person suffers a loss as a result of a felonious assault while acting on behalf of the Company.</td>
</tr>
<tr>
<td><strong>Hospital Confinement</strong></td>
<td>An additional benefit equal to the lesser of 2% of the Insured Person’s death benefit amount or $3,000/month up to a maximum of 12 months per period of hospital confinement. Benefit payable from 1st day of confinement pro-rated daily.</td>
<td>After 7 consecutive days of hospital confinement due to a covered injury.</td>
</tr>
<tr>
<td><strong>Psychological Therapy</strong></td>
<td>Usual and customary cost of therapy up to the lesser of 5% of the Insured Person’s death benefit amount or $5,000/covered accident.</td>
<td>Insured Person requires medically necessary psychological therapy provided under the care or supervision of a physician as a result of a covered injury.</td>
</tr>
<tr>
<td><strong>Reasonable Accommodation</strong></td>
<td>Up to $5,000 per covered accident payable to the Company for pre-approved work site accommodations within 12 months of covered accident.</td>
<td>Pilot suffers a loss due to a covered injury and work site changes are required in returning the insured pilot to work.</td>
</tr>
<tr>
<td><strong>Reconstructive Surgery</strong></td>
<td>Usual and customary costs up to 10% of the Insured Person’s death benefit amount, lifetime maximum of $23,500.</td>
<td>Physician determines that reconstructive or cosmetic surgery is necessary as a result of a covered accident when the Insured Person suffers critical burns.</td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
<td>Reimbursement of reasonable and necessary expenses up to a maximum of $10,000/covered accident.</td>
<td>Insured Person incurs expenses for medically necessary rehabilitative training within two years after a covered accident that results in a covered dismemberment or paralysis.</td>
</tr>
</tbody>
</table>
### Additional Optional AD&D Benefits

<table>
<thead>
<tr>
<th>This Additional Benefit...</th>
<th>Pays...</th>
<th>When...</th>
</tr>
</thead>
</table>
| **Seat Belt and Air Bag** | 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 $35,250. | Seat belt: Insured Person suffers loss of life as a result of covered bodily injury from an automobile accident in which use of an original factory installed, properly fastened seat belt is documented. For a covered child, use of a properly installed and fastened child restraint device must be documented.  
Air bag: Insured Person suffers loss of life as a result of a covered bodily injury from an automobile accident and a seat belt benefit is payable and Insured Person is positioned in a seat protected by a properly functioning, original factory installed air bag that inflates on impact.  
No benefit is payable if the vehicle is used in race, speed or endurance test or for acrobatic or stunt driving. |
| **Tuition Benefit – Insured Dependent Children** | Lesser of 5% of pilot or covered spouse’s death benefit amount or $10,000/year for up to 4 consecutive years for each covered dependent child. | Covered child is in 12th or higher grade and continues as a full-time student or enrolls within 1 year of a covered accident at an accredited institution. Benefit payable upon receipt of proof of enrollment for that term. If no covered children under age 23 eligible for the benefit within 1 year of covered accident, pays $2,500 to designated beneficiary. |
| **Tuition Benefit – Insured Spouse** | Up to $5,000/year for a maximum of 4 consecutive years if surviving covered spouse enrolls as a student in an accredited institution within 3 years of insured spouse’s death. | Covered spouse provides proof of enrollment for that term in an accredited institution. |
| **Family Income** | 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 injury. |
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 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) Where the covered loss is suffered within one year after the date of the covered accident.

**Travel Assistance Services**

Travel Assistance Services are only provided through Travel Guard® and only while the Insured Person is traveling 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, 1-800-626-2427
- To call collect from anywhere outside the United States and Canada, contact an AT&T International Operator to place your call to Houston at 715-267-2525

* Applicable only if you have Pilot & Dependent(s) 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.
Optional Accidental Death and Dismemberment (AD&D) Plan

January 2013

Travel Assistance Services (Travel Guard®)

<table>
<thead>
<tr>
<th>This Additional Benefit...</th>
<th>Applies when...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel Medical Emergency Services</td>
<td>Insured Person requires assistance to secure the availability of the services of a local physician and arrange hospital confinement.</td>
</tr>
<tr>
<td>Emergency Cash</td>
<td>Insured Person is caught in an emergency and needs cash. In coordination with insured's finances, provides cash through banks, consulates, hotels, and Western Union.</td>
</tr>
<tr>
<td>General Assistance</td>
<td>Information is needed on transmission and retention of urgent messages, translations and communication during emergencies, advice on contacting and using services available from consulates, government agencies, translators, and other service providers that can help with travel-related problems.</td>
</tr>
<tr>
<td>Pre-departure Services</td>
<td>Insured Person needs information on immunization requirements, medical exams and treatments, passport and visa requirements, weather, and travel hazards.</td>
</tr>
<tr>
<td>Lost Baggage/Passport</td>
<td>Insured Person whose baggage has been lost or delayed by a carrier and who needs assistance. Will provide advice regarding how to recover lost or delayed luggage. Insured Person loses passport, service notifies the appropriate authorities of lost passport and provides directions for replacement.</td>
</tr>
<tr>
<td>Insurance Coordination</td>
<td>Insured Person needs assistance with the completion of insurance and medical claim forms or verification of that person's insurance coverage.</td>
</tr>
<tr>
<td>Legal Assistance</td>
<td>Insured Person is in need of legal assistance. Can arrange help from local attorney, embassies, and consulates. If Insured Person is arrested or in danger of being arrested, the service can provide that person with the name of an attorney who can provide representation.</td>
</tr>
<tr>
<td>Travel Agency</td>
<td>Insured Person needs to replace lost or stolen airline ticket by arranging payment through that person's credit card. Hotel reservations can be arranged.</td>
</tr>
<tr>
<td>Evacuation and Repatriation</td>
<td>Covered Injury or Emergency Sickness occurs while an Insured Person is traveling more than 100 miles from their Primary Home and physician orders services. Travel Guard® must make all arrangements and must authorize all expenses in advance for benefit to be payable. Repatriation (return of remains) benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law. Primary Home is country of residence before expatriation. Policy exclusions do not apply to the Emergency Evacuation benefit. Sickness exclusion does not apply to the Repatriation benefit. Reasonable expenses for emergency evacuation/repatriation, return of children/companion to Primary Home, visit of family member/friend to Insured that is alone and hospitalized.</td>
</tr>
</tbody>
</table>

Optional AD&D benefits are not paid for losses having to do with:

- Sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning.
- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
- Declared or undeclared war or an act of declared or undeclared war either within the geographical limits, territorial waters or airspace above the United States.
• Loss caused by, contributed to or resulting from injury sustained while serving in the armed forces of any country (excluding service in the National Guard or a Reserve Unit that does not exceed 60 days).

Filing a Claim

For information on filing claims, refer to “Basic and Optional Accidental Death & Dismemberment (AD&D)” on page 1-32.

When Coverage Ends

Your coverage ends on the earliest of:

• The day you cease to be in a class of pilots 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, this 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 permanent full-time employee of a participating employer and participates in the Optional AD&D Plan, you may be eligible for coverage as a dependent. Contact Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area, within 31 days of the end of your coverage. Refer to the “Rules Applicable to All Insurance Plans” on page L-2 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 the FedEx Benefits Enrollment Website.” It is your responsibility to ensure that payroll deductions end. If they do not end within two pay periods, notify Pilot Benefits Administration, 1-866-795-6353 or 1-901-434-6353 in the Memphis area. There is a three-month time limit for requesting refunds of Optional AD&D Insurance payroll-deducted overpayments due to cancellation of coverage.

Option to Purchase Individual Optional AD&D

When coverage ends under Optional AD&D, an individual AD&D policy is available prior to age 80. Coverage begins upon receipt of premium and application within 31 days after coverage ends under Optional AD&D. The amount of insurance converted cannot exceed $250,000 and not be less than $100,000.

Reenrolling in the Plan

Reenrollment in the Optional AD&D Plan does not require Evidence of Insurability. 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 or 1-901-434-6353 in the Memphis area.
Survivor’s Income Benefit (SIB) Plan

Effective January 1, 2007, the Survivor’s Income Benefit (SIB) was eliminated as part of the Collective Bargaining Agreement between Federal Express Corporation and the Air Line Pilots Association, International, effective October 30, 2006. The terms and conditions of the Survivor’s Income Benefit provided by the Federal Express Corporation Survivor Income Benefit Plan (the “FedEx SIB”), as described in the FedEx SIB policy and the 2004 Pilot Benefit Book, shall continue with respect to pilots who died prior to January 1, 2007. Pilots who die on or after January 1, 2007, shall not be covered by the FedEx SIB.
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 the Business Travel Accident Plan. Company aircraft is defined as an aircraft owned, rented, chartered or leased by the Company. The Business Travel Accident Plan is insured by National Union Fire Insurance Company.

Eligibility

Pilot Eligibility


Civil Reserve Air Fleet (CRAF) Mission Coverage

Pilots continue to be eligible for coverage:

• When performing Civil Reserve Air Fleet (CRAF) missions or
• For a covered injury suffered by an Insured Person due to a terrorist act worldwide

Pursuant to the Letter of Agreement between the Company and the Association dated March 7, 2003, 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.

CRAF mission coverage is provided by National Union Fire Insurance Company.

Dependent Eligibility

The Business Travel Accident Plan covers your spouse and dependent children who are traveling with you on or in conjunction with your business trip, or a trip for the purpose of your relocation, or on a Company aircraft.

If your spouse is employed by FedEx Express or another FedEx Company that is a participating employer in this Plan, he or she will be covered as a dependent when accompanying you on Company business provided the spouse’s trip is authorized and/or paid in whole or part by the employer.

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.

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.

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.

The maximum total claims amount paid for any one of the following accidents, or any combination that occur during the same accident, will be $50 million:

- Aircraft accident
- War Risk Accident
- On Premises Violent Crime Accident
- On Premises Bomb Scare Accident
- On Premises Terrorism Accident

Should the total claims amount paid for any one of the referenced accidents, or any combination that occur during the same accident, exceed the maximum, then $50 million will be paid to the beneficiaries of the Insured Persons on a proportionate basis.

In the event of a loss resulting from an accident not listed above, no maximum aggregate will apply.

References made to benefit amount for all benefits listed in the Business Travel Accident Plan apply to the percentage of death benefits payable to you or your eligible dependents as stated above.

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:

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Percentage of Death Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of both hands, both arms, both legs, both feet, both eyes, or any combination</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of speech and hearing in both ears</td>
<td></td>
</tr>
<tr>
<td>Loss of one arm or one leg</td>
<td>70%</td>
</tr>
<tr>
<td>Loss of speech, hearing in both ears, one hand, one foot, or entire sight in one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Loss of thumb and index finger of the same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>
Loss is defined as:

- Loss of an arm or leg – Actual and complete severance through 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 in an eye – Irrecoverable loss of the entire sight in that eye.
- Loss of the thumb and index finger – Actual and complete severance through or above the joint closest to 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.

If an Insured Person as a result of the same covered accident sustains more than one Loss, only one amount, the largest, will be paid. In no event will the benefits payable under this provision due to the same covered accident exceed the Insured Person’s applicable benefit amount.

**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.

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Percentage of Death Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quadriplegia (total paralysis of both upper and both lower limbs)</td>
<td>100%</td>
</tr>
<tr>
<td>Triplegia (total paralysis of three limbs)</td>
<td>75%</td>
</tr>
<tr>
<td>Paraplegia (total paralysis of both lower limbs)</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia (total paralysis of upper and lower limbs on same side of body)</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia (total paralysis of one limb)</td>
<td>25%</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Description</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coma</strong></td>
<td>1% of the Insured Person’s benefit amount each month after the first 30 days of a coma; maximum 100 months. If death from this covered accident results within the first 365 days, any amount paid under this provision reduces any death benefit payable.</td>
<td>Insured Person sustains a covered injury that results in a coma within 30 days of the covered accident and coma continues for 30 consecutive days.</td>
</tr>
<tr>
<td><strong>Emergency Evacuation/Repatriation</strong></td>
<td>Reasonable expenses for emergency evacuation/repatriation, return of children/companion to Primary Home, visit of family member/friend to Insured that is alone and hospitalized.</td>
<td>Covered Injury or Emergency Sickness occurs while an Insured Person is traveling more than 100 miles from their Primary Home and physician orders services. Travel Guard® must make all arrangements and must authorize all expenses in advance for benefits to be payable. Repatriation (return of remains) benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which the Insured Person is entitled to benefits under any Workers’ Compensation Act or similar law. Primary Home is country of residence before expatriation. Policy exclusions do not apply to the Emergency Evacuation benefit. Sickness exclusion does not apply to the Repatriation benefit.</td>
</tr>
<tr>
<td><strong>Violent Crime</strong></td>
<td>Additional 50% of death benefit amount</td>
<td>Insured Person suffers a loss due to any willful or unlawful use of force in connection with the commission of or attempt to commit a crime that results in a Covered Injury to the Insured Person.</td>
</tr>
<tr>
<td><strong>50% Gross Up for Foreign Payments</strong></td>
<td>Up to additional 50% of benefit amount</td>
<td>The Principal Sum Benefit amount may be increased up to an additional 50% in the event a penalty tax or surcharge would apply in the country where payment of such Principal Sum Benefit amount is to be rendered only because such payment would be made either by the Company or the Policyholder as Trustee for the Insured in accordance with the Beneficiary Provision of this policy as it applies to foreign pilots. The amount of the increased payment will be in direct proportion to the amount of any such penalty but in no event will the Principal Sum payable to the Claimant be more than $1,125,000.</td>
</tr>
<tr>
<td><strong>Psychological Therapy</strong></td>
<td>Usual and customary cost of therapy up to the lesser of 5% of the Insured Person’s death benefit amount or $5,000/covered accident</td>
<td>Insured Person requires medically necessary psychological therapy provided under the care or supervision of a physician as a result of a covered injury.</td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
<td>Reimbursement of reasonable and necessary expenses up 20% of the death benefit amount subject to a minimum of $1,000 and up to a maximum of $10,000/covered accident.</td>
<td>Insured Person incurs expenses for medically necessary rehabilitative training within two years after a covered accident that results in a covered dismemberment or paralysis.</td>
</tr>
</tbody>
</table>
Additional Business Travel Accident Insurance Benefits

<table>
<thead>
<tr>
<th>This Additional Benefit...</th>
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<th>When...</th>
</tr>
</thead>
</table>
| Seat Belt and Air Bag     | 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: Insured Person suffers loss of life as a result of covered bodily injury from an automobile accident in which use of an original factory installed, properly fastened seat belt is documented. For a covered child, use of a properly installed and fastened child restraint device must be documented.  
Air bag: Insured Person suffers loss of life as a result of a covered bodily injury from an automobile accident and a seat belt benefit is payable and Insured Person is positioned in a seat protected by a properly functioning, original factory installed air bag that inflates on impact.  
No benefit is payable if the vehicle is used in race, speed or endurance test or for acrobatic or stunt driving. |

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.

Travel Assistance Services

Travel Assistance Services are only provided through Travel Guard® and only while the Insured Person is traveling 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, 1-800-626-2427
- To call collect from anywhere outside the United States and Canada, contact an AT&T International Operator to place your call to Houston at 715-267-2525

Travel Assistance Services (Travel Guard®)

<table>
<thead>
<tr>
<th>This Additional Benefit...</th>
<th>Applies When...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel Medical Emergency Services</td>
<td>Insured Person requires assistance to secure the availability of the services of a local physician and arrange hospital confinement.</td>
</tr>
<tr>
<td>Emergency Cash</td>
<td>Insured Person is caught in an emergency and needs cash. In coordination with insured’s finances, provides cash through banks, consulates, hotels, and Western Union.</td>
</tr>
<tr>
<td>General Assistance</td>
<td>Information is needed on transmission and retention of urgent messages, translations and communication during emergencies, advice on contacting and using services available from consulates, government agencies, translators, and other service providers that can help with travel-related problems.</td>
</tr>
</tbody>
</table>
Business Travel Accident Plan

### Travel Assistance Services (Travel Guard®)

<table>
<thead>
<tr>
<th>This Additional Benefit...</th>
<th>Applies When...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-departure Services</td>
<td>Insured Person needs information on immunization requirements, medical exams and treatments, passport and visa requirements, weather, and travel hazards.</td>
</tr>
<tr>
<td>Lost Baggage/Passport</td>
<td>Insured Person whose baggage has been lost or delayed by a carrier and who needs assistance. Will provide advice regarding how to recover lost or delayed luggage. Insured Person loses passport, service notifies the appropriate authorities of lost passport and provides directions for replacement.</td>
</tr>
<tr>
<td>Insurance Coordination</td>
<td>Insured Person needs assistance with the completion of insurance and medical claim forms or verification of that person’s insurance coverage.</td>
</tr>
<tr>
<td>Legal Assistance</td>
<td>Insured Person is in need of legal assistance. Can arrange help from local attorney, embassies, and consulates. If Insured Person is arrested or in danger of being arrested, the service can provide that person with the name of an attorney who can provide representation.</td>
</tr>
<tr>
<td>Travel Agency</td>
<td>Insured Person needs to replace lost or stolen airline ticket by arranging payment through that person’s credit card. Hotel reservations can be arranged.</td>
</tr>
<tr>
<td>Evacuation and Repatriation</td>
<td>Covered Injury or Emergency Sickness occurs while an Insured Person is traveling more than 100 miles from their Primary Home and physician orders services. Travel Guard® must make all arrangements and must authorize all expenses in advance for benefit to be payable. Repatriation (return of remains) benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which the Insured Person is entitled to benefits under any Workers’ Compensation Act or similar law. Primary Home is country of residence before expatriation. Policy exclusions do not apply to the Emergency Evacuation benefit. Sickness exclusion does not apply to the Repatriation benefit. Reasonable expenses for emergency evacuation/repatriation, return of children/companion to Primary Home, visit of family member/friend to Insured that is alone and hospitalized.</td>
</tr>
</tbody>
</table>

### Other Provisions

Business Travel Accident benefit pays if the Insured Person suffers a loss due to any of the following:

- Covered accidental exposure to the elements
- Death as the result of riding in a conveyance that is forced to land, is stranded, sinks or is wrecked as a result of a covered accident and the body is not recovered within one year of the covered accident
- Covered injury suffered while a passenger on a conveyance which is under control of a hijacker or skyjacker
- Covered injury suffered on Company premises due to bomb scare, search or explosion
- Covered injury suffered by Insured Person due to terrorist act worldwide

### What’s Not Covered – Exclusions

You are not covered if your death or dismemberment is directly or indirectly caused by:

- Sickness, disease or infections of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning
- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury

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Pilot Benefit Book
• Declared or undeclared war or an act of declared or undeclared war either within
the geographical limits, territorial waters or airspace above the United States

• Loss caused by, contributed to or resulting from injury or death sustained while
serving in the armed forces of any country

**When Coverage Ends**

Your coverage ends on the earliest of:

• The day you cease to be in a class of pilots 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

**Filing a Claim**

For information on filing claims, refer to “Business Travel Accident” on page I-32.

For any questions, contact Pilot Benefits Administration at 1-866-795-6353 or
1-901-434-6353 in the Memphis area.
Retirement

Your FedEx Express retirement benefits provide a solid foundation for your retirement income. Plus, features like Vanguard’s VOICE® Network make staying on top of your savings easy.

The information you need... begins on page...
FedEx Retirement Plans R-2
Pension Plan and Non-Qualified Plans R-4
Pilots’ Retirement Savings Plan (PRSP) R-48
Pilots’ Money Purchase Pension Plan (PMPPP) R-80

For information on retiree health coverage, refer to the “Health Care – Medical, Prescription Drug, Dental and Vision Benefits,” page H-1, and “What to Do When” chapter under “Continuing Coverage After Retirement” beginning on page W-6.
FedEx Retirement Plans

The FedEx retirement programs help you work toward financial security in your retirement all 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), the Federal Express Corporation Non-Qualified Section 415 Excess Pension Plan for Pilots (the 415 Limit Plan), and the Federal Express Corporation Pilots’ Money Purchase Pension Plan (PMPPP). Then, since personal savings are necessary to help you provide for the kind of retirement you want, FedEx also provides a means by which you can personally save for your retirement through the Pilots’ Retirement Savings Plan (PRSP). The Pilots’ Retirement Savings Plan includes the Pre-tax/401(k), Employer Match, Catch-Up, After-tax and Sick Bank Accounts. FedEx pays half the cost (you pay the other half) for your Social Security benefits, see “Social Security – A Reminder,” page R-25 for more information.

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 (you earned) while you were covered under their 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 1-866-303-0556. 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 Vested 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.

Qualified vs. Non-Qualified Plans

A “qualified” plan, the most secure kind of pension 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, the Pilots’ Retirement Savings Plan and the Pilots’ Money Purchase Pension Plan are all forms of qualified plans.

“Non-Qualified” plans offer less protection than 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 of 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 Express.

Upon termination of employment, the Non-Qualified benefits are considered “definitely determinable” and FICA taxes are due and payable by both you and the Company 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, the PMPPP 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, PMPPP 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, PMPPP 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 ERISA or other Federal applicable law.
Pension Plan and Non-Qualified Plans

NOTE: References to FedEx or Company include all FedEx companies participating in the Pension Plan.

Federal Express Corporation is a Participating Employer in the FedEx Corporation Employees’ Pension Plan (the Pension Plan (this is a qualified defined benefit plan)), and sponsors two non-qualified plans (collectively the Non-Qualified Plans)—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) 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) 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 of $260,000 less the benefit paid from the 415 Limit Plan.

The compensation limit and the Section 415 benefit limit are subject to indexing annually based on increases in the cost of living.

### Participating Employers

Eligible employees include any U.S.-based or domestic employees of the Participating Employers listed below:

<table>
<thead>
<tr>
<th>FedEx Corporation Employees’ Pension Plan Participating Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>FedEx Corporation</td>
</tr>
<tr>
<td>Federal Express Corporation (FedEx Express)</td>
</tr>
<tr>
<td>FedEx Ground Package System, Inc. (excluding employees classified as package handlers)</td>
</tr>
<tr>
<td>FedEx Corporate Services, Inc.</td>
</tr>
<tr>
<td>FedEx Trade Networks, Inc.</td>
</tr>
<tr>
<td>FedEx Trade Networks Transport &amp; Brokerage, Inc.</td>
</tr>
<tr>
<td>FedEx Trade Networks Trade Services, Inc.</td>
</tr>
<tr>
<td>World Tariff, Limited</td>
</tr>
<tr>
<td>FedEx Freight Corporation</td>
</tr>
<tr>
<td>FedEx Custom Critical, Inc.</td>
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<tr>
<td>FedEx SupplyChain Systems, Inc.</td>
</tr>
<tr>
<td>Federal Express Virgin Islands, Inc.</td>
</tr>
<tr>
<td>FedEx Truckload Brokerage, Inc.</td>
</tr>
<tr>
<td>FedEx TechConnect, Inc.</td>
</tr>
<tr>
<td>FedEx SmartPost, Inc. (excluding employees classified as Parcel Assistants)</td>
</tr>
</tbody>
</table>

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. Refer to definition in “Hours of Service,” page R-7. 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 which is not a Participating Employer, your applicable service during your previous employment with that Controlled Group Member will be combined with your service with your Participating Employer to determine your eligibility for the Pension Plan. (For a list of Controlled Group Members, see “Scope and Guidelines,” page I-1.)

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 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 with regard 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 and you do not incur a break in service, 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.

- If you had not met all eligibility requirements prior to your termination date and you incur a break in service\(^*\), your hours of service prior to your termination are not considered and you are eligible on the first of the month coincident with or next following the date you meet all eligibility requirements.

\(^*\)Break in service is a Plan Year during which you have not been credited with more than 500 hours of service.

Non-Qualified Plans

If you are employed 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 Plan 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 qualified Pension Plan’s Participating Employers, which include FedEx Express, pay the full cost of the 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. Refer to “Making Application for Benefits and When Payments Commence,” page R-22.

**Normal Retirement Date**

Your normal retirement date is the first day of the month coincident with or next following the date on which you attain age 60, after:

- Completing five years of credited service for vesting, or
- Reaching your fifth anniversary of plan participation.

If you retire on or after your normal retirement date, you are eligible to receive an unreduced monthly benefit.

**Early Retirement Date**

Your early retirement date precedes the normal retirement date. You may decide to retire any time between the ages of 55 and 60, after you become vested. For information on vesting, refer to “Credited Service for Vesting,” page R-9.

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 60 after completing five years of credited service for vesting. If you retire early, you are eligible to receive a reduced monthly benefit. (See “Early Retirement Benefit,” page R-17.)

**NOTE:** Any early retirement reduction (refer to “Early Retirement Benefit Calculation” on page R-17) 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 70½, 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 70½. 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...
Deferred Benefit Commencement

You may retire or terminate and elect to delay the commencement of your pension benefits to any date up to age 70½. If you do not commence prior to age 70½, 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, if any, will be actuarially increased if you terminate employment with all Controlled Group Members and defer your commencement past your normal retirement date.

Working Past Your Normal Retirement Date (Age 60)

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 which apply to your participation in the Pension Plan upon your reemployment by a participating employer.

Suspension of Pension Benefit Rules

A retiree who is reemployed by any FedEx company must work less than 70 hours per month in order to collect uninterrupted monthly pension benefits. Therefore, FedEx will monitor your monthly hours, which are based upon the total payroll period ending date hours. For any month (as defined by the payroll period ending dates) that you work 70 or more hours, you will be notified that the next available pension payment will be stopped.

NOTE: Please keep in mind that you must work less than 70 hours a month (based on payroll period ending dates) in order to prevent suspension of a subsequent monthly pension payment. There could be four or five payroll period ending dates in a month for an hourly employee.

Contact the FedEx Retirement Service Center, 1-866-303-0556, for further information if you are considering reemployment after retirement.

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. Refer to “Making Application for Benefits and When Payments Commence,” page R-22.

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 — Hours of service include each hour that you are paid or entitled to pay by any Controlled Group Member, including time off for vacation, holidays, paid medical absences, jury duty or military duty as required by law. Hours associated
with non-taxable amounts paid from a Pilot’s Occupational Illness/Injury Sick Bank shall be counted as hours of service for eligibility, vesting and benefit accrual.

This does not include hours you are paid or entitled to pay just to comply with:

- Unemployment compensation laws,
- Disability insurance laws,
- Payment made for medical expense reimbursement, or
- Service during hours of family medical leaves (except the first 501 hours, which may be used to prevent a one-year break in service). See “Breaks in Service” for more information.

Hours credited by the Payroll Department are used in determining credited service while actively at work. The Payroll Department credits pilots with 95 hours per pay period. Pilots receive credited hours of service for periods of disability, subject to the provisions discussed below. Hours of credited service for disability leave periods are calculated as follows: Days of Leave ÷ 7 Days x 45 Hours = Total Credited Hours per Leave.

**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 Tigers). You may accrue up to a **maximum of 25 years** of credited service for benefit accrual.

### Credited Years of Service During a 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.
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.

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. (For a description of benefits payable in the event of your death, see “Survivor Benefits,” page R-24.

Contact the FedEx Retirement Service Center at 1-866-303-0556 for information on crediting service hours during a military leave.

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 percent 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 also repay the distribution with interest and recapture your prior benefit accrual service. 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.”

For more information on vesting, see “Credited Service for Vesting,” page R-9.

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, as defined on page R-7
- Years of vesting service, as defined on page R-9
- Eligible Earnings (also referred to as Compensation)
- Average Earnings
- Average Annual Benefit Amount (see Appendix 1 on page R-27)
- Age/Service Multiplier
- Additional Benefit Percentage

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 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 and 2007
- 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
- PMPPP contributions
- Excess Life Premiums
- Earnings above the IRS compensation limit (earnings above the IRS compensation limit are covered under the Compensation Limit Plan)
- 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

**Average Earnings**

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 Qualified Pension Plan are subject to the limit under Code Section 401(a)(17) (the compensation limit).

See Appendix 1 of this section, page R-27, for other important definitions.

**Maximum Compensation Limit [Section 401(a)(17)]**

The IRS limits the maximum compensation that can be used to determine your benefits under the Qualified Pension Plan. The limit may be indexed by the Secretary of the Treasury based on increases in the cost of living.
For calendar year 2002 and 2003, the 401(a)(17) limit is $200,000. This $200,000 limit is applied retroactively to all prior calendar year eligible earnings for any employee who terminates or retires after June 1, 2002.

If you were previously employed by a FedEx Corporation Controlled Group Member (for a list of Controlled Group Members, see “Scope and Guidelines,” page I-1) which is not a Participating Employer in the Pension Plan, your applicable eligible earnings with that Controlled Group Member will be combined with the eligible earnings of the Participating Employer to determine Pension Plan limits.

### 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 on page R-44. 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 at FedEx.

#### 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 Tigers.

**Example of FedEx Only Service**

Let’s assume you are a pilot who has 25 years of credited service for vesting as of May 31, 2007, all with FedEx. On June 1, 1999, you were 48 years old with 13 years of credited service for vesting. Using the chart in Appendix 2 on page R-44, 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. 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. Total credited service for benefit accrual at FedEx is limited to 25 years.
Example of Flying Tiger and FedEx Service

Now, let’s assume you are a pilot who has 25 years of credited service for vesting as of May 31, 2011, but 3 of those years are with Flying Tigers. And, as with the earlier example, you were 48 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 Tigers—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 22 —your total years of credited service with FedEx. 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 12. Total credited service for benefit accrual at FedEx is limited to 25 years.

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 on page R-45. 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 at FedEx.

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 Tigers.

Example of FedEx Only Service

Let’s assume you are a pilot who has 25 years of credited service for vesting as of May 31, 2011, all with FedEx. On October 30, 2006, you were 55 years old with 20 years of credited service for vesting. Using the chart in Appendix 3 on page R-45, 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. 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 5. Total credited service for benefit accrual at FedEx is limited to 25 years.

Example of Flying Tiger and FedEx Service

Now, let’s assume you are a pilot who has 25 years of credited service for vesting as of May 31, 2011, but 3 of those years are with Flying Tigers. And, as with the earlier example, you were 55 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 Tigers—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 22 —your total years of credited service with FedEx. 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 5. Total credited service for benefit accrual at FedEx is limited to 25 years.

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.

<table>
<thead>
<tr>
<th>Age</th>
<th>2011 Maximum Benefits Under Section 415 (b)</th>
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<tr>
<td>65</td>
<td>$195,000</td>
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<tr>
<td>64</td>
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<td>56</td>
<td>$126,048</td>
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<td>55</td>
<td>$117,755</td>
</tr>
</tbody>
</table>

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, page R-44)

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 (as described on page R-12) 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 (as described on page R-13) 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 on page R-27.)

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,
  - (ii) **2% times years** of credited service for benefit accrual after June 1, 1999,
  - (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 of June 1, 2011. Your age as of June 1, 1999, was 48. Let's also assume you have 25 years of credited service—13 years as of June 1, 1999, and 12 years after June 1, 1999. Using the chart in Appendix 2 on page R-44, your Age/Service Multiplier would be 2.08%. Your age as of October 30, 2006, was 55 and you had 20 years of credited service as of October 30, 2006. Using the chart in Appendix 3 on page R-45, your Additional Benefit Percentage would be 0.03%. Using the chart in Appendix 4 on page R-46, your Average Non-Qualified Plan Eligible Earnings based on the highest five years is $231,000. This amount is used in Formulas 1 and 2. Using the chart in Appendix 5 on page R-47, your Average Annual Benefit Amount is $4,575. 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. \[.02 \times 25 \text{ (credited service for benefit accrual)} \times \$231,000 \text{ (Average Non-Qualified Plan Eligible Earnings)} = \$115,500.00 \text{ (total annual pension)}\]
2. \[\$115,500 \text{ (total annual pension)} \div 12 \text{ (months)} = \$9,625 \text{ (total monthly pension)}\]

**Formula 2:**

1. \[\{.0208 \text{ (Age/Service Multiplier)} \times 13 \text{ (credited service for benefit accrual as of June 1, 1999)}\} + \{.02 \times 12 \text{ (credited service for benefit accrual after June 1, 1999)}\} + \{.0003 \text{ (Additional Benefit Percentage)} \times 20 \text{ (credited service for benefit accrual as of October 30, 2006)}\} \times \$231,000 \text{ (Average Non-Qualified Plan Eligible Earnings)} = \$119,288.40 \text{ (total annual pension)}\]
2. \[\$119,288.40 \text{ (total annual pension)} \div 12 \text{ (months)} = \$9,940.70 \text{ (total monthly pension)}\]

**Formula 3:**

1. \[\$4,575 \text{ (Average Annual Benefit Amount)} \times \{\{.0208 \text{ (Age/Service Multiplier)} \times 13 \text{ (credited service for benefit accrual as of June 1, 1999)}\} + \{.02 \times 12 \text{ (credited service for benefit accrual after June 1, 1999)}\} + \{.0003 \text{ (Additional Benefit Percentage)} \times 20 \text{ (credited service for benefit accrual as of October 30, 2006)}\} \div .02 = \$118,126.50 \text{ (total annual pension)}\]
2. \[\$118,126.50 \text{ (total annual pension)} \div 12 \text{ (months)} = \$9,843.88 \text{ (total monthly pension)}\]
Because Formula 2 provides a larger benefit than Formula 1 or Formula 3, your total monthly benefit would be $9,940.70 a month, payable for your lifetime under the Straight Life Annuity payment option. See page R-21.

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 $9,940.70 would be paid from both the Pension Plan and the Compensation Limit Plan. When the Average Pension Plan Eligible Earnings of $223,000 (based on Pension Plan Eligible Earnings limited by the IRS compensation limit, see Appendix 4 on page R-46) is used in the benefit calculation, the results are as follows:

**Formula 1:**

1. \(0.02 \times 25\) (credited service for benefit accrual) \(\times\) $223,000 (Average Pension Plan Eligible Earnings) = $111,500 (annual pension)
2. \(\frac{111,500}{12}\) (monthly pension) = $9,291.67

**Formula 2:**

1. \(\left\{0.0208 \text{ (Age/Service Multiplier)} \times 13\right\} + \left\{0.02 \times 12\right\} + \left\{0.0003 \text{ (Additional Benefit Percentage)} \times 20\right\} \times $223,000 = \$115,157.20\) (annual pension)
2. \(\frac{115,157.20}{12}\) (monthly pension) = $9,596.43

**Formula 3:**

1. \(\frac{4,575 \times \left\{0.0208 \text{ (Age/Service Multiplier)} \times 13\right\} + \left\{0.02 \times 12\right\} + \left\{0.0003 \text{ (Additional Benefit Percentage)} \times 20\right\} \times $223,000}{0.02} = \$118,126.50\) (total annual pension)
2. \(\frac{118,126.50}{12}\) (total monthly pension) = $9,843.88

Because Formula 3 provides a larger benefit than Formula 1 or Formula 2, your monthly benefit from the Pension Plan would be $9,843.88, 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 $9,940.70 (from Calculation 1) and the benefit from the Pension Plan of $9,843.88 (from Calculation 2) is $96.82 ($9,940.70 - $9,843.88 = $96.82), 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 $9,843.88 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 $9,843.88
- 415 Limit Plan monthly benefit $0.00
- Compensation Limit Plan monthly benefit $96.82
- Total monthly pension benefit $9,940.70
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 your normal retirement date, your normal retirement monthly benefit is reduced by .25% (.0025 or 1/12th of 3%) for each month your Benefit Commencement Date precedes your Normal Retirement Date. This reduction is made because your payments start sooner than they would at normal retirement date (age 60) and would therefore continue for a longer period of time.

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, 2011, at age 55. Your age as of June 1, 1999, was 43. Let’s also assume you have 25 years of credited service—13 years as of June 1, 1999, and 12 years after June 1, 1999. Using the chart in Appendix 2, your Age/Service Multiplier would be 2.08%. Your age as of October 30, 2006, was 50 and you had 20 years of credited service for benefit accrual as of October 30, 2006. Using the chart in Appendix 3 on page R-45, your Additional Benefit Percentage would be 0.02%. Using the chart in Appendix 4 on page R-46, your Average Non-Qualified Plan Eligible Earnings based on the highest five years is $231,000. This amount is used in Formulas 1 and 2. Using the chart in Appendix 5 on page R-47, your Average Annual Benefit Amount is $4,575. 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) \(0.02 \times 25 \text{ (credited service for benefit accrual)} \times \$231,000 \text{ (Average Non-Qualified Plan Eligible Earnings)} = \$115,500 \text{ (total annual pension)}\)
(2) \(\frac{\$115,500 \text{ (total annual pension)}}{12 \text{ (months)}} = \$9,625 \text{ (total monthly pension payable at age 60)}\)

Formula 2:
(1) \([0.0208 \text{ (Age/Service Multiplier)} \times 13 \text{ (credited service for benefit accrual as of June 1, 1999)}] + [0.02 \times 12 \text{ (credited service for benefit accrual after June 1, 1999)}] + [0.0002 \text{ (Additional Benefit Percentage)} \times 20 \text{ (credited service for benefit accrual as of October 30, 2006)}] \times \$231,000 \text{ (Average Non-Qualified Plan Eligible Earnings)} = \$118,826.40 \text{ (total annual pension)}\)
(2) \(\frac{\$118,826.40 \text{ (total annual pension)}}{12 \text{ (months)}} = \$9,902.20 \text{ (total monthly pension payable at age 60)}\)

Formula 3:
(1) \(\$4,575 \text{ (Average Annual Benefit Amount)} \times [0.0208 \text{ (Age/Service Multiplier)} \times 13 \text{ (credited service for benefit accrual as of June 1, 1999)}] + [0.02 \times 12 \text{ (credited service for benefit accrual after June 1, 1999)}] + [0.0002 \text{ (Additional Benefit Percentage)} \times 20 \text{ (credited service for benefit accrual as of October 30, 2006)}] = \$118,826.40 \text{ (total annual pension)}\)

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.)
(1) 1 - [.0025 x 60 (number of months payments begin before age 60)] = .8500
(2) .8500 x $9,902.20 (total monthly benefit payable at age 60) = $8,416.87 (reduced
monthly pension payable as a Straight Life Annuity at early retirement age 55)

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)] = .8500
(2) .8500 x $9,902.20 (total monthly benefit payable at age 60) = $8,416.87 (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.

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 $8,162.87 would be paid from both the Pension Plan and the Compensation Limit Plan. When the Average Pension Plan Eligible Earnings of $223,000 (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 $223,000 (Average Pension Plan
Eligible Earnings) = $111,500 (annual pension)
(2) $111,500 (annual pension) ÷ 12 (months) = $9,291.67 (monthly pension payable at
age 60)

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)]
+ [.0002 (Additional Benefit Percentage) x 20 (credited service for benefit accrual
as of October 30, 2006)]} x $223,000 (Average Pension Plan Eligible Earnings) =
$114,711.20 (annual pension)
(2) $114,711.20 (annual pension) ÷ 12 (months) = $9,559.27 (monthly pension
payable at age 60)

Formula 3:
(1) $4,575 (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)] + [.0002 (Additional Benefit Percentage) x 20 (credited service for benefit accrual as of October 30, 2006)]} ÷
.02 = $117,669 (annual pension)
(2) $117,669 (annual pension) ÷ 12 (months) = $9,805.75 (monthly pension payable at
age 60)

Because Formula 3 provides a larger benefit than Formula 1 or Formula 2, your monthly normal retirement benefit under the Pension Plan would be $9,805.75 payable for your lifetime under the Straight Life Annuity payment option at age 60.

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)] = .8500
(2) .8500 x $9,805.75 (monthly benefit payable at age 60) = $8,334.89 (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 $8,416.87 (from Calculation 4) and the early benefit from the Pension Plan of $8,334.89 (from Calculation 5) is $81.98 ($8,416.87 - $8,334.89 = $81.98) 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 $8,416.87 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: $8,334.89
- 415 Limit Plan monthly benefit: $0.00
- Compensation Limit Plan monthly benefit: $81.98
- Total monthly pension benefit: $8,416.87

**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 at your normal retirement date (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 pension benefit is $1,000 or less, you are eligible to receive your benefit in a lump-sum payment. 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 PRISM. 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.

In order to request a retirement kit, you must contact the FedEx Retirement Service Center at 1-866-303-0556, 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 on page R-21.

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 retirement packet will include a Spousal Consent Waiver for Qualified Joint and Survivor Annuity and Consent to Non-Spouse Beneficiary.

### Spouse Definition

For purposes of the Pension Plan and Non-Qualified Plans, “spouse” shall have the same meaning as set forth in 1 United States Code Annotated Section 7 (1 U.S.C.A. § 7) (a person of the opposite sex who is a husband or a wife), and shall be deemed to
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.

- **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:

<table>
<thead>
<tr>
<th>Annuities</th>
<th>Your Age Is 60</th>
<th>Your Age Is 60</th>
<th>Your Age Is 60</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Your Survivor’s Age Is 60</td>
<td>Your Survivor’s Age Is 55</td>
<td>Your Survivor’s Age Is 50</td>
</tr>
<tr>
<td><strong>50% Joint and Survivor</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your monthly benefit</td>
<td>$9,080</td>
<td>$8,890</td>
<td>$8,720</td>
</tr>
<tr>
<td>Survivor’s monthly benefit</td>
<td>$4,540</td>
<td>$4,445</td>
<td>$4,360</td>
</tr>
<tr>
<td><strong>75% Joint and Survivor</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your monthly benefit</td>
<td>$8,680</td>
<td>$8,430</td>
<td>$8,190</td>
</tr>
<tr>
<td>Survivor’s monthly benefit</td>
<td>$6,510</td>
<td>$6,323</td>
<td>$6,143</td>
</tr>
<tr>
<td><strong>100% Joint and Survivor</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your monthly benefit</td>
<td>$8,320</td>
<td>$8,010</td>
<td>$7,730</td>
</tr>
<tr>
<td>Survivor’s monthly benefit</td>
<td>$8,320</td>
<td>$8,010</td>
<td>$7,730</td>
</tr>
</tbody>
</table>

**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 1-877-303-0556. Customer service representatives are available Monday – Friday from 8:00 a.m. to 5:00 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 at 1-866-303-0556, 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 70 ½ or older (refer to “Active Employees age 70 ½ 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; additionally, your retirement effective date must be entered in a timely manner into PRISM.

Your application for benefits, including any required notarized spousal waiver form, must be received in the FedEx Retirement Service Center on or before the Benefit Commencement Date. Otherwise, your Benefit Commencement Date will be the first of the month after the FedEx Retirement Service Center receives your completed application for benefits, including any required notarized spousal waiver form.

This application must be received in the FedEx Retirement Service Center on or before the Benefit Commencement Date. Otherwise, your benefit payment will be recalculated and will not begin until the first of the month next following receipt of the completed application in the FedEx Retirement Service Center. You will not receive a retroactive payment. 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 Benefit Commencement Date. In any case, you always have a minimum of 7 days beginning when you receive this kit until receipt of your first check in which to request a different form of payment.

For example, if your application for benefits is received on the first day of the month that benefit payments were to commence, benefit payments will begin as of the first of that month. However, if the application is received after the first day of the month that benefit payments were to commence, your Benefit Commencement Date will be the first day of the following month and you will not receive a retroactive payment.

An Application for Benefits and the selection of a specific form of payment is only valid if you are alive on your Benefit Commencement Date. (Refer to “Survivor Benefits.”)

NOTE: Your first monthly pension check cannot be processed until your retirement date is effective in PRISM. Based on your actual retirement date, when your application for benefits is received and when your retirement date is entered in PRISM, your first pension check could be delayed by several weeks.

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 normal retirement age 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. Upon your retirement, you will receive a retirement packet containing a W-4P form (for your qualified pension payment), a W-4 form (for your Non-Qualified pension payments, if applicable) and State Income Tax Withholding Election forms for your qualified benefit payment and Non-Qualified benefit payments, if applicable. If you do not complete and return the W-4P form and W-4 form (if applicable), the IRS requires automatic withholding of federal income tax as if you are married with three exemptions. If you do not complete and return the State Income Tax Withholding Election Form for your pension payment and you reside in a state which requires mandatory withholding from pension payments, state income tax will be withheld at a rate determined by the state in which you reside.
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 benefit payment option 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.

**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. Refer to the “What to Do When” chapter beginning on page W-1 for more information.
- 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 your credited service for benefit accrual and Average Earnings 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. The survivor does not receive retroactive benefit payments.

**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 QDRO Administration
Mercer
400 W. Market Street, Suite 700
Louisville, KY 40202-3346
1-888-598-7260 Toll Free
1-502-561-4572
1-502-561-8999 (fax)

You or your attorney may call 1-888-598-7260 to speak with a representative or request governing procedures and other documents, which are provided without charge. You may also request this information via email at QDRO@mercer.com.

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.

Steps for Requesting to Commence a Pension Benefit

(1) **Contact the FedEx Retirement Service Center, 1-866-303-0556 at least 30 days but no more than 90 days before your Benefit Commencement Date.** Retirement calculations are only valid up to 90 days.

(2) The FedEx Retirement Service Center will send a retirement packet to your home address that will include all required forms. Generally, you will receive your first payment about 3 weeks after your benefit commencement date. Refer to “Making Application for Benefits and When Payments Commence,” page R-22.

(3) **Complete and return** the forms and proof of age for yourself (and beneficiary, if applicable) to the FedEx Retirement Service Center on or before your Benefit Commencement Date.

Steps to Commence a Terminated Vested Benefit

(1) **Notify the FedEx Retirement Service Center, 1-866-303-0556 of any change in your home address as listed in PRISM.** The FedEx Retirement Service Center will send you a Report of Benefits no later than 120 days after the close of the Plan Year (May 31) in which your termination date is entered in PRISM.

(2) **If applicable, complete and return** the forms for receiving a lump-sum payment of $1,000 or less to the FedEx Retirement Service Center. If eligible for monthly benefits, keep the Report of Benefits with all other vital records and contact the FedEx Retirement Service Center **90 days before the desired Benefit Commencement Date** (commencing as early as age 55). Your benefit payment will commence on the first of the month coincident or next following the date you have met all plan application requirements and the FedEx Retirement Service Center receives all required forms. Refer to “Making Application for Benefits and When Payments Commence,” page R-22.
Steps to Commence a Pre-Retirement Death Benefit for a Survivor or Beneficiary

If you are eligible to commence an immediate Pre-Retirement Death Benefit:

1. The FedEx Retirement Service Center will send you the appropriate paperwork within three weeks after the death is reported.
2. Complete and return the forms and required documentation to the FedEx Retirement Service Center on or before your Benefit Commencement Date.

If you are eligible to commence a Pre-Retirement Death Benefit in the future:

1. The FedEx Retirement Service Center will send you the appropriate paperwork within 60 days of the earliest date you are eligible to commence a benefit.
2. Complete and return the forms and required documentation to the FedEx Retirement Service Center on or before your Benefit Commencement Date.


If you want to commence a Pre-Retirement Death Benefit on a date later than the earliest date possible, you (the survivor) should contact the FedEx Retirement Service Center, 1-866-303-0556, at least 30 days but no more than 90 days before your Benefit Commencement 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,” page I-17.
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), see page R-15. Your Annual Benefit Amount under the qualified 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:

<table>
<thead>
<tr>
<th>Before January 1, 2007</th>
<th>On or After January 1, 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAP</td>
<td>$.13</td>
</tr>
<tr>
<td>F/O</td>
<td>$.09</td>
</tr>
<tr>
<td>S/O</td>
<td>$.07</td>
</tr>
</tbody>
</table>

**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 on and After October 30, 2006

<table>
<thead>
<tr>
<th>Service</th>
<th>SCA CAP</th>
<th>FPS/TAA LCA CAP</th>
<th>F/O or Flex/PCA CAP</th>
<th>SCA S/O</th>
<th>Other S/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$36.00</td>
<td>$26.00</td>
<td>$16.00</td>
<td>$17.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>2</td>
<td>$38.00</td>
<td>$28.00</td>
<td>$18.00</td>
<td>$19.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>3</td>
<td>$40.00</td>
<td>$30.00</td>
<td>$20.00</td>
<td>$21.00</td>
<td>$16.00</td>
</tr>
<tr>
<td>4 or more</td>
<td>$42.00</td>
<td>$32.00</td>
<td>$22.00</td>
<td>$21.00</td>
<td>$16.00</td>
</tr>
</tbody>
</table>

### Override Amount Before October 30, 2006

<table>
<thead>
<tr>
<th>Service</th>
<th>CAP or F/O</th>
<th>S/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$16.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>2</td>
<td>$18.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>3</td>
<td>$20.00</td>
<td>$16.00</td>
</tr>
<tr>
<td>4</td>
<td>$22.00</td>
<td>$18.00</td>
</tr>
</tbody>
</table>

**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 the Corporation and were in an active pay status (or on military leave of absence) throughout the Amendable Period (June 1, 2004, to October 30, 2006) the following amounts will be added to your Annual Benefit Amount based on Seat and Craft as of November 1, 2006. For pilots retiring between November 1, 2006, and December 31, 2006, the annual benefit amount for calendar years 2006 and 2007 was included in their 2006 retirement calculation.

<table>
<thead>
<tr>
<th>For 2006 Calendar Year</th>
<th>Narrow Body</th>
<th>Wide Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAP</td>
<td>$250.00</td>
<td>$280.00</td>
</tr>
<tr>
<td>F/O</td>
<td>$150.00</td>
<td>$168.00</td>
</tr>
<tr>
<td>S/O</td>
<td>$ 70.00</td>
<td>$ 80.00</td>
</tr>
</tbody>
</table>
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, the following amount (limited to $52) will be added to your Annual Benefit Amount for calendar year 2011: 1% of your 2010 Annual Benefit Amount.

**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 on page R-45. 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 at FedEx.

**Average Annual Benefit Amount**

Average Annual Benefit Amount (an example is shown on 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:

**Hourly Benefit Multiplier**

<table>
<thead>
<tr>
<th>Craft</th>
<th>Seat</th>
<th>Year Group</th>
<th>Hourly Benefit Multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>12 or more</td>
<td>2.66</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>11</td>
<td>2.65</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>10 to 9</td>
<td>2.63</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>5 to 8</td>
<td>2.58</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>2 to 4</td>
<td>2.55</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>12 or more</td>
<td>2.26</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>1</td>
<td>2.25</td>
</tr>
<tr>
<td>Craft</td>
<td>Seat</td>
<td>Year Group</td>
<td>Hourly Benefit Multiplier</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>8 to 10</td>
<td>2.21</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>5 to 7</td>
<td>2.17</td>
</tr>
<tr>
<td>Wide Body</td>
<td>F/O</td>
<td>12 or more</td>
<td>1.88</td>
</tr>
<tr>
<td>Wide Body</td>
<td>F/O</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>1 to 4</td>
<td></td>
</tr>
<tr>
<td>Wide Body</td>
<td>F/O</td>
<td>2 to 10</td>
<td>1.42</td>
</tr>
<tr>
<td>Wide Body</td>
<td>F/O</td>
<td>12 or more</td>
<td></td>
</tr>
<tr>
<td>Narrow Body</td>
<td>F/O</td>
<td>6 to 11</td>
<td></td>
</tr>
<tr>
<td>Wide Body</td>
<td>S/O</td>
<td>12 or more</td>
<td></td>
</tr>
<tr>
<td>Wide Body</td>
<td>S/O</td>
<td>6 to 11</td>
<td></td>
</tr>
<tr>
<td>Narrow Body</td>
<td>F/O</td>
<td>2 to 5</td>
<td>1.00</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>S/O</td>
<td>12 or more</td>
<td></td>
</tr>
<tr>
<td>Narrow Body</td>
<td>S/O</td>
<td>3 to 11</td>
<td></td>
</tr>
<tr>
<td>Wide Body</td>
<td>S/O</td>
<td>2 to 5</td>
<td></td>
</tr>
<tr>
<td>Wide Body</td>
<td>F/O</td>
<td>1</td>
<td>0.67</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>F/O</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Narrow Body</td>
<td>S/O</td>
<td>1 to 2</td>
<td></td>
</tr>
</tbody>
</table>

Schedule of Hourly Benefit Multiplier

Effective 1/1/88 through 12/31/89

Craft Seat Year Group Hourly Benefit Multiplier

- Narrow Body
- Wide Body
- F/O
- S/O
- CAP
## Schedule of Hourly Benefit Multiplier

Effective 1/1/90 through 12/31/90

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Schedule of Hourly Benefit Multiplier

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### Schedule of Hourly Benefit Multiplier

Effective 1/1/2000 through 12/31/2000

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<td>Narrow Body</td>
<td>F/O</td>
<td>1 to 2</td>
<td></td>
</tr>
<tr>
<td>Narrow Body</td>
<td>F/O</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Narrow Body</td>
<td>S/O</td>
<td>1 to 5</td>
<td></td>
</tr>
<tr>
<td>Craft</td>
<td>Seat</td>
<td>Year Group</td>
<td>Hourly Benefit Multiplier</td>
</tr>
<tr>
<td>----------------</td>
<td>------</td>
<td>------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>15</td>
<td>5.06</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>14</td>
<td>5.01</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>12 to 13</td>
<td>4.92</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>10 to 11</td>
<td>4.81</td>
</tr>
<tr>
<td>Wide Body</td>
<td>CAP</td>
<td>6 to 9</td>
<td>4.70</td>
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<td>CAP</td>
<td>2 to 5</td>
<td>4.63</td>
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<td>Narrow Body</td>
<td>CAP</td>
<td>15</td>
<td>4.36</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>14</td>
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<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>12 to 13</td>
<td>4.22</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>10 to 11</td>
<td>4.12</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>CAP</td>
<td>6 to 9</td>
<td>4.01</td>
</tr>
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<td>CAP</td>
<td>2 to 5</td>
<td>3.93</td>
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<td>3.52</td>
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<tr>
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<td>CAP</td>
<td>10 to 15</td>
<td>3.52</td>
</tr>
<tr>
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<td>2 to 11</td>
<td>2.87</td>
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<td>F/O</td>
<td>10 to 15</td>
<td>2.87</td>
</tr>
<tr>
<td>Wide Body</td>
<td>S/O</td>
<td>2 to 9</td>
<td>2.18</td>
</tr>
<tr>
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<td>S/O</td>
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<td>2.18</td>
</tr>
<tr>
<td>Wide Body</td>
<td>S/O</td>
<td>3 to 9</td>
<td>2.18</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>F/O</td>
<td>1 to 2</td>
<td>1.22</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>F/O</td>
<td>1</td>
<td>1.22</td>
</tr>
<tr>
<td>Narrow Body</td>
<td>S/O</td>
<td>1 to 5</td>
<td>1.22</td>
</tr>
</tbody>
</table>
Appendix 2

Use this chart to calculate your retirement benefit under Formulas 2 and 3:

<table>
<thead>
<tr>
<th>Your Years of Credited Service for Vesting as of June 1, 1999</th>
<th>Your Age as of June 1, 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than 50</td>
</tr>
<tr>
<td>Less than 10</td>
<td>2.00%</td>
</tr>
<tr>
<td>10</td>
<td>2.05%</td>
</tr>
<tr>
<td>11</td>
<td>2.06%</td>
</tr>
<tr>
<td>12</td>
<td>2.07%</td>
</tr>
<tr>
<td>13</td>
<td>2.08%</td>
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<tr>
<td>14</td>
<td>2.09%</td>
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<tr>
<td>15</td>
<td>2.10%</td>
</tr>
<tr>
<td>16</td>
<td>2.11%</td>
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<tr>
<td>17</td>
<td>2.12%</td>
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<td>18</td>
<td>2.13%</td>
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<tr>
<td>19</td>
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<td>20</td>
<td>2.15%</td>
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<tr>
<td>21</td>
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<td>22</td>
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<td>23</td>
<td>2.18%</td>
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<tr>
<td>24</td>
<td>2.19%</td>
</tr>
<tr>
<td>25 or more</td>
<td>2.20%</td>
</tr>
</tbody>
</table>
Appendix 3

Use this chart to calculate your retirement benefit under Formulas 2 and 3.

<table>
<thead>
<tr>
<th>Years of Credited Service for Vesting as of October 30, 2006</th>
<th>50</th>
<th>51</th>
<th>52</th>
<th>53</th>
<th>54</th>
<th>55</th>
<th>56</th>
<th>57</th>
<th>58</th>
<th>59 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
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<tr>
<td>11</td>
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<td>0.01%</td>
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<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
</tr>
<tr>
<td>12</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
</tr>
<tr>
<td>13</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
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<tr>
<td>15</td>
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<td>0.04%</td>
<td>0.04%</td>
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</tr>
<tr>
<td>21</td>
<td>0.03%</td>
<td>0.03%</td>
<td>0.03%</td>
<td>0.03%</td>
<td>0.03%</td>
<td>0.03%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
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<tr>
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<td>0.03%</td>
<td>0.03%</td>
<td>0.03%</td>
<td>0.03%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
</tr>
<tr>
<td>23</td>
<td>0.03%</td>
<td>0.03%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
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<td>24</td>
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<td>0.03%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.04%</td>
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<td>0.04%</td>
<td>0.04%</td>
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<tr>
<td>25 or more</td>
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<td>0.04%</td>
<td>0.04%</td>
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<td>0.05%</td>
<td>0.05%</td>
</tr>
</tbody>
</table>
Appendix 4

This chart shows how the Average Earnings were determined for the examples on pages R-15 through R-16.

<table>
<thead>
<tr>
<th>Year</th>
<th>Non-Qualified Plan Eligible Earnings</th>
<th>Pension Plan Eligible Earnings (Limited to Compensation Limit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$260,000</td>
<td>$245,000</td>
</tr>
<tr>
<td>2009</td>
<td>$250,000</td>
<td>$245,000</td>
</tr>
<tr>
<td>2008</td>
<td>$240,000</td>
<td>$230,000</td>
</tr>
<tr>
<td>2007</td>
<td>$235,000</td>
<td>$225,000</td>
</tr>
<tr>
<td>2006</td>
<td>$170,000*</td>
<td>$170,000</td>
</tr>
<tr>
<td>Total</td>
<td>$1,155,000</td>
<td>$1,115,000</td>
</tr>
<tr>
<td>Average</td>
<td>$1,155,000 ÷ 5 = $231,000</td>
<td>$1,115,000 ÷ 5 = $223,000</td>
</tr>
</tbody>
</table>

*Note the Pilot did not exceed the IRS compensation limit for 2006.
This chart shows how the average annual benefit amount was determined for the examples on pages R-15 through R-19.

<table>
<thead>
<tr>
<th>Year</th>
<th>Craft</th>
<th>As of January 1</th>
<th>Hourly Benefit Multiplier</th>
<th>Regular Hours</th>
<th>Overtime Hours</th>
<th>Total Flight Hours</th>
<th>International Hours</th>
<th>Seat Multiplier</th>
<th>Override Amount</th>
<th>Bid Periods</th>
<th>Additional Annual Amount</th>
<th>Annual Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Wide Body</td>
<td>Captain 25</td>
<td>4.91</td>
<td>1,021.0</td>
<td>61.5</td>
<td>1,113.3</td>
<td>64.8</td>
<td>0.18</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>5,478</td>
</tr>
<tr>
<td>2009</td>
<td>Wide Body</td>
<td>Captain 24</td>
<td>4.76</td>
<td>978.84</td>
<td>0</td>
<td>978.8</td>
<td>0</td>
<td>0.18</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>4,659</td>
</tr>
<tr>
<td>2008</td>
<td>Wide Body</td>
<td>Captain 23</td>
<td>4.63</td>
<td>978.5</td>
<td>0</td>
<td>978.5</td>
<td>53.2</td>
<td>0.18</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>4,540</td>
</tr>
<tr>
<td>2007</td>
<td>Narrow Body</td>
<td>Captain 22</td>
<td>3.87</td>
<td>1,016.50</td>
<td>44.0</td>
<td>1,082.5</td>
<td>15.6</td>
<td>0.18</td>
<td>22</td>
<td>0</td>
<td>280</td>
<td>4,472</td>
</tr>
<tr>
<td>2006</td>
<td>Narrow Body</td>
<td>Captain 21</td>
<td>3.55</td>
<td>979.2</td>
<td>0</td>
<td>979.2</td>
<td>0</td>
<td>0.13</td>
<td>22</td>
<td>0</td>
<td>250</td>
<td>3,726</td>
</tr>
</tbody>
</table>

In this example, the Average Annual Benefit Amount is $4,575. (The Average Annual Benefit Amount is the total of the highest five Annual Benefit Amounts divided by 5.)

* Hourly Benefit Multiplier and Seat Multiplier – see page R-27 for definition.

Annual Benefit Amount equals:

\[
\text{Annual Benefit Amount} = \text{Hourly Benefit Multiplier} \times \text{Total Flight Hours} + \text{Seat Multiplier} \times \text{International Hours} + \text{Override Amount} \times \text{Bid Periods} + \text{Additional Annual Amount}
\]
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. 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, After-tax contributions and, if eligible, Catch-up contributions through convenient payroll deductions. In addition, FedEx Express will make Employer Matching contributions and Sick Bank contributions for eligible participants. The Vanguard Group, Inc. serves as the record-keeper.

You are eligible for the PRSP if your employment is covered by a collective bargaining agreement that provides for your participation in this Plan.

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

Eligibility for Pre-tax/401(k), After-tax, and if Eligible, Catch-up and Rollover Contributions

If you are employed by FedEx Express, as a pilot, you can begin making Pre-tax/401(k) contributions, After-tax contributions, and if eligible, Catch-up contributions and Rollover contributions on your Plan Entry Date. Your Entry Date is the first day of the month coincident with or next following:

- Your attainment of age 21; and
- Your completion of 6 months of employment with FedEx Express or another Controlled Group Member. (For a list of Controlled Group Members, see “Scope and Guidelines,” page I-1.)

Eligibility for Employer Matching and Employer Sick Bank Contributions

If you are employed by FedEx Express, as a pilot, you are eligible to receive Employer Sick Bank Contributions and Employer Matching contributions on your Pre-tax/401(k) contributions 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 if you are 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 are eligible to receive Employer Matching and Employer Sick Bank contributions on January 1 next following the Plan Year during which you were credited with at least 1,000 hours of service.

Hours of Service

Hours of service include each hour that you are paid or entitled to pay by FedEx Express, including time off for vacation, holidays, medical absences, jury duty or military duty as required by law. Hours associated with non-taxable amounts paid from a Pilot’s Occupational Illness/Injury Sick Bank shall be counted as hours of service for eligibility, vesting and benefit accrual.

This does not include hours you are paid or entitled to pay just to comply with:

- Unemployment compensation laws,
- Disability insurance laws,
• Payment made for medical expense reimbursement,

• Service during hours of family medical leaves (except for the first 501 hours, which may be used to prevent a one-year break in service).

Hours credited by the Payroll Department are used in determining credited service while actively at work. The Payroll Department credits active pilots with 95 hours per pay period.

Pilots receive credited service for periods of disability which are calculated as follows:

\[
\text{Days of Leave} \div 7 \text{ Days} \times 45 \text{ Hours} = \text{Total Credited Hours per Leave}
\]

If you are an individual who, on or after June 1, 1992, first becomes eligible for a disability benefit under the terms of the Federal Express Corporation Short Term Disability Plan or the Federal Express Corporation Long Term Disability Plan or the Federal Express Corporation Long Term Disability Plan for Pilots (as such plans may exist from time to time) or who becomes entitled to receive Workers’ Compensation benefits, hours of service shall be credited to you as if your hours of service had been continually credited during the period of such benefit entitlement up to your normal retirement age, or if greater, and to the extent required by law, for the period for which you qualify for such benefits.

**If You Are Reemployed**

**Eligibility for Pre-tax/401(k), After-tax and, If Eligible, Catch-up and Rollover Contributions**

If you terminate employment and are later reemployed, the following rules apply to your eligibility for making Pre-tax/401(k), After-tax, Catch-up and Rollover contributions:

• If you were a participant prior to your termination date, you are eligible on your reemployment date.

• If you have satisfied all conditions for eligibility prior to your termination date and are reemployed, you will be eligible on the later of your Entry Date or your reemployment date.

• If you have not satisfied the conditions for eligibility prior to your termination date and are reemployed, you will become a participant either on:
  – The later of your reemployment date or the first of the month coincident with or next following 6 months after your original employment date if your period of severance is less than 6 months after your last termination, or
  – Your reemployment date if your period of severance is more than 6 months but less than 12 months after your last termination date, or
  – The first of the month coincident with or next following 6 months after your reemployment date if your period of severance is 12 months or more after your last termination date.

**Eligibility for Employer Matching and Employer Sick Bank Contributions**

If you terminate employment and are later reemployed, the following rules apply to your eligibility to receive Employer Matching and Employer Sick Bank contributions:

• If you were a participant prior to your termination date, you are eligible on your reemployment date.

• If you had met all eligibility requirements and you terminated employment prior to your Entry Date, you become eligible on the first of the month coincident with or next following your reemployment date.
If you had not met all eligibility requirements prior to your termination date and you do not incur a break in service*, 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.

If you had not met all eligibility requirements prior to your termination date and you incur a break in service*, your hours of service prior to your termination are not considered and you are eligible on the first of the month coincident with or next following the date you meet all eligibility requirements.

*Break in service is a calendar year during which you have not been credited with more than 500 hours of service.

**Employment within FedEx Corporation Controlled Group Members**

If you were previously employed by a FedEx Corporation Controlled Group Member other than FedEx Express, your applicable service during your previous employment with that Controlled Group Member will be combined with your service with FedEx Express to determine your PRSP eligibility. For a list of Controlled Group Members, see “Scope and Guidelines,” page I-1.

If you are an eligible employee of FedEx Express, you will be eligible to make Pre-tax/401(k), After-tax and, if eligible, Catch-up contributions in the PRSP 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,
– You have completed at least 6 months of service with the Controlled Group Member, and
– You were an active participant in a tax-qualified retirement plan sponsored by a Controlled Group Member.

If you are an eligible employee of FedEx Express, you will be eligible to receive Employer Sick Bank contributions and Employer Matching contributions on your Pre-tax/401(k) contributions in the PRSP 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,
– You have completed at least one Year of Service with the Controlled Group Member (refer to “Eligibility for Employer Matching and Employer Sick Bank Contributions” on page R-48 for details), and
– You were an active participant in a tax-qualified retirement plan sponsored by a Controlled Group Member.

**Correspondence**

All PRSP correspondence is sent to your paycheck address, if available, otherwise to your home address listed in PRISM. You are responsible for updating any change of address in PRISM or reporting any change of address to your Assistant Chief Pilot. If you are no longer employed by FedEx, call Vanguard, 1-800-523-1188, to change your address.

**Enrollment**

When you become eligible to participate, you will receive an initial enrollment kit. To manage your PRSP account call Vanguard’s 24-hour Interactive VOICE Network at 1-800-523-1188. You will need a Personal Identification Number (PIN) to use VOICE. To create a PIN, follow the prompts.

If, during the month of your Entry Date, you wish to make Pre-tax/401(k), After-tax, and if eligible, Catch-up and Rollover contributions to the Plan, follow the instructions in “Steps to Enroll,” page R-51. You may enroll at any time after your Entry Date into the Plan. If you enroll, payroll deductions begin as soon as possible following your enrollment.
You should contact Vanguard at 1-800-523-1188 or vanguard.com to select your investment options. If you do not choose an investment option, your Pre-tax/ 401(k), Employer Matching, Employer Sick Bank, After-tax, and if eligible, Catch-up and Rollover contributions are automatically invested in the Target Retirement Fund closest to the year in which you will turn age 65. See “Investment Options,” page R-62.

Investments in Target Retirement Funds are subject to the risks of their underlying funds. The year in the fund 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 Fund is not guaranteed at any time, including on or after the target date.

Steps to Enroll

Enroll using VOICE Network:

(1) Call 1-800-523-1188
   Spanish speaking participants: Call 1-800-828-4487
   Hearing impaired: Call 1-800-749-7273

   The Vanguard VOICE Network guides you through the enrollment process for payroll deferral percentage, elections and selecting your investment options. Written confirmation of your payroll deduction and investment choices will be mailed to your home address within seven business days.

(2) Enroll online at vanguard.com;
   –Enter vanguard.com in your computer's browser.
   –Click on Personal Investors
   –Follow the online instructions to register and enroll. You will need your plan number (093015).

Your Vanguard
Personal
Identification Number
(PIN)

Your PIN is confidential. It is important that you remember your PIN; you will not be able to access your accounts through Vanguard’s VOICE® Network without it. If you forget your PIN, you must call Vanguard VOICE. You will need your SSN, date of birth and Plan Number (093015) to set up a PIN and then you must go back into VOICE to use it. Your PIN is not required to speak to a Vanguard associate.

Your Cost

FedEx pays the administrative cost for the plan. You will incur an indirect cost when the investment fund in which you are invested deducts annual fund operating expenses or short-term trading fees from fund assets. This is typical of mutual funds. Refer to the fund prospectus for additional information.

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 vanguard.com under the “My Profile” tab once you have logged into your account. You cannot use PRISM to designate a beneficiary. You also have the option to complete a PRSP beneficiary form provided by Vanguard and return it to Vanguard at the address on the form. Beneficiary forms can be obtained by contacting Vanguard at 1-800-535-1188.

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, Vanguard must receive acceptable legal documentation which 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 previously consented to the designation of another person as your beneficiary on the beneficiary form. Your spouse’s written consent must have been witnessed by a notary public. The completed, signed beneficiary designation must be on file with Vanguard prior to the date of your death. It is
important that you periodically review your beneficiary designation, which appears on your quarterly statement, because the most recent valid beneficiary form on file determines who receives any death benefits. Keep it up-to-date, especially if your marital status changes.

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.

**Definition of a Spouse**

For PRSP purposes, all references to “spouse” shall have the same meaning as set forth in 1 United States Code Annotated Section 7 (1 U.S.C.A. § 7) (a person of the opposite sex who is a husband or wife), and shall be deemed to refer solely to persons who have entered into a marriage, as defined in 1 U.S.C.A. § 7 (a legal union between one man and one woman as husband and wife).

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 Vanguard Participant Services.

**PRSP Contributions**

The following types of contributions can be made to the PRSP:

- Pre-tax/401(k) contributions
- Employer Matching contributions
- Employer Sick Bank contributions
- After-tax contributions
- Catch-up contributions
- Rollover contributions

All PRSP contributions are held in a trust fund. The Plan’s cash assets are managed and invested by the trustee, as directed by you. Pre-tax/401(k), After-tax, and Catch-up contributions are based on your eligible earnings.

**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 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 and 2007

• 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, 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

• PMPPP contributions

• Excess Life Premiums

• Earnings above the IRS compensation limit

• 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

Sources of Contributions

Pre-tax/401(k) Contributions

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.

Your contributions are deposited twice each month to your Pre-tax/401(k)
Contribution Account. Deposits are made about five business days after the 15th and
the last day of the month.

Your Pre-tax/401(k) contributions are subject to the Internal Revenue Code Section
402(g) Annual Dollar Limit (page R-60), the 415(c) defined contribution limit (page R-
59) and the “Non-discrimination Test” (page R-59).

Once you reach the IRS 402(g) or Plan limit, your contribution will automatically
cease for that plan year and then restart the next January. If you reach the 415(c) limit,
contributions will be reduced according to the abatement order described on page R-
59.
Non-highly Compensated Employees
If you are a non-highly compensated employee, you can contribute from 1% to 50% per paycheck of your eligible earnings in 1% increments, on a Pre-tax basis through payroll deductions.

Highly Compensated Employees
If you are a highly compensated employee (HCE), as defined by the IRS, the amount you can save through Pre-tax/401(k) contributions is limited to 15% per paycheck of your eligible earnings, in 1% increments. The actual percentage for HCEs is subject to periodic FedEx review because of government limits. For the definition of HCE, see “Important Limits on Contributions,” page R-59.

Each January, participants contributing more than 15% in Pre-tax/401(k) contributions and whose classification changes from a non-highly compensated to a highly compensated status will be notified by Vanguard that their contributions will automatically be reduced to 15%. Participants changing from a highly compensated to a non-highly compensated status will be notified by Vanguard of their ability to increase their contributions above 15%.

Employer Matching Contributions
Currently, FedEx contributes $.50 on the dollar for the first Pre-tax/401(k) $1,000 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. The matching contribution is deposited within five business days after each payroll.

During the initial plan year (June 1, 2002, through December 31, 2002), the maximum Employer Matching contribution was a prorated amount equal to 7/12 of the maximum $500, or $291.67. For Plan Year 2003 (January 1, 2003, through December 31, 2003), the Employer Matching contribution was dollar for dollar up to the first $500 that you contribute in Pre-tax/401(k) contributions, up to the maximum Employer Matching contribution of $500. Beginning with Plan Year 2004, the Employer Matching contribution returned to $.50 on the dollar for the first $1,000 of your Pre-tax/401(k) contributions, up to the maximum Employer Matching contribution of $500 per plan year.

Sick Bank Contributions
FedEx Express will also 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 will be considered as Eligible Earnings in the year that you receive the payment.

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. The actual percentage is subject to FedEx
review because of government limits. These contributions are **not** pre-tax, but earnings on your contributions are tax-deferred.

Contributions are deposited twice each month to your After-tax Contribution Account. Deposits are made about five business days after the 15th and the last day of the month. Once you reach an IRS or Plan limit, your contribution will automatically cease for that plan year and then restart the next January.

**Exception**

If you are a highly compensated employee (HCE) as defined by the IRS, your After-tax contributions are limited to 5% of your eligible earnings, in 1% increments subject to the annual compensation limit (see page R-11). For the definition of HCE, see “Important Limits on Contributions,” page R-59.

Each January, participants contributing more than 5% in After-tax contributions and whose classification changes from a non-highly compensated to a highly compensated status will be notified by Vanguard that their contribution will automatically be reduced to 5%. Participants changing from a highly compensated to a non-highly compensated status will be notified by Vanguard of their ability to increase their contribution above 5%.

**Catch-Up Contributions**

Eligible participants may elect to make additional pre-tax Catch-up contributions. To be eligible, you must be age 50 or older, or will attain age 50 by the end of the calendar year. 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 if a non-highly compensated employee (NHCE), or 15% if a highly compensated employee (HCE); or
- You reach the IRS pre-tax dollar limit 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) contributions.

To make Catch-up contributions, you must elect a separate pre-tax Catch-up payroll deduction each year by designating a percentage from 1% to 30% of your eligible earnings to be deducted per paycheck.

Your Catch-up contributions may not exceed a specified dollar limit in any one calendar year. For 2012, this amount is $5,500. After 2012, the dollar limit may be adjusted for increases in the cost of living.

Catch-up contributions are not subject to the 415(c) limit described on page R-59.

Contributions are deposited twice each month to your Catch-up Contribution Account. Deposits are made about five business days after the 15th and the last day of the month.

To make a Catch-up contribution election, contact Vanguard at **1-800-523-1188** or **vanguard.com**. Refer to “Steps to Change the Amount You Save in the PRSP,” page R-58. Catch-up contributions will be effective as soon as possible after your election.

**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 upon meeting certain criteria. However, if you are directly transferring from one Controlled Group Member to another, you are not eligible to make a rollover contribution.

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 Vanguard, 1-800-523-1188.

Comparison Chart of Pre-tax/401(k), After tax and Catch-up Contributions

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Pre-tax/401(k)</th>
<th>After-tax</th>
<th>Catch-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Retirement savings</td>
<td>Long-term savings (not necessarily for retirement)</td>
<td>Retirement savings</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Attainment of age 21 and 6 months of employment</td>
<td>Same as Pre-tax/401(k)</td>
<td>Same as Pre-tax/401(k), and must be age 50 or older, or will reach age 50 by end of the calendar year</td>
</tr>
<tr>
<td>Amount you can contribute</td>
<td>Subject to government limits:</td>
<td>Subject to government limits:</td>
<td>Subject to government limits (except for the 415(c) limit):</td>
</tr>
<tr>
<td></td>
<td>• Non-highly compensated employees: 1%-50% of eligible earnings</td>
<td>• Non highly compensated employees: 1%-20% of eligible earnings</td>
<td>From 1% to 30% of eligible earnings up to the calendar year limit if:</td>
</tr>
<tr>
<td></td>
<td>• Highly compensated employees: 1%-15% of eligible earnings</td>
<td>• Highly compensated employees: 1%-5% of eligible earnings</td>
<td>• You have contributed up to the Pre-tax/401(k) contribution limit of 50% if NHCE, or 15% if HCE; or</td>
</tr>
<tr>
<td></td>
<td>For government limits, refer to “Important Limits on Contributions,” page R-59.</td>
<td>For government limits, refer to “Important Limits on Contributions,” page R-59.</td>
<td>• You reach the IRS dollar limit during the Plan Year</td>
</tr>
<tr>
<td>Employer Matching contributions</td>
<td>$.50 for each dollar of first $1,000, up to $500 maximum.</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Pilot Benefit Book
Comparison Chart of Pre-tax/401(k), After tax and Catch-up Contributions

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Pre-tax/401(k)</th>
<th>After-tax</th>
<th>Catch-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income taxes</strong></td>
<td>Pre-tax/401(k) contributions not included in taxable income when made. Pre-tax/401(k) contributions and earnings not taxed until withdrawn. In limited situations, favorable tax treatment may be available. 10% additional excise tax for early withdrawals may apply. Required 20% income tax withheld on distributions/withdrawals that are eligible to be rolled over and not directly transferred to an eligible retirement plan, which includes an Individual Retirement Account (IRA). Taxable distributions/withdrawals that are not eligible to be rolled over are subject to a 10% income tax withholding. In this situation, you have the option to waive the 10% withholding amount.</td>
<td>After-tax contributions included in taxable income when made. Earnings on After-tax contributions not taxed until withdrawn. 10% additional excise tax on early withdrawals may apply. Required 20% income tax withheld on distributions/withdrawals that are eligible to be rolled over and not directly transferred to an eligible retirement plan, which includes an Individual Retirement Account (IRA). Taxable distributions/withdrawals that are not eligible to be rolled over are subject to a 10% income tax withholding. In this situation, you have the option to waive the 10% withholding amount.</td>
<td>Same as Pre-tax/401(k)</td>
</tr>
<tr>
<td><strong>Withdrawals</strong></td>
<td>Your Pre-tax/401(k) account can only be withdrawn for the following reasons: - Age 59½ or older - Financial hardship ($500 minimum) - Death or total disability (total distribution) - Employment termination (total distribution) - Retirement (total distribution) When a hardship distribution is issued, your Pre-tax/401(k), After-tax and Catch-up contributions are suspended for a period of 6 months from the date of the hardship distribution.</td>
<td>Regular withdrawals allowed twice each Plan Year. Withdrawals are processed within one week upon Vanguard’s receipt of the withdrawal application. Minimum regular withdrawal is $500, or entire account if less than $500. When a hardship distribution is issued, your Pre-tax/401(k), After-tax and Catch-up contributions are suspended for a period of 6 months from the date of the hardship distribution.</td>
<td>Same as Pre-tax/401(k)</td>
</tr>
</tbody>
</table>
Changing the Amount You Save

You can change the amount you contribute to the PRSP at any time. Contact Vanguard at vanguard.com or 1-800-523-1188 to:

- increase or decrease your contribution percentage,
- stop your contributions, or
- reenroll if you have stopped your contributions.

Your contribution change will begin with the next feasible pay period. Refer to “Steps to Enroll,” page R-51.

Steps to Change the Amount You Save in the PRSP

(1) Call Vanguard at 1-800-523-1188.

–Have your Social Security number, plan number (093015) and PIN ready. The Vanguard VOICE® Network will guide you through the enrollment process for payroll deductions and investment options. If you wish to speak with a Vanguard Participant Services associate at any time during the call, Press 0. You do not need your PIN.

–Written confirmation of your payroll deduction and investment choices will be mailed to you within three business days.

or

(2) Contact Vanguard online at vanguard.com (You will need to be registered. You will need your Social Security number and plan number [093015] to register.)

–Click on Go to Personal Investors, “Log on to your Account.”
–Enter user name and password.
–Click on “Change My Payroll Deductions”; then follow online instructions.

For more information, call Vanguard at 1-800-523-1188.

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), hours of service for Plan eligibility will include service for the time you were in the military as well as service before your military duty. 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), After-tax and, if applicable, 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 will be credited monthly in the same amount as if you had been at work during your period of MLOA. These will be credited as you make up your Pre-tax/401(k) contributions.

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.

For more information, call Vanguard at 1-800-523-1188.

**Important Limits on Contributions**

**Nondiscrimination Test**

The IRS requires FedEx to “test” the Pre-tax/401(k) contributions periodically to make sure the Plan does not favor “highly compensated” employees. The contribution limit for highly compensated employees is based on the average percentage non-highly compensated employees save. If necessary, highly compensated employees will be notified if their contributions will be suspended. If your contributions are reduced or stopped due to contribution limits, your deductions will resume the next plan year.

**Definition of Highly Compensated**

You are considered an HCE as defined by the IRS for the 2012 plan year (January 1, 2012, through December 31, 2012) if your earnings for the 2011 plan year (January 1, 2011, through December 31, 2011) were in excess of $110,000 and you were in the top 20% of employees by pay.

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 combined amount that can be contributed annually to the Pilots’ Retirement Savings Plan (PRSP) and the Pilots’ Money Purchase Pension Plan (PMPPP) is limited. This limit applies to all contributions made to your PMPPP account and contributions made to your PRSP accounts through Pre-tax/401(k) contributions, After-tax contributions, Sick Bank contributions, and Employer Matching contributions on your Pre-tax/401(k) contributions. Catch-up contributions are excluded from this limit.

For the initial Plan Year (June 1, 2002, through December 31, 2002), the limit was the lesser of:

- 100% of your eligible earnings; or
- $23,333.33 (7/12 of $40,000)

For the 2012 Plan Year, the limit is the lesser of:

- 100% of your eligible earnings; or
- $50,000

This limit is scheduled to be indexed by the Secretary of the Treasury based on increases in the cost of living.
If contributions during the Plan Year to your PMPPP and PRSP accounts exceed the Section 415(c) Plan Year limit, the excess contributions (plus earnings) will be reduced in the following order and returned to you:

- PRSP Sick Bank contributions
- PRSP After-tax contributions
- PRSP Pre-tax/401(k) contributions
- PRSP Employer Matching contributions
- PMPPP contributions

Within each of the above categories of After-tax, Pre-tax/401(k) and Employer Matching contributions, in the PRSP, military make-up contributions will be reduced last.

**Employee Tax-deferred Contribution Limit – [Section 402(g) of the Internal Revenue Code (IRC)]**

The calendar year limit on Pre-tax/401(k) contributions is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$16,500</td>
</tr>
<tr>
<td>2010</td>
<td>$16,500</td>
</tr>
<tr>
<td>2011</td>
<td>$16,500</td>
</tr>
<tr>
<td>2012</td>
<td>$17,000</td>
</tr>
</tbody>
</table>

Once you reach the limit, your contributions will automatically cease and restart in January of the following year at the previously elected percentage. If the limit is exceeded, your account will be reduced by any excess contributions (plus earnings) and will be automatically refunded to you.

You will receive a confirmation from Vanguard of the contribution percentage that will be applied effective January 1. Please call Vanguard, 1-800-523-1188, if you have questions.

**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 compensation limit was $116,666.67 (7/12 of $200,000) for the initial Plan Year (June 1, 2002, through December 31, 2002). Thereafter, the calendar year compensation limit is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>$225,000</td>
</tr>
<tr>
<td>2008</td>
<td>$230,000</td>
</tr>
<tr>
<td>2009</td>
<td>$245,000</td>
</tr>
<tr>
<td>2010</td>
<td>$245,000</td>
</tr>
<tr>
<td>2011</td>
<td>$245,000</td>
</tr>
<tr>
<td>2012</td>
<td>$250,000</td>
</tr>
</tbody>
</table>
**FedEx Corporation Controlled Group Limits**

If you were previously employed by a FedEx Corporation Controlled Group Member other than FedEx Express, your applicable eligible earnings and contributions during your previous employment with that Controlled Group Member will be combined with your FedEx Express eligible earnings and contributions to determine the Plan’s limit on contributions. For a list of Controlled Group Members, see “Scope and Guidelines,” page I-1.

**PRSP Accounts**

References to account in this summary plan description generally refer to all of your various accounts taken together. However, a series of separate recordkeeping accounts will be established and maintained under the Plan 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 PRSP has fourteen accounts.

The following eleven accounts are the current active savings accounts:

- **Pre-tax/401(k) Contributions Account**—This account is for your Pre-tax contributions to the Plan.
- **Military Leave Pre-tax/401(k) Contributions Account**—This account is for make-up Military leave Pre-tax contributions to the Plan following a period of qualifying military service.
- **Employer Match Contributions Account**—This account is for Employer Matching contributions to your Pre-tax/401(k) contributions.
- **Military Leave Employer Match Contributions Account**—This account is for Employer Matching contributions to your make-up Pre-tax/401(k) contributions following a period of qualifying military service.
- **Sick Bank Account**—This account is for your contributions attributable to your unused sick leave in excess of 686 hours.
- **After-tax Contribution Account**—This account is for your After-tax contributions to the Plan.
- **Military Leave After-tax Contributions Account**—This account is for your make-up Military leave After-tax contributions to the Plan following a qualifying military service.
- **Catch-up Contributions Account**—This account is for additional Pre-tax contributions to the Plan made by eligible participants.
- **Military Leave Catch-up Contributions Account**—This account is for your make-up Military leave Catch-up contributions to the Plan following a period of qualifying military service.
- **Rollover Account**—This account is for your rollover contributions from a prior employer’s tax-qualified retirement plan.
- **QNEC Account**—This account is for amounts attributable to qualified non-elective contributions.

The following three 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 Plan.
  - Regular Employer Account—This account is for your share, if any, of FedEx’s Profit Sharing cash contributions to the Plan.
• Company Stock Distribution Account (also known as the Investment Credit Stock Account)—This account is for contributions made by FedEx to the Plan before 1987. Due to federal regulations, the value of this account is not available for loans or in-service withdrawals for employees under age 59 ½ including hardship withdrawals. Your stock in this account cannot be withdrawn until retirement, termination, total disability, death, or upon reaching age 59 ½.

• Company Stock (ESOP)—The Employee Stock Ownership Plan was designed to allocate $50 million in Federal Express Common Stock (992,556 shares) 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 this Plan was a spin-off, the ESOP was maintained by FedEx as a separate retirement plan. Due to federal regulations, the value of your ESOP shares is not available for loans or in-service withdrawals for employees under age 59 ½, including hardship withdrawals. Your stock in this account cannot be withdrawn until retirement, termination, total disability, death or upon reaching age 59 ½. No additional contributions can be made to your ESOP account.

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 of your accounts in the PRSP.

Account Statements
As a PRSP participant, you receive a statement of your accounts after each calendar quarter. The statement, which lists your account balances, contributions, earnings and other activity, is sent about two to three weeks after the end of the quarter. Recent statements are also available at vanguard.com.

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, your Pre-tax/401(k), Employer Matching, Employer Sick Bank, After-tax, and if eligible, Catch-up and Rollover contributions are automatically invested in the Target Retirement Fund closest to the year in which you will turn age 65 (except that, if you do not choose an investment option for your first Employer Sick Bank contribution, it will be automatically invested in the same investment options as your Employer Matching contributions, if any).

The PRSP offers a diversified lineup of investment options. To learn more about the following Vanguard® mutual funds, contact Vanguard® at 1-800-523-1188 or at vanguard.com.

The investment options in the PRSP are organized into three tiers:
• Vanguard Target Retirement Funds
• Vanguard LifeStrategy® Funds
• Core funds

Vanguard Target Retirement Funds
Vanguard Target Retirement Funds provide a professionally maintained, diversified mix of investments that shifts emphasis to more conservative investments as you move closer to retirement.

Investments in Target Retirement Funds are subject to the risks of their underlying funds. The year in the fund name refers to the approximate year (the target date) when an investor in the fund would leave the workforce at an assumed retirement age of 65. The fund 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 Fund is not guaranteed at any time, including on or after the target date.
Please note that while the Target Retirement Funds shift to more conservative asset allocations as the target date approaches, the funds continue to have exposure to stocks/equities. For example, the Target Retirement Income Fund is for retirees who may need to draw income. If you invest in this fund, your investments will have an allocation of 30% stocks, 65% bonds and 5% short-term reserves. On average, individuals who retire at age 65 may expect to enjoy 17-20 years in retirement, and many will enjoy even longer lives. The investment allocation for each Target Retirement Fund factors in average life expectancy after the target date is reached and, as a result, continues to have exposure to equities 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 Fund invests in several broadly diversified Vanguard funds—primarily low-cost Vanguard index funds.

As previously explained, Target Retirement Funds are one-fund options that automatically shift their emphasis to more conservative investments over time. However, it is important to know that the fund 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 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.

<table>
<thead>
<tr>
<th>Fund Name/Ticker Symbol</th>
<th>Fund Type (stocks and bonds)</th>
<th>Objective</th>
<th>Risk Level (Determined as of 6/30/12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanguard Target Retirement Income Fund VTINX</td>
<td>Balanced</td>
<td>Seeks to provide current income and some capital appreciation.</td>
<td>Conservative to moderate</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2010 Fund VTENX</td>
<td>Balanced</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2015 Fund VTXVX</td>
<td>Balanced</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2020 Fund VTWNX</td>
<td>Balanced</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2025 Fund VTTVX</td>
<td>Balanced</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2030 Fund VTHRX</td>
<td>Balanced</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate to aggressive</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2035 Fund VTHX</td>
<td>Balanced</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate to aggressive</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2040 Fund VFORX</td>
<td>Balanced</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate to aggressive</td>
</tr>
</tbody>
</table>
Vanguard 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.

<table>
<thead>
<tr>
<th>Fund Name/ Ticker Symbol</th>
<th>Fund Type</th>
<th>Objective</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanguard Target Retirement 2045 Fund VTIVX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate to aggressive</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2050 Fund VFIFX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate to aggressive</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2055 Fund VFFVX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate to aggressive</td>
</tr>
<tr>
<td>Vanguard Target Retirement 2060 Fund VTTSX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide capital appreciation and current income consistent with its current asset allocation.</td>
<td>Moderate to aggressive</td>
</tr>
</tbody>
</table>

Vanguard LifeStrategy Funds

<table>
<thead>
<tr>
<th>Fund Name/ Ticker Symbol</th>
<th>Fund Type</th>
<th>Objective</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanguard LifeStrategy Conservative Growth Fund VSCGX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide current income and low-to-moderate capital appreciation.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard LifeStrategy Moderate Growth Fund VSMGX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide capital appreciation and a low-to-moderate level of current income.</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

Core funds If you have some investing experience and the time to research your plan’s fund options, consider creating a diversified portfolio of core funds. These are funds of various asset classes that, when used in combination, can provide the diversification you need.
<table>
<thead>
<tr>
<th>Fund Name/ Ticker Symbol</th>
<th>Fund Type</th>
<th>Objective</th>
<th>Risk Level (Determined as of 6/30/12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanguard Prime Money Market Fund Institutional Shares VMRXX</td>
<td>Money market</td>
<td>Seeks to provide current income while maintaining liquidity and a stable share price of $1.</td>
<td>Conservative</td>
</tr>
<tr>
<td>Vanguard Retirement Savings Trust No ticker symbol</td>
<td>Stable value</td>
<td>Seeks to provide current and stable income while maintaining a stable share value of $1.</td>
<td>Conservative</td>
</tr>
<tr>
<td>Janus Flexible Bond Fund Class I Shares JFLEX</td>
<td>Bond</td>
<td>Seeks to obtain maximum total return, consistent with preservation of capital.</td>
<td>Conservative to moderate</td>
</tr>
<tr>
<td>Vanguard Inflation-Protected Securities Fund VIPSX</td>
<td>Bond</td>
<td>Seeks to provide investors inflation protection and income consistent with investment in inflation-indexed securities.</td>
<td>Conservative to moderate</td>
</tr>
<tr>
<td>Vanguard Total Bond Market Index Fund Institutional Shares VBTIX</td>
<td>Bond</td>
<td>Seeks to track the performance of a broad, market-weighted bond index.</td>
<td>Conservative to moderate</td>
</tr>
<tr>
<td>Vanguard Wellington™ Fund VWELX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide long-term capital appreciation and reasonable current income.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard 500 Index Fund Signal® Shares VIFSX</td>
<td>Domestic stock</td>
<td>Seeks to track the performance of a benchmark index that measures the investment return of large-capitalization stocks.</td>
<td>Moderate to aggressive</td>
</tr>
<tr>
<td>Vanguard Windsor™ Fund VWNDX</td>
<td>Domestic stock</td>
<td>Seeks to provide long-term capital appreciation and income.</td>
<td>Moderate to aggressive</td>
</tr>
<tr>
<td>Vanguard Extended Market Index Fund Signal Shares VEMSX</td>
<td>Domestic stock</td>
<td>Seeks to track the performance of a benchmark index that measures the investment return of small- and mid-capitalization stocks.</td>
<td>Aggressive</td>
</tr>
<tr>
<td>Vanguard Mid-Cap Index Fund Signal Shares VMISX</td>
<td>Domestic stock</td>
<td>Seeks to track the performance of a benchmark index that measures the investment return of mid-capitalization stocks.</td>
<td>Aggressive</td>
</tr>
<tr>
<td>Vanguard PRIMECAP Fund VPMCX</td>
<td>Domestic stock</td>
<td>Seeks to provide long-term capital appreciation.</td>
<td>Aggressive</td>
</tr>
<tr>
<td>Vanguard Small-Cap Index Fund Signal Shares VSIIX</td>
<td>Domestic stock</td>
<td>Seeks to track the performance of a benchmark index that measures the investment return of small-capitalization stocks.</td>
<td>Aggressive</td>
</tr>
<tr>
<td>Vanguard International Growth Fund VWIGX</td>
<td>International stock</td>
<td>Seeks to provide long-term capital appreciation.</td>
<td>Aggressive</td>
</tr>
</tbody>
</table>
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 Funds are subject to the risks of their underlying funds. The year in the fund 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 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 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. Once shares are exchanged, your shares will not be available for an in-kind distribution.

- 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 Federal Express 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. Vanguard’s commission on FedEx stock sold in the Plan 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 1 p.m., Eastern time, for trades regarding the FedEx Corporation Stock Fund.

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 Vanguard Fiduciary 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 Plan.

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, Vanguard 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. 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 Institutional Shares and Vanguard Inflation-Protected Securities Fund are designated as competing funds.

You can transfer money from Vanguard Retirement Savings Trust into a stock fund, balanced fund, or an intermediate- or long-term bond fund at any time. However, the money must remain there for 90 days before you can transfer it into a shorter-term bond or money market fund (such as Vanguard Prime Money Market Fund or Vanguard Inflation-Protected Securities Fund).

This investment restriction is imposed by the financial institutions that issue the contracts in Vanguard Retirement Savings Trust’s portfolio. The restriction is designed to discourage frequent shifting of money from one fund to another to take advantage of slight changes in interest rates. Such frequent transfers drive up the cost of managing Vanguard Retirement Savings Trust, which harms all Vanguard Retirement Savings Trust investors.

Please refer to the prospectus of each investment fund for a more detailed summary, as well as any changes to these policies.

#### Frequent trading policy

A frequent-trading policy applies to all funds in the PRSP, with the exception of Vanguard Retirement Savings Trust and Vanguard Prime Money Market Fund Institutional 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 60 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 60-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 60-day restriction described above will not apply to any change that you make to the investment of future contributions. The prospectus for each fund 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 Vanguard at 1-800-523-1188 or online at vanguard.com.

This policy will not apply to the following:

- Vanguard Retirement Savings Trust and Vanguard Prime Money Market Fund Institutional 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 a Plan
- Redemptions of shares as part of a plan termination or at the direction of the Plan
- Redemptions of shares by Vanguard 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 by the fiduciary for the Plan in accordance with the investment guidelines for the Plan.

**How to Select or Change Your Investment Options**

Your Choices — The PARSES’s investment lineup is organized into three tiers: Vanguard Target Retirement Funds, Vanguard LifeStrategy Funds, and Core funds. Consider choosing a single Vanguard Target Retirement or LifeStrategy Fund or create your own mix from the Core 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 can also 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** — Vanguard 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 vanguard.com or by calling Vanguard's VOICE Network at 1-800-523-1188. You can also speak to a Vanguard associate between 7:30 a.m. and 8:00 p.m., Central time, Monday–Friday, by calling Vanguard at 1-800-523-1188.

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.

Vanguard will send a written confirmation of your elections or changes to your home address within seven business days.

For more information about any fund, including investment objectives, risks, charges and expenses, call Vanguard at 1.800.523.1188 to obtain a prospectus. The prospectus contains this and other important information about the fund. Read and consider the prospectus information carefully before you invest. You can also download Vanguard fund prospectuses at vanguard.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 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.

When requesting a loan and withdrawal at the same time, please speak with a Vanguard Participant Services associate at 1-800-523-1188, instead of accessing VOICE®, to receive guidance regarding the order and timing of your benefit.

**Withdrawals**

**Eligibility forWithdrawals**

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.

**When Withdrawals Are Allowed [subject to limitations]**

<table>
<thead>
<tr>
<th>Type of Withdrawal</th>
<th>Profit Sharing Contributions Account</th>
<th>Pre-tax/401(k) Contribution Account</th>
<th>After-tax Contribution Account</th>
<th>Rollover Account</th>
<th>Catch-up Contribution Account</th>
<th>Sick Bank Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-service withdrawal</td>
<td>Yes¹</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>• Age 59½ or older</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Less than age 59½:</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>– Less than five years of participation in this Plan</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>– Five or more years of participation in this Plan</td>
<td>Yes¹</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hardship withdrawal</td>
<td>Yes¹</td>
<td>Yes²</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

¹ Any stock included in a withdrawal will be paid in the form of cash instead of a Stock Certificate.
² No hardship withdrawal of Employer Matching contributions and earnings, and no hardship withdrawal of earnings on your Pre-tax/401(k) contributions after 12/31/1988.

**In-Service Withdrawal**

If you meet the eligibility requirements as shown in the chart above, 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 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 Contribution 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 no 10% excise tax will apply. Refer to “Withdrawal Tax Considerations,” page R-73.

Steps to Take to Request an In-Service Withdrawal

1. Call Vanguard at 1-800-523-1188. An application will be mailed the next business day.
2. Complete and mail the application back as directed on the form.
3. Your check will be mailed within one week of Vanguard receiving the properly completed application.
4. Alternatively, you can request an express withdrawal and the check will be sent the next business day.

Hardship Withdrawal

Withdrawals are made for hardship reasons from the following accounts in the order that they are listed:

- After-tax Contribution Account
- Profit Sharing Contributions Account
- Sick Bank Account
- Rollover Account
- Pre-tax/401(k) Contribution Account (except employer matching contributions and earnings, and earnings on your Pre-tax/401(k) contributions after December 31, 1988); and
- Catch-up Contribution Account

Hardship withdrawals may be made at any time for a minimum of $500; however, you must first take out any available loans and in-service withdrawals from this Plan. 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.
- Repair of damage to principal residence if the expenses qualify as a casualty deduction.
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 Vanguard 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 Plan adopted the IRS safe harbor provisions. Under these provisions, you will be prohibited from making contributions to all plans* for 6 consecutive months following the receipt of a hardship distribution.

*All plans maintained by FedEx Corporation means all qualified and nonqualified deferred compensation plans, all stock option, stock purchase or similar plans, for example Pre-tax/401(k) contributions, After-tax contributions, Catch-up contributions, and payroll deductions to the FedEx Corporation Employee Stock Purchase Plan.

Steps to Take to Request a Hardship Withdrawal

(1) Call Vanguard at 1-800-523-1188 to request a Hardship Withdrawal Application (“Application”). Vanguard will send you an Application the next business day. You should receive your Application in the mail within seven to 10 days of initiating your withdrawal. If you have registered for secure online account access, your Application will also be available for download through the Secure Message Center within two to 24 hours of your request. You must log on to your account at vanguard.com to access the Application. The Application will remain valid for 45 days from the date on the application.

(2) Complete the Application and return it to Vanguard along with the required supporting documentation, to the following:

ATTN: Federal Express Corporation Pilots’ Retirement Savings Plan – Plan #093015
The Vanguard Group
P.O. Box 1101
Valley Forge, PA 19482-1101

Overnight packages should be sent to:
ATTN: Federal Express Corporation Pilots’ Retirement Savings Plan – Plan #093015
The Vanguard Group
100 Vanguard Blvd.
Malvern, PA 19355

You should retain a copy of documentation of proof of the financial hardship for your records. All supporting documentation must be dated within 90 days of your withdrawal request. The type of supporting documentation you send depends on the reason for your financial hardship.

All documentation should be dated, authorized and on appropriate paper (i.e. contain the institution’s logo, letterhead). Photocopies and faxed copies will be accepted. Non-English documentation will be referred back to you to provide a certified English translation. Vanguard shall be entitled to rely on any such certified English translation as if it were the original documentation. Documentation that is ambiguous, questionable or related to an unusual situation or does not otherwise meet the standards outlined in these procedures will be referred to FedEx’s attention for final determination. Vanguard will not be responsible for verifying the authenticity of any of the supporting documents.
For Information about required supporting documentation, log onto vanguard.com. You will need to be registered. You will need your Social Security number and plan number (PRSP: #093015) to register:

–Click on Personal Investors, “Log on.”
–Enter user name and password.

For more information or if you have questions, call Vanguard at 1-800-523-1188.

(3) Your request will be forwarded to Vanguard’s Hardship Determination Team for review by a Determination Administrator (“Administrator”).

**Approval of Request:** If the Application and the supporting documentation meet the requirements provided for under the terms of the Plan, the request will be approved and submitted for processing.

**Denial of Request:** If the Application and/or supporting documentation is incomplete or does not meet the terms of the Plan, or applicable laws or regulations under ERISA or the Code, you will be contacted by phone (or a letter will be mailed to you if Vanguard is unable to reach you by phone, or if you do not contact Vanguard within 48 hours) to provide additional information to substantiate your request. You can provide additional written documentation to substantiate the original amount of the request provided the Application has not expired.

a. If the requested amount exceeds the amount substantiated in the supporting documentation (including any amounts for taxes and/or penalties), you will be contacted via phone or letter to approve the lesser amount. Upon verbal or written approval by you, if the lesser amount meets the Plan minimum the hardship will be processed.

i. You will **not** be contacted for further approval if:

1. the requested amount exceeds the amount substantiated in the supporting documentation (including any amounts for taxes and/or penalties); and
2. the discrepancy is not greater than $25 or 2.5% of the requested hardship withdrawal amount.

b. If there are insufficient funds in your account due to market value fluctuation and as a result, the original amount of the request cannot be satisfied, the withdrawal will be processed if the maximum amount available meets the Plan minimum. If a withdrawal cannot be processed due to the decrease in account value, the Application will be returned to you with a letter stating that the withdrawal cannot be processed.

**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 on page R-77)
• 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. (Refer to “Payments to an Alternate Payee,” page R-78)

• 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.

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:

• After-tax Contribution 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 Account

• Rollover Account

• Pre-tax/401(k) Contribution Account (employee contributions)

• Catch-up Contribution Account

As the principal is repaid, the order reverses. The interest charged on the loan is credited to the account(s) from which the loan was taken.

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.

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 Institutional 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 and deducted from your first and second paychecks in the month. A $100 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 $100 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, see “Loan Default Rules,” page R-75. Outstanding loan balances may be paid off early. However, partial payoffs and renegotiations are not 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.

Contact Vanguard to initiate a principal residence loan. Vanguard will review all requests for principal residence loans before they are processed. To accommodate Vanguard’s review, when you request a principal residence loan, you will receive an application and must return that application to Vanguard with documentation that proves eligibility for the loan. You must send a copy of your purchase agreement or your mortgage agreement. The documentation must be dated within 90 days of your loan request. For additional information about the loan process, contact Vanguard.

If you terminate or retire from a Controlled Group Member, die, become disabled (as defined on page R-77) or choose to receive all account balances, the loan balance becomes due. If you do not make a full repayment, your loan balance will be treated as a distribution.

Steps to Take to Apply for a Loan

1. Contact Vanguard at 1-800-523-1188 or online at vanguard.com to request a loan.

General Purpose

2. Your check will be processed within one week after your request—generally the next business day. No paperwork is required.

3. You will also receive a promissory note regarding the terms of your loan from Vanguard for your files.

Principal Residence

2. Vanguard will send you an application packet within seven to 10 business days.

3. Sign and return the application with required documentation (a copy of your purchase agreement or your mortgage agreement) to Vanguard.

4. Upon receipt of your application and supporting documentation, Vanguard will review your request and if your paperwork is in good order, process your loan within three business days.

5. Allow seven to 10 days for delivery of your check. You may also request to receive your loan via electronic bank transfer (EBT).

Loan Default 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 payment deductions should resume. If your loan payment does not resume, it is your responsibility to call Vanguard at 1-800-523-1188. Your loan end date will be extended by the period of non-military leave of absence.
absence, but not beyond the 12-month statutory limit per occurrence or the 5-year limit for a general-purpose loan. At the end of your loan term, a balloon payment may be required for any principal and accrued interest for the period you were on a non-military leave of absence.

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 payments should resume. If your loan payment does not resume, it is your responsibility to call Vanguard, 1-800-523-1188. Your loan end date will be extended by the period of the military leave of absence. At the end of your loan term, a balloon payment may be required for any principal and accrued interest for the period you were on leave.

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 as soon as assets in your Plan accounts are distributable. 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 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 available for distribution. You will be unable to take a new loan from the PRSP until you repay the full amount of your deemed distribution plus applicable accrued interest. The deemed distribution will count as an outstanding loan amount against the maximum number of loans available. Once you repay your deemed distribution balance with accrued interest, you may then be eligible to receive a new loan subject to the PSRP’s restrictions. The one-year wait between loans will restart on the date your deemed distribution is repaid.

Call Vanguard at 1-800-523-1188 to request information on paying off your defaulted loan.

You are responsible for updating any change of address in PRISM or reporting any change of address to your Assistant Chief Pilot. If you are no longer employed by FedEx, call Vanguard, 1-800-523-1188, to change your address.

**Distributions (When Payment 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 listed on page R-20.

Vanguard will send information to apply for your benefits no earlier than 45 days following your termination or retirement date as reflected in PRISM. If your balance is greater than $1,000, you may choose to defer your payment until age 70. If your account balance is $1,000 or less, your account balance is distributed as soon as administratively possible after 45 days. (See “Total Distribution Forms of Payment”).

If you terminate employment with a Participating Employer and become employed by another Controlled Group Member which is not a Participating Employer, 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 as long as 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. (For a list of Controlled Group Members, refer to “Plan Eligibility Scope and Guidelines,” page I-1). 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 Vanguard at 1-800-523-1188 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 forms of benefit payment listed on page R-20. Your beneficiary will be required to submit proof of your death to Vanguard.

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 forms of payments on page R-20 or defer payment until December 31 of the calendar year in which you (the participant) would have attained age 70.

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 forms of payments on page R-20 or defer payment until December 31 of the calendar year containing the fifth anniversary of your (the participant's) death.

**Steps to Take to File an Application for Benefits**

**Death**

1. Your beneficiary must notify Vanguard at 1-800-523-1188 of your death and submit necessary information to Vanguard.

2. Vanguard 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 may also 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.

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.

- **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 Institutional 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**

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 on file at Vanguard. The termination or retirement packet will include a spousal waiver of the Joint and Survivor Annuity form of payment as well as a form for your spouse's consent of a non-spouse beneficiary.

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 fact, 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 Pilots' Retirement Savings Plan 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:

Mercer
FedEx QDRO Administration
400 W. Market Street, Suite 700
Louisville, KY 40202-3346
1-888-598-7260
1-502-561-7809
1-502-561-8999 (fax)

You or your attorney may also call the QDRO Administration Center at 1-888-598-7260 to speak with a representative or request governing procedures and other documents, which are provided without charge. You may also request this information via email at QDRO@mercer.com.

Claims and Appeals
Information about filing a claim for benefits, reconsidering a claim, appealing a denial and legal action is provided in “Disability – Retirement Only,” page I-33 and “All Other Plans (including Retirement),” page I-33.

Steps to Take to Access Your Account by Telephone
(1) Call Vanguard at 1-800-523-1188 from a touch-tone phone
   Spanish-speaking participants: Call 1-800-828-4487
   Hearing-impaired: Call TTY at 1-800-749-7273

(2) The Vanguard VOICE Network will guide you through the enrollment process for payroll deductions and investment options. (To speak with a Vanguard Participant Services associate, press 0 at any time during your call [Associates are available from 8:30 a.m. to 9:00 p.m. Eastern time, Monday through Friday]. You do not have to know your PIN to speak with an associate.)

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.
Pilots’ Money Purchase Pension Plan (PMPPP)

The Pilots’ Money Purchase Pension Plan (PMPPP) became effective June 1, 1999. The purpose of the plan is to provide retirement benefits for eligible pilots in addition to the benefits provided by the Pension and Pilots’ Retirement Savings Plans. This defined contribution plan is only for employees covered by a collective bargaining agreement that provides for participation in this plan. The terms of the plan are based on the collective bargaining agreement between Federal Express Corporation and the Air Line Pilots Association. The Vanguard Group, Inc. serves as record-keeper of the Plan.

If you are a resident of Puerto Rico, different tax rules may apply.

Plan Year

The plan year for the PMPPP is from January 1 through December 31. A change in the Plan Year resulted in a short Plan Year (stub year) of June 1, 2002, through December 31, 2002.

Eligibility

If you were a Pilot on May 30, 1999, you automatically became a plan participant on June 1, 1999. Otherwise, once you become 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 Controlled Group Member, if you were credited with at least 1,000 hours of service during your first year of employment. See page I-1 for a listing of Controlled Group Members and “Hours of Service,” below. 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.

Hours of Service

Hours of service include each hour that you are paid or entitled to pay by FedEx Express, including time off for vacation, holidays, paid medical absences, jury duty or military duty as required by law.

Hours associated with non-taxable amounts paid from a Pilot’s Occupational Illness/Injury Sick Bank shall be counted as hours of service for eligibility, vesting and benefit accrual.

This does not include hours you are paid or entitled to pay just to comply with:

• Unemployment compensation laws,

• Workers’ Compensation laws*

• Disability insurance laws

• Payment made for medical expense reimbursement or

• Service during hours of family medical leaves (except the first 501 hours that are used to prevent a one-year break in service).

Hours credited by the Payroll Department are used in determining credited service while actively at work. The Payroll Department credits active pilots with 95 hours per pay periods.
Pilots receive credited service for periods of disability* which are calculated as follows:

\[
\text{Days of Leave} \div 7 \text{ Days} \times 45 \text{ Hours} = \text{Total Credited Hours per Leave}
\]

*If you are an individual who, on or after June 1, 1992, first becomes eligible for a disability benefit under the terms of the Federal Express Corporation Short Term Disability Plan or the Federal Express Corporation Long Term Disability Plan or the Federal Express Corporation Long Term Disability Plan for Pilots (as such plans may exist from time to time) or who becomes entitled to receive Workers' Compensation benefits, hours of service shall be credited to you as if your hours of service had been continuously credited during the period of such benefit entitlement up to your normal retirement age, or if greater, and to the extent required by law, for the period for which you qualify for such benefits.

**If You Are Reemployed or Are No Longer a Pilot**

If you terminate your employment or are no longer a Pilot and are reemployed or again become a Pilot, the following rules apply with regard to your PMPPP participation:

- If you participated in the PMPPP on the date you terminated employment or ceased to be a Pilot, you will resume participation on the first day of the month coincident with or next following the date you again become a Pilot.

- If you were not eligible to participate on the date you terminated employment or ceased to be a Pilot, you will be eligible to participate on the first day of the month coincident with or next following the date you complete the eligibility requirements starting the date you are reemployed.

- If you were eligible but had not started to participate on the date you terminated employment or ceased to be a Pilot, you will be eligible to participate on the first day of the month coincident with or next following the date you are reemployed.

**Employment within FedEx Corporation Controlled Group Members**

If you were previously employed by a FedEx Corporation Controlled Group Member which is not a Participating Employer of the Pilots’ Money Purchase Pension Plan (PMPPP), your applicable service during your previous employment with that Controlled Group Member will be combined with your service with FedEx Express to determine your eligibility. For a list of Controlled Group Members, refer to page I-1.

You will be eligible to participate in the Federal Express Corporation Pilots’ Money Purchase Pension Plan:

- On your date of employment with FedEx Express, provided: (i) you have satisfied the eligibility requirements for plan participation while employed by one of the FedEx Corporation Controlled Group Members, and (ii) immediately prior to your date of hire with FedEx Express, you were an active participant in a retirement plan sponsored by one of the non-participating Controlled Group Members; or

- On the first of the month coincident with or next following the date on which you have satisfied the eligibility requirements for plan participation, taking into account your combined service with the FedEx Corporation Controlled Group Member and your service with FedEx Express.

**Correspondence**

All PMPPP correspondence is sent to your paycheck address, if available, otherwise to your home address listed in PRISM. You are responsible for updating any change of address in PRISM or reporting an address change to your Assistant Chief Pilot. If you are no longer employed, contact Vanguard to change your address.

**Enrollment**

Once you have met all the Plan eligibility requirements, participation in the Plan is automatic.
When you become eligible to participate, you will automatically receive an informational package that includes a beneficiary form. You should complete the beneficiary form and return it as directed on the form. You also have the option of designating your beneficiary online at vanguard.com.

You should call Vanguard, 1-800-523-1188, to select your investment options or go online to the Vanguard website, vanguard.com. If you do not choose an investment option, your PMPPP contributions are automatically invested in the Target Retirement Fund closest to the year in which you will turn age 65.

Investments in Target Retirement Funds are subject to the risks of their underlying funds. The year in the fund 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 Fund is not guaranteed at any time, including on or after the target date.

Your Vanguard Personal Identification Number (PIN)

Your PIN is confidential. It is important that you remember your PIN; you will not be able to access your accounts through Vanguard’s VOICE® Network without it. If you forget your PIN, you must call Vanguard to request a new one. The same PIN is used to access your accounts in the Pilots’ Retirement Savings Plan and Pilots’ Money Purchase Pension Plan. Your PIN is not required in order to speak to a Vanguard Associate or to access your account on the Vanguard website.

Your Cost

FedEx pays the administrative cost for the plan. You will incur indirect costs when the investment funds in which you are invested deduct annual fund operating expenses from fund assets. This is typical with mutual funds. Refer to each fund’s prospectus for additional information.

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 vanguard.com under the “My Profile” tab once you have logged into your account. You cannot use PRISM to designate a beneficiary. You also have the option to complete a PMPPP beneficiary form provided by Vanguard and return it to Vanguard at the address on the form. Beneficiary forms can be obtained by contacting Vanguard at 1-800-523-1188.

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 vested death benefit payment will be made only to the legal guardian of the minor. In the event of your death, Vanguard must receive acceptable legal documentation which 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 previously consented to the designation of another person as your beneficiary on the QPSA beneficiary form. Your spouse’s written consent must be witnessed by a notary public. The completed, signed beneficiary form must be on file with Vanguard prior to the date of your death. It is important that you periodically review your beneficiary designation, which appears on your quarterly statements, because the most recent valid beneficiary form on file determines who receives any death benefits. Keep your beneficiary information up-to-date, especially if your marital status changes.

If your beneficiary dies before your PMPPP account 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

**Definition of Spouse**

For Pilots’ Money Purchase Pension Plan purposes, all references to the Pilot’s “spouse” shall have the same meaning as set forth in 1 United States Code Annotated Section 7 (1 U.S.C.A. § 7) (a person of the opposite sex who is a husband or a wife), and shall be deemed to refer solely to persons who have entered into a marriage, as defined in 1 U.S.C.A. § 7 (a legal union between one man and one woman as husband and wife).

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 Vanguard Participant Services.

**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 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 and 2007

• Lump Sum paid in 2011

• Vacation buybacks

Eligible earnings include pay prior to deductions, e.g. pre-tax health care, dependent care and 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
• PMPPP contributions
• Excess Life Premiums
• Earnings above the IRS compensation limit
• 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

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), hours of service for Plan eligibility will include service for the time you were in the military as well as service before your military duty. You must present proof of your activation date and release from active duty date to your Manager.

If applicable, any contributions missed during your MLOA will be made by using your imputed earnings determined in accordance with USERRA. MLOA make up contributions will be made within the time frame required under USERRA. Contributions may not exceed the applicable limits for the year in which they would have been contributed.

For more information, contact Vanguard at 1-800-523-1188.

Important IRS Limits

Maximum Compensation Limit [Section 401(a)(17) of the Internal Revenue Code (IRC)]

The IRS limits the maximum compensation that can be used to determine your benefits under the retirement plans. This limit is indexed by the Secretary of the Treasury based on increases in the cost of living.

The compensation limit was $116,666.67 (7/12 of $200,000) for the short Plan Year (June 1, 2002, through December 31, 2002). Thereafter, the calendar year limit is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>$225,000</td>
</tr>
<tr>
<td>2008</td>
<td>$230,000</td>
</tr>
<tr>
<td>2009</td>
<td>$245,000</td>
</tr>
<tr>
<td>2010</td>
<td>$245,000</td>
</tr>
<tr>
<td>2011</td>
<td>$245,000</td>
</tr>
<tr>
<td>2012</td>
<td>$250,000</td>
</tr>
</tbody>
</table>

Pilots’ Retirement Savings Plan and Pilots’ Money Purchase Plan Contribution Limit — [Section 415(c) of the Internal Revenue Code (IRC)]

The combined amount that can be contributed annually to the PRSP and the PMPPP is limited. This limit applies to all contributions to your PMPPP account and contributions made to your PRSP accounts through Pre-tax/401(k) contributions, After-tax contributions, Employer Matching contributions on your Pre-tax/401(k)
contributions, and Sick Bank contributions. Catch-up contributions are excluded from this limit.

For the 2012 plan year, the limit is the lesser of:

- 100% of your eligible earnings; or
- $50,000

The limit is scheduled to be indexed by the Secretary of the Treasury based on increases in the cost of living.

If the contributions during the plan year to your PRSP and PMPPP accounts exceed the Section 415(c) Plan Year limit, the excess contributions (plus earnings) will be reduced in the following order and, if applicable, the excess will be automatically returned to you:

- PRSP Employer Sick Bank Contributions
- PRSP After-tax Contributions
- PRSP Pre-tax/401(k) Contributions
- PRSP Employer Matching Contributions
- PMPPP contributions

Within each of the above categories of contributions, military make-up contributions will be reduced last.

FedEx Corporation Controlled Group Limits

If you were previously employed by a FedEx Corporation Controlled Group Member which is not a Participating Employer of the PMPPP, your applicable eligible earnings and contributions during your previous employment with that Controlled Group Member will be combined with your FedEx Express eligible earnings and contributions to determine the PMPPP limits on contributions. For a list of Controlled Group Members, refer to page I-1.

Pilots’ Money Purchase Pension Plan Accounts

- **Money Purchase Plan Account**—This account is for your employer contributions.
- **Military LOA Money Purchase Plan Account**—This account is for your employer contributions upon your return from military leave.
- **Rollover Account**—This account is for your rollover contributions. If you were a participant in a tax-qualified retirement plan of a former employer, you can transfer (roll over) your former account balance to the PMPPP upon meeting certain criteria. However, if you are directly transferring from another Controlled Group Member to FedEx Express, you are not eligible to make a rollover contribution. 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, contact Vanguard. You must be a plan participant before you can roll over contributions.

Vesting

Vesting refers to your right to receive a benefit when you terminate employment, subject to the distribution rules. See “Termination of Employment or Retirement,” page R-76. You are 100% vested in your account when you become eligible to participate in the Plan.

Account Statements

As a PMPPP participant, you receive a statement of your accounts each calendar quarter. The statement, which lists your account balances, contributions, earnings and
other activity, is sent about two to three weeks after the end of the quarter. Recent statements are also available at vanguard.com.

**Investment Options**

No investment is without risk. Since your choices could have a substantial impact on the amount you ultimately receive from the PMPPP, you should consider your investments.

If you do not choose an investment option, your contributions are automatically invested in the Target Retirement Fund closest to the year in which you will turn 65.

The PMPPP offers a diversified lineup of investment options. To learn more about the following Vanguard mutual funds, contact Vanguard at 1-800-526-1188 or at vanguard.com.

The investment options in the PMPPP are organized into three tiers:

- Vanguard Target Retirement Funds
- Vanguard LifeStrategy Funds
- Core funds

**Vanguard Target Retirement Funds**

Vanguard Target Retirement Funds provide a professionally maintained, diversified mix of investments that shifts emphasis to more conservative investments as you move closer to retirement.

Investments in Target Retirement Funds are subject to the risks of their underlying funds. The year in the fund name refers to the approximate year (the target date) when an investor in the fund would leave the workforce at an assumed retirement age of 65. The fund 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 Fund is not guaranteed at any time, including on or after the target date.

Please note that while the Target Retirement Funds shift to more conservative asset allocations as the target date approaches, the funds continue to have exposure to stocks/equities. For example, the Target Retirement Income Fund is for retirees who may need to draw income. If you invest in this fund, your investments will have an allocation of 30% stocks, 65% bonds and 5% short-term reserves. On average, individuals who retire at age 65 may expect to enjoy 17-20 years in retirement, and many will enjoy even longer lives. The investment allocation for each Target Retirement Fund factors in average life expectancy after the target date is reached and, as a result, continues to have exposure to equities 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 Fund invests in several broadly diversified Vanguard funds—primarily low-cost Vanguard index funds.

As previously explained, Target Retirement Funds are one-fund options that automatically shift their emphasis to more conservative investments over time. However, it is important to know that the fund 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 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.
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.

### Core funds

If you have some investing experience and the time to research your plan’s fund options, consider creating a diversified portfolio of core funds. These are funds of various asset classes that, when used in combination, can provide the diversification you need.

<table>
<thead>
<tr>
<th>Fund Name/Ticker Symbol</th>
<th>Fund Type</th>
<th>Objective</th>
<th>Risk Level (Determined as of 6/30/12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanguard LifeStrategy Conservative Growth Fund VSCGX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide current income and low-to-moderate capital appreciation.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard LifeStrategy Moderate Growth Fund VSMGX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide capital appreciation and a low-to-moderate level of current income.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard Prime Money Market Fund Institutional Shares VMRXX</td>
<td>Money market</td>
<td>Seeks to provide current income while maintaining liquidity and a stable share price of $1.</td>
<td>Conservative</td>
</tr>
<tr>
<td>Vanguard Retirement Savings Trust No ticker symbol</td>
<td>Stable value</td>
<td>Seeks to provide current and stable income while maintaining a stable share value of $1.</td>
<td>Conservative</td>
</tr>
<tr>
<td>Janus Flexible Bond Fund Class I Shares JFLEX</td>
<td>Bond</td>
<td>Seeks to obtain maximum total return, consistent with preservation of capital.</td>
<td>Conservative to moderate</td>
</tr>
<tr>
<td>Vanguard Inflation-Protected Securities Fund VIPSX</td>
<td>Bond</td>
<td>Seeks to provide investors inflation protection and income consistent with investment in inflation-indexed securities.</td>
<td>Conservative to moderate</td>
</tr>
<tr>
<td>Vanguard Total Bond Market Index Fund Institutional Shares VBTIX</td>
<td>Bond</td>
<td>Seeks to track the performance of a broad, market-weighted bond index.</td>
<td>Conservative to moderate</td>
</tr>
<tr>
<td>Vanguard Wellington Fund VWELX</td>
<td>Balanced (stocks and bonds)</td>
<td>Seeks to provide long-term capital appreciation and reasonable current income.</td>
<td>Moderate</td>
</tr>
<tr>
<td>Vanguard 500 Index Fund Signal Shares VIFSX</td>
<td>Domestic stock</td>
<td>Seeks to track the performance of a benchmark index that measures the investment return of large-capitalization stocks.</td>
<td>Moderate to aggressive</td>
</tr>
<tr>
<td>Vanguard Windsor Fund VWNDX</td>
<td>Domestic stock</td>
<td>Seeks to provide long-term capital appreciation and income.</td>
<td>Moderate to aggressive</td>
</tr>
</tbody>
</table>
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 Funds are subject to the risks of their underlying funds. The year in the fund 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 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 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.

Policies That Affect Your Investment Direction

While the PMPPP allows a great deal of flexibility for you to choose your investments, Vanguard 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. 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 PMPPP, Vanguard Prime Money Market Fund Institutional Shares and Vanguard Inflation-Protected Securities Fund are designated as competing funds.

You can transfer money from Vanguard Retirement Savings Trust into a stock fund, balanced fund, or an intermediate- or long-term bond fund at any time. However, the money must remain there for 90 days before you can transfer it into a shorter-term bond or money market fund (such as Vanguard Prime Money Market Fund or Vanguard Inflation-Protected Securities Fund).

This investment restriction is imposed by the financial institutions that issue the contracts in Vanguard Retirement Savings Trust's portfolio. The restriction is designed to discourage frequent shifting of money from one fund to another to take advantage of slight changes in interest rates. Such frequent transfers drive up the cost of managing Vanguard Retirement Savings Trust, which harms all Vanguard Retirement Savings Trust investors.

Please refer to the prospectus of each investment fund for a more detailed summary, as well as any changes to these policies.

**Frequent-trading policy**

A frequent-trading policy applies to all funds in the PMPPP, with the exception of Vanguard Retirement Savings Trust and Vanguard Prime Money Market Fund Institutional 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 60 calendar days. The term “exchange” refers to a transaction in which proceeds from a redemption of fund shares in the PMPPP are used to purchase another investment offered within the PMPPP.

Please note that the 60-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 60-day restriction described above will not apply to any change that you make to the investment of future contributions. The prospectus for each fund 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 Vanguard at 1-800-523-1188 or online at vanguard.com.

This policy will not apply to the following:

- Vanguard Retirement Savings Trust and Vanguard Prime Money Market Fund Institutional 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 a Plan
• Redemptions of shares as part of a Plan termination or at the direction of the Plan
• Redemptions of shares by Vanguard 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 PMPPP 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 PMPPP’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 by the fiduciary for the Plan in accordance with the investment guidelines for the Plan.

How to Select or Change Your Investment Options
Your Choices — The PMPPP’s investment lineup is organized into three tiers: Vanguard Target Retirement Funds, Vanguard LifeStrategy Funds, and Core funds. Consider choosing a single Vanguard Target Retirement or LifeStrategy Fund or create your own mix from the Core 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 can also 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 — Vanguard 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 vanguard.com or by calling Vanguard’s VOICE Network at 1-800-523-1188. You can also speak to a Vanguard associate between 7:30 a.m. and 8:00 p.m., Central time, Monday–Friday, by calling Vanguard at 1-800-523-1188.
If you make elections/changes before the stock market closes (normally 3:00 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 3:00 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.

Vanguard will send a written confirmation of your elections or changes to your home address within seven business days.

For more information about any fund, including investment objectives, risks, charges and expenses, call Vanguard at 1-800-523-1188 to obtain a prospectus. The prospectus contains this and other important information about the fund. Read and consider the prospectus information carefully before you invest. You can also download Vanguard fund prospectuses at vanguard.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 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.

**Employer Contributions**

Until January, 2008, Federal Express made a monthly cash contribution to the Pilots' Money Purchase Pension Plan Account for each participant in an amount equal to six percent (6%) of the participant's eligible earnings for the prior month. In January 2008 Federal Express made an additional, one-time contribution to each Participant in an amount outlined below:

- For a Participant whose total Compensation for 2007 was less than $225,000 (the limit imposed on Compensation for 2007) the Company made a one-time contribution of 1% of the sum of the Participant's Compensation for October, November and December, 2007. The sum of the Company's contributions to the Participant's Separate Account did not exceed $14,062.50. If the Participant received no Compensation for October, November or December 2007, no additional contribution was made.

- For a Participant whose total Compensation for 2007 was equal to $225,000 (the limit imposed on Compensation for 2007 under Section 401(a)(17) of the Code), the following applied:
  - For a Participant who received Compensation, or who received wages that would be considered Compensation but for the limit imposed by Section 401(a)(17), in
each of October, November and December 2007, the Company made a one-time contribution of $562.50. The sum of the Company’s contribution to the Participant’s Separate Account did not exceed $14,062.50.

–For a Participant who received Compensation, or who received wages that would be considered Compensation but for the limit imposed by Section 401(a)(17), in exactly two of the final three months of 2007, the Company made a one-time contribution of $375. The sum of the Company’s contribution to the Participants Separate Account did not exceed $13,875.

–For a Participant who received Compensation, or who received wages that would be considered Compensation but for the limit imposed under Section 401(a)(17), in only one of the final three months of 2007, Federal Express made a one-time contribution of $187.50. The sum of the Company’s contribution to the Participant’s Separate Account did not exceed $13,687.50.

–For a Participant who received neither Compensation, nor wages that would be considered Compensation but for the limit imposed under Section 401(a)(17), in any of the final three months of 2007, the Company made no additional contribution.

Since February 1, 2008, the monthly contribution amount has been seven percent (7%) of the participant’s eligible earnings for the prior month. Contributions are limited by the IRS 401(a)(17) Maximum Compensation Limit.

All Plan contributions are held in a trust fund. The PMPPP’s cash assets are managed and invested by the trustee, as directed by you.

<table>
<thead>
<tr>
<th>Distributions (When Payment Can Be Made)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement or Termination of Employment</td>
</tr>
<tr>
<td>If you retire from the Controlled Group on or after your normal retirement date (age 60) or your early retirement date (age 55) or you terminate employment from the Controlled Group before either of those dates, the following distribution rules apply:</td>
</tr>
<tr>
<td>• If your account balance is $5,000 or less and you do not elect a direct rollover within the election period, you will receive a one-time distribution of your entire account balance.</td>
</tr>
<tr>
<td>• If your balance is greater than $5,000, you may choose to defer your distribution to April 1 after attaining age 70 ½ or you may choose to immediately commence your benefit under one of the forms of benefit payment described in the “Forms of Benefit Payment” section below.</td>
</tr>
</tbody>
</table>

No earlier than 45 days following your termination or retirement date, as reflected in PRISM, you will be sent information and forms to apply for your benefits.

You will not be eligible to receive a distribution from the PMPPP if you transfer from Federal Express Corporation to any other Controlled Group Member.

<table>
<thead>
<tr>
<th>Forms of Benefit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your account balance is greater than $5,000, you may choose to have your account paid in one of several forms. 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.</td>
</tr>
</tbody>
</table>

**Normal Form of Payment**

The IRS requires that your pension be paid in the following forms unless another option is specifically elected.

If you are unmarried, payment is normally a monthly benefit paid to you for the rest of your life. This is called a Single Life Annuity.
If you are married, payment is normally a monthly benefit paid to you for the rest of your life. When you die, 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 Joint and Survivor Annuity with 50%, 75% or 100% continued to your spouse, unless your spouse consents to your payment choice and your designated beneficiary. Your spouse’s written consent must be witnessed by a notary public and on file at Vanguard. The retirement packet will include a spousal waiver of the Joint and Survivor Annuity form of payment, as well as a form for your spouse’s consent to a non-spouse beneficiary.

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.

**Optional Forms of Payment**

You may want to receive benefits in some other way. If you do, you can select one of the following payment options:

- **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 amounts paid directly to you. To avoid the 20% withholding, you may request a direct rollover distribution to be made to a qualified rollover IRA or another qualified retirement plan. 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% penalty tax in addition to federal, state and local income tax.

- **Direct Rollover** – Provides a payment of your account balance to a 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.

- **Optional Joint and Survivor Annuity** – You receive a level monthly pension 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. The amount of your benefit will be determined by the purchase of the appropriate annuity contract. If you choose the Annuity option, you will be responsible for any fees involved with the purchase.

- **Straight Life Annuity** – You receive a level monthly benefit for life. The amount of your benefit will be determined by the purchase of the appropriate annuity contract. If you choose the Annuity option, you will be responsible for any fees involved with the purchase.

- **Installments** – You receive monthly, quarterly, semiannual or annual payments. You may choose the payment period, up to 20 years or your life expectancy, if less.

**Important Information When Selecting a Joint and Survivor Annuity Form of Payment**

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 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 Pilots’ Money Purchase Pension Plan 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 the benefit payable to you may not be reduced by more than 50%.

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.

Death

Pre-Retirement Death Benefit
If you die, your beneficiary will be eligible to receive your entire account balance. Your beneficiary will be required to submit proof of your death to Vanguard. Survivor benefits are payable as follows:

Non-Spouse Beneficiary
- If your account balance is $5,000 or less, your account balance will be distributed to your beneficiary as soon as administratively possible.
- If your account balance is greater than $5,000, your beneficiary can be paid in a lump sum unless your beneficiary elects one of the forms of payment described in the “Forms of Benefit Payment” section on page R-77 (with the exception of a Direct Rollover). If installment payments are selected, such installment payments must begin within the first year of your (the participant’s) death. Your beneficiary may also elect to defer distribution (other than installments) until December 31 of the calendar year containing the fifth anniversary of your (the participant’s) death.

Spousal Beneficiary
- If your account balance is $5,000 or less, your balance will be distributed to your spouse as soon as administratively possible.
- If your account balance is greater than $5,000, your account balance can be used to buy a Qualified Pre-Retirement Survivor Annuity (QPSA). With a QPSA, your spouse will receive a level monthly benefit each month following your death until the month in which your spouse dies. You may waive this benefit with your spouse’s written, notarized consent, or your spouse may waive this benefit following your death. If waived, your spouse may elect one of the forms of payment described in the “Forms of Benefit Payment” section on page R-77. Your spouse may also elect to defer distribution to no later than December 31 of the calendar year you (the participant) would have attained age 70½.

Post Retirement Death Benefit
If you elected one of the optional joint and survivor annuities or the installment option and you die after you begin receiving payment, your beneficiary’s benefit is based on the payment option you selected.

Steps to Take to File an Application for Benefits

Death

(1) Your beneficiary must notify Vanguard at 1-800-523-1188 of your death and submit necessary information to Vanguard.

(2) Vanguard will verify the beneficiary and coordinate the distribution process.

Payments to an Alternate Payee

With the exception of a Qualified Domestic Relations Order (QDRO), your benefit from the Pilots’ Money Purchase 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 Pilots’ Money Purchase 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 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 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:

Mercer
FedEx QDRO Administration
400 W. Market St., Suite 700
Louisville, KY 40202-3346
1-888-598-7260
1-502-561-7809
1-502-561-8999 (fax)

You or your attorney may also call the QDRO Administration Center at 1-888-598-7260 to speak with a representative or request governing procedures and other documents, which are provided without change. You may also request this information via email at QDRO@mercer.com.

Claims and Appeals
Information for filing a claim for benefits, reconsidering a claim, appealing a denial and legal action is explained in the section entitled “Introduction,” subheading “Claims and Appeals,” pages I-17.

Steps to Take to Access Your Account by Telephone
(1) Call Vanguard at 1-800-523-1188 from a touch-tone phone.
   Spanish-speaking participants: Call 1-800-828-4487
   Hearing-impaired: Call TTY at 1-800-749-7273

(2) The Vanguard VOICE Network will guide you through the process for investment options.
   (To speak with a Vanguard Participant Services associate, press 0 at any time during your call [Associates are available from 8:30 a.m. to 9:00 p.m. Eastern time, Monday through Friday]. You do not have to know your PIN to speak with an associate.)
# Company Jumpseat

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Company Jumpseat

General

1. 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 jumpseat policy, effective January 25, 1998, and included in this Pilot Benefit Book (PBB).

2. As detailed in the contract, Section 26.J.2., a pilot may use a Company staging jumpseat to position himself in Memphis for the start of his scheduled trip (“No Harm, No Foul”), provided he meets the requirements of that section and the Jumpseat policy.

3. Violations of the Company 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 Jumpseat Policy (e.g., for no-shows), are not considered discipline subject to Sections 19 and 21.

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 (e-mail is sufficient) from the Duty Officer (for day of operations situations) or the pilot's ACP/RCP (for situations involving more lead time) sent to Jumpseat Administration.

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 contact their ACT's to be included in the jumpseat privilege.

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).

Travel Status

When you make a jumpseat reservation, you are assigned a travel status. Your status puts you in a specific category of travel. From lowest to highest, the priority of each travel category for which a pilot can make a reservation is as follows:

1. Personal (P) All pilots are eligible for jumpseat privileges starting with their hire date. Reservations for personal travel are accepted on a first-come, first-served basis.

   Pilots with urgent personal travel needs shall contact the Duty Officer, who shall address the situation and work with Jumpseat Administration to resolve it. In the event of a personal emergency, any status jumpseater may be bumped if necessary.

2. Staging (S) Pilots who commute by air from their primary residence to their base are eligible for staging travel. This status allows staging and destaging to/from base. In order to stage, a pilot must name one 3-letter ramp identifier, (which Federal Express flies to), as the airport serving his primary residence, from which the pilot will stage. The pilot must also indicate his current base. Pilots are eligible to stage from any FedEx ramp within 100 nautical miles of their primary residence/staging city. Primary residence is the employee's principal place of dwelling, as indicated in PRISM. Primary residence for Staging may not change more frequently than 90
days unless it is with the consent of the Company. With a change in residence, the employee must name one 3-letter ramp identifier which Federal Express flies to as their new primary residence/staging city.

While staging is considered Personal travel, it has the same priority as Business or Decade travel for reservation purposes. The pilot is responsible for canceling reservations and adhering to the showtimes (see Check In and Required Show Time).

For bumping purposes, Staging travel has the same authority as Business or Decade; neither may bump the other. However, if one must be bumped, it is Staging. Staging may bump Personal travel reservations up to 3 business days (Monday-Friday) before the day of the flight (See Bumping).

Thirty (30) days after a pilot receives a company paid relocation to a principal residence co-located at their new base they are no longer eligible to stage.

3. Decade (d) Decade travel is available to all pilots who have completed at least 10 years continuous service. This privilege allows the pilot to make one round trip reservation per fiscal year with the priority of Decade travel. If the pilot changes the travel dates, the privilege is forfeited for that fiscal year. Employees with 20 years of continuous service may book up to two round trips per fiscal year in Decade status.

Decade reservations may bump Personal travel reservations up to 3 business days (Monday-Friday) before the day of the flight and are subject to being bumped by higher priority travel (See Bumping).

4. Business (B) Pilots are eligible for Business travel jumpseat privileges beginning on their hire date. Business travel is defined as travel which otherwise would be paid by Federal Express. Deviation travel banks are not reduced as a result of pilots traveling in Business status in lieu of commercial deadheads. Business may bump a personal travel reservation up to 3 business days (Monday-Friday) before the day of the flight (See Bumping). Business status while deviating shall be in accordance with Section 8.C.1.i of the contract. Pilots are not required to have manager authorization to book a reservation. The provisions of Section 26.J.2 of the contract do not apply to Business travel status.

Carriage of Persons on Cargo Aircraft

Certain persons may be carried on cargo flights without complying with certain passenger requirements (see FAR 121.583). Carriage of such persons and allocation of available jumpseats shall be in accordance with the Flight Operations Manual (the current applicable section of which is FOM 2.93 Carriage of Persons on Cargo Aircraft).

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 two weeks of the current date. The new reservation day starts at 12:00 a.m., Central Time. Walk-up jumpseating is not permitted except as outlined in the FOM.

Example: Monday, October 13, for a flight Monday, October 27.

You may make reservations for any flight on Monday, October 27 as early as 12:00 a.m. Central Time, October 13.

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 standbys are contacted when flights become available, time permitting. An e-mail notification, time permitting, may be sent to the first standby when a set becomes available. The open seat(s) is held available for standby jumpseater(s) until 6 hours prior to departure. At that time, the standby list is discarded and many open seat(s) may be reserved on a first-come, first-served basis.

**Bumping**

1. Bumping (preempting) another person from a jumpseat for Business, Staging, or Decade 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.

<table>
<thead>
<tr>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Monday</th>
</tr>
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</table>

*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.*

<table>
<thead>
<tr>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bumping Day</td>
<td>Business Day 1</td>
<td></td>
<td></td>
<td>Business Day 2</td>
<td>Flight Day</td>
</tr>
</tbody>
</table>

*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.*

<table>
<thead>
<tr>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bumping Day</td>
<td>Business Day 1</td>
<td></td>
<td>Holiday</td>
<td>Business Day 2</td>
<td>Flight Day</td>
<td></td>
</tr>
</tbody>
</table>

*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 misbooked passenger 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 an FAA/NTSB inspector or an employee traveling in a business or emergency status. Pilots deadheading on Operational Emergency status may bump specific flights when multiple flights exist. The decision as to which flight(s) will be bumped is made by Flight Management.

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 Business, Staging, or Decade on a rerouted/cancelled flight, or a flight where an emergency has been declared, cannot bump another jumpseater even if he holds a higher priority status.

**NOTE:** Business, Staging, and Decade pilots 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.

**Cancellation**

1. If the pilot holds 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 their responsibility to decide whether to cancel or keep their confirmed reservation on the other flight.

2. If the pilot is unable to use a jumpseat they have reserved, they must cancel their reservations soon as possible. A cancellation must be made no less than 6 hours before the scheduled departure time for Personal, Decade or Staging travel, or no less than 2 hours before the scheduled departure for Business travel without the no-show penalties being applied. If extenuating circumstances led to a no-show, upon request, Jumpseat Administration and the pilot's ACP 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 standard no-show penalty should be reversed.

3. If you hold bookings on more than one flight (e.g., on Flt. XXX into Memphis and on Flt. YYY out of Memphis) you must cancel them as two separate flight reservations. Jumpseat Administration does not assume that the Flt. XXX reservation is not valid just because you 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
   (c) Call 1-800-544-9040 or 901-224-5420 (Option 5 from the phone menu) and leave your name, employee number, flight number(s) you are canceling, and the date(s) of flight(s) on the cancellation tape
   (d) Complete a walk-in request form in Jumpseat Administration

**NOTE:** Speaking with ramp personnel does not effect a cancellation. If you do not cancel your reservation through one of the four approved methods, you are considered a no-show for the flight and are subject to having your Company jumpseat privileges suspended. You are ultimately responsible for your own jumpseat reservations.

**Requirements for Jumpseating**

1. Before checking in for a flight, be certain that you meet the following requirements:
   (a) You must have your bags screened prior to checking in for your flight. After your bags are screened, you must check in for your flight in person with the appropriate Company employee. You are required to go through screening only once, provided your baggage remains within the secure area. You must comply with all TSA and Company requirements.
   (b) FAA regulations require that you pack and know the contents of your baggage. Dangerous goods are prohibited (See Dangerous Goods, 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). Your baggage must be in your control at all times, and you must not carry items from
unknown persons. Your baggage should be limited to only what you can carry up the boarding steps. Oversize 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 you when you jumpseat.
(d) Good personal hygiene is expected.
(e) Personal electronic devices must be turned off during the flight unless approved by the Captain.
(f) Pilots must request authorization in writing from the Vice President, Corporate Security, or his designee, to carry firearms/weapons. If approved, an authorization letter with specific handling details is issued and must be carried with you at all times. In all cases, the Captain of each flight must be notified of the firearm/weapon prior to boarding the aircraft. The firearm must be placed in an inaccessible area during the flight (See Firearms/Weapons). See FOM 13.17 for further details. Provisions for the carriage of firearms by FFDO's are found in FOM 13.19.
(g) The consumption of alcoholic beverages within eight hours of departure is strictly prohibited.
(h) Smoking is prohibited on the aircraft or on any airport ramp (except in designated locations).
(i) It is the pilot's responsibility to insure that the emergency contact information in PRISM is up-to-date.

2. International Travel

(a) In addition to the requirements of section 1 above, pilots are 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-hours 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 personal 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. Noncompliance 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
(b) Jumpseat Administration personnel in Memphis
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. As a safety measure, appropriate footwear and attire are required to ride any jumpseat. The following items are considered inappropriate jumpseat attire for all pilots:
   (a) Micro-mini skirts
   (b) Shorts (including company-issued)
   (c) T-shirts (including those with FedEx logo)
   (d) Jogging/exercise suits
   (e) Workout clothing
   (f) Bare midriff
   (g) Tight, sheer/see-through clothing
   (h) Tank tops
   (i) Beach clothing
   (j) Cut-off clothing
   (k) Clothing with offensive terminology or graphics
   (l) Clothing with holes/ragged edges
   (m) Excessively long, bulky or flowing clothing
   (n) Leggings
   (o) Sandals/mules/high-heel shoes
   (p) Dirty/worn out jeans
   (q) Fatigues

3. This dress code also includes any other clothing that would detract from the business image of Federal Express.

4. Pilots must adhere to any request from a reservationist, ramp agent, flight coordinator, or Captain to alter clothing, shave, or deboard due to inappropriate and/or unsafe attire. Each one has the authority to deny jumpseat passage to anyone deemed inappropriately dressed.

5. Pilots must comply with the dress code policy at all times. Ramp agents should ensure compliance with the dress code policy before allowing you to board the aircraft. If you do not meet the dress code, you will not be allowed to travel until you comply.

NOTE: Failure to be appropriately dressed upon check-in at ramp locations or in Memphis could result in denied boarding.

Check-In and Required Show Time

1. Pilots are responsible for checking in by published show time. Check-in is at least one hour prior to scheduled departure. Some flights have extended show times due to possible early departures (refer to flight information in Freebird or ask Jumpseat Administration). Arriving earlier than your show time 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 be visible at all times. 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.

**No Shows**

1. If you fail to report for a scheduled jumpseat or arrive less than one hour before scheduled time of departure you will be considered a “no-show” and receive a jumpseat suspension notice. If you arrive after the scheduled show time, Jumpseat Administration in Memphis/Ramp Operations elsewhere, will determine the impact on the operation and may allow boarding of the flight, with the Captain’s concurrence.

2. If you don’t accompany the operating flight crew to the aircraft, you must be onboard the aircraft 30 minutes prior to scheduled departure.

3. If you receive a suspension notice for a jumpseat booked for Personal, Staging or Decade travel, your jumpseat privileges will be suspended for 30 days for the first offense within a 365 day period, 90 days for the second offense, and 1 year (365 days) for the third offense.

**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 (901) 434-9544, 8:00 a.m. – 5:00 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.

**Firearms/Weapons**

1. Unauthorized firearms or weapons are not permitted on FedEx aircraft.

2. Provisions for the carriage of firearms by FFDO’s are found in FOM 13.19.

3. Pilots must request authorization in writing from the Vice President, Corporate Security, or his designee, to carry firearms/weapons. If approved, an authorization letter with specific handling details is issued and must be carried with you at all times. In all cases, the Captain of each flight must be notified of the firearm/weapon prior to boarding the aircraft. The firearm must be placed in an inaccessible area during the flight. See FOM 13.17 for further details. Provisions for the carriage of firearms by FFDO’s are found in FOM 13.19.

**NOTE:** Any approval granted by the Vice President of Corporate Security, or his designee, presumes that the employee is in compliance with any applicable government law, statute, ordinance, code or regulation governing the possession or carrying of a weapon or firearm.
4. Inform the Captain of your flight that you are carrying a firearm and show him your authorization letter before boarding the aircraft. The firearm must be placed in an inaccessible area during the flight.

5. Possessing or carrying unauthorized weapons on Company property may result in immediate discipline, up to and including termination, subject to Sections 19 and 21 of the collective bargaining agreement.

NOTE: Weapons and firearms are those designated as such by applicable local, state and federal statutes to include, but not limited to, disabling tear gas dispensers, guns, starting pistols, flare pistols, and any pocket or hunting knife with a blade exceeding 3 inches in length.

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 has complete authority over the crew and the jumpseating passengers on his flight from the time they report for the flight until the flight is terminated. His 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 relocated anyone who presents potential danger to the safety of the flight.

2. Below 10,000 MSL, maintain sterile cockpit procedures.

3. Store your baggage 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 pace makers 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
1. Never take action to operate any emergency equipment unless directed by an operating pilot. Exceptions to this rule are:
   
   (a) When acting in the role as an additional pilot performing duties as directed or briefed by the Captain.

   (b) When a pilot is unavailable, and the situation dictates immediate action on your part.

   (c) During a loss of aircraft pressurization, which requires that you put on your oxygen mask without delay.

   (d) 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 Jumpseat Incident form to make a report. The jumpseat incident report is on the ALPA Website under “Jumpseat Committee.”
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.

Reciprocal Jumpseat Agreements

1. FedEx management, in conjunction with the ALPA Jumpseat Committee, will enter into 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. Reciprocal access to cockpit jumpseats is available only through the Cockpit Access Security System (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 conduct themselves in a courteous and professional manner at all times. 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/idx/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 other carriers should utilize the ALPA jumpseat incident form to make a report. The jumpseat incident report is on the ALPA Website under “Jumpseat Committee.” The Jumpseat Committee and the Company, as appropriate, shall investigate the alleged abuse and take action(s) as appropriate.

5. FedEx pilots are encouraged to provide the other carriers’ pilots ALPA Jumpseat “Thank you” cards. These are available at all domiciles and major hubs or near the ALPA bulletin board.
# 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, jury duty, military, personal and bereavement absences, as described in the Collective Bargaining Agreement. For information on such policies, contact your Assistant Chief Pilot.

Catalog Store

The Company Store Online – FedEx Collection (formerly Catalog Store)

The FedEx Company Store 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 http://www.bdasites.com/fedexcollection or visit The FedEx Catalog Collection Store at the following locations in the Memphis area:

- FedEx World Tech Center
- FedEx World Headquarters

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you should contact the Catalog Store directly at www.bdasites.com/fedexcollection.

Credit Association

You and your immediate family (spouse, children, stepchildren, parents, stepparents, brothers, sisters and grandparents) may join the FedEx Employees Credit Association. You are eligible to join as soon as FedEx issues you an employee number. To join, complete a membership card, pay the $1 membership fee and make a deposit of $25. See your Assistant Chief Pilot or call the Credit Association at 1-800-228-8513 or 1-901-344-2500 in the Memphis area to get a membership card.

The following services are offered by the Credit Association:

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</tr>
<tr>
<td></td>
<td>Available through payroll deduction or voluntary deposits. Payroll deductions can transfer to family member account, if desired. May be used as collateral for a secured loan.</td>
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<tr>
<td></td>
<td>Available for FedEx groups such as bowling and golf leagues, Enduro Team, etc.</td>
</tr>
<tr>
<td>Share certificate accounts</td>
<td>Certificates of deposit. Available for various amounts (three-, six- and 12-month maturity).</td>
</tr>
<tr>
<td>Christmas Club account</td>
<td>Payroll deduction or direct deposit.</td>
</tr>
<tr>
<td>Individual retirement account (IRA)</td>
<td>Retirement savings. Both Traditional and Roth IRAs are offered.</td>
</tr>
<tr>
<td>Money Market account</td>
<td>A special savings account that pays higher dividends.</td>
</tr>
<tr>
<td>Money orders</td>
<td>$1 each.</td>
</tr>
<tr>
<td>Traveler's checks</td>
<td>No service charge.</td>
</tr>
<tr>
<td>Safety deposit boxes</td>
<td>Available in five different sizes.</td>
</tr>
<tr>
<td>Share draft accounts</td>
<td>Checking accounts. $25 initial deposit. Direct deposit is available.</td>
</tr>
</tbody>
</table>
### Other Benefits and Services

**Service** | **Description**
---|---
Automated teller cards | 24-hour teller. Can be used at all Cirrus, Exchange, STAR, Honor, Co-op and Pulse ATM locations.
MARS Express Phone | Telephone inquiry and transaction service; 1-800-833-3544 or 1-901-332-9232 in the Memphis area.
Signature loans | Amounts determined by applicant’s Credit Bureau score.
First mortgage loans | Home mortgage loan. Financing up to a maximum of 95% (97% for first-time buyer program). Various types of loans, competitive rates, payments made through direct deposit. All FedEx locations in continental U.S. serviced.
Second mortgage loans | Home mortgage loan. Financing up to 90% on fixed loans and 90% on lines of credit. Credit Association pays all closing costs on home equity loans only.
Secured loans | May be secured by share and share certificate accounts or may be used for any purchase of:
- Automobiles – new and used
- Motorcycles – new only (current year)
- Motorized recreational vehicles – new and used
- Nonmotorized recreational vehicles – new only; campers must be in title state
- Boats – new and used; must be titled
- Airplanes – new and used
Visa | Credit card. Competitive rates for regular Classic Visa and Classic Visa secured with your savings.
Notary public service | Offered in Memphis only. Credit Association membership not required. Free to members.
Debit cards | Express Check cards can be used at any location that accepts the Visa card and any CIRRUS, Exchange, STAR, Honor and Pulse ATM locations.
Home Financial Center | REX (Remote Express) PC access for account inquiries, transactions and unlimited bill payment. REX access now available via our home page.
Internet | Product information and applications online: [http://www.fecca.com](http://www.fecca.com).
MARS Loans by Phone | Express Loans by Phone allows you to apply for loans 24 hours a day by using the automated Loans by Phone system at (901) 332-9232 or (800) 833-3544.
Blue Book quotes | National Auto Dealer Association Publication. Price quotes for new and used automobiles, motorcycles and recreational vehicles.

You may apply for signature or secured loans. Certain qualifications apply. Interest rates on these loans are generally lower than those of other lending institutions. Dividends paid on share and share certificate accounts are offered at competitive rates.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you should contact the Credit Association directly at 1-800-228-8513 or 1-901-344-2500 in the Memphis area.

### Flexible Spending Accounts

**Dependent Care Reimbursement Account (DCRA)**

The Dependent Care Reimbursement Account (DCRA) is designed to help you save tax dollars on child care services, elder care, or care for a disabled spouse or dependent that you usually pay with after-tax dollars. Amounts set aside for the DCRA 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.
Eligibility & Enrollment  

Who is Eligible to Enroll
You must be a pilot and actively at work during the time your eligible dependent(s) is 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/her own care.

NOTE: Pilots who live in Puerto Rico, Guam and Virgin Islands are not eligible to participate in the DCRA.

When You Can Enroll

New Hire Enrollment — If you are a new hire pilot, you must enroll by the deadline as specified in your Personalized Letter provided in your New Hire Enrollment packet. The effective date of coverage is the date you make your election by going to the FedEx Benefits Enrollment Website at https://fedex.ehr.com.

Annual Benefits Enrollment — You can enroll during the Annual Benefits Enrollment period by going to the FedEx Benefits Enrollment Website at fedex.ehr.com. See the Enroll by Web guide, included in your Annual Benefits Enrollment packet, for instructions. If you make your election by the 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. Participation in the DCRA requires an annual election. i.e., if you wish to re-enroll, you must re-enroll each year as FedEx cannot default your election from one year to the next. If you fail to make your election by the deadline indicated in your Personalized Letter, you cannot enroll until the next Annual Benefits Enrollment unless you have a Qualified Change in Family Status or Employment Event and make your election within 31 days following the event.

Active Pilot With Change in Family Status or Employment Event — You must enroll within 31 days of the date of the event. Refer to the “Changing Your Election” section on page O-12.

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 DCRA 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 complete list at www.wageworks.com/dclist.

Ineligible Expenses
• 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 DCRA reimbursement:
• 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.

How DCRA Works – Thing to Consider
Determine how much money you may wish to place in your account based on your estimate of dependent care expenses for the upcoming calendar year.

• Minimum election is $250.
• Maximum election is $5,000.
• This Benefit is for Dependent Care Expenses only, it is not for health care expense of your dependent(s); HCSA is the correct benefit for these health care expenses.

You must use the money in your DCRA for eligible expenses you incur during the calendar year in which the contributions are made. You have until May 31 of the following year to request reimbursement for eligible expenses incurred before the end of the year by filing a Pay Me Back 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 DCRA after the deadline for requesting reimbursement (May 31 of the following calendar year), the IRS requires it to be forfeited.

• Once you determine the annual amount that you wish to contribute to the DCRA, you must enroll by going to the FedEx Benefits Enrollment Website at fedex.ehr.com. The annual contribution that you enter in the DCRA enrollment process will automatically calculate your pay period deductions.
Each pay period, the DCRA amount you elected is deducted from your paycheck before your taxes are calculated. Generally, amounts reimbursed to you from your DCRA 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 DCRA, you are representing to the Company that your contributions to your DCRA are not expected to exceed the above limits.

The DCRA 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 DCRA, you must reduce the amount of dependent care expenses that qualify for the tax credit by the amount you received from the DCRA.

Request payment of your eligible DCRA expenses through your selected payment method.

- You may request payment of your DCRA expenses either by using “Pay My Provider” or “Pay Me Back” discussed later in this section.
- 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 DCRA.
- 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.

Changing Your Election
You may change your election, only if you have a Change in Family Status or Employment event during the calendar year and make your election within 31 days following the qualifying event. To make your election, access the FedEx Benefits Enrollment Website at fedex.ehr.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 your contributions).

If You Are on a Leave of Absence
If you go on a leave of absence, your DCRA deductions will stop. You can continue to submit eligible dependent care expenses to WageWorks that were incurred prior to your leave of absence. Your dependent care expenses incurred during your leave of absence are not eligible for reimbursement. If you go on military leave, you can continue to submit eligible dependent care expenses that were incurred during the calendar year you went on military leave. You have until May 31 of the following year or until your account is exhausted to file claims for reimbursement.

If you are out on military leave of absence your DCRA benefit does not end; however, you can only claim dependent care expenses up to the amount that has been
deducted from your pay. When you return from military leave of absence, please call PBA to start your DCRA payroll deductions again.

Regardless of the type of leave of absence you are on (excluding military leave of absence), you must re-enroll in the DCRA within 31 days of the date you return to work. Otherwise, you cannot enroll until the next Annual Benefits Enrollment period unless you have a Change in Family Status or Employment Event and make your election within 31 days following the event.

Change in Family Status and Employment Events include:

• Birth or adoption of a child
• 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 by you or your spouse
• Change by you or your spouse from full-time to part-time or vice versa

Advantages of Participating in the DCRA

One important advantage of participating in the DCRA is that the amount you contribute to your DCRA and the amount you are reimbursed for eligible expenses are not subject to federal, Social Security and Medicare taxes (FICA) and in most locations, state and local income taxes. As a direct result of this personal tax savings, you will increase your spendable income. In addition, your contributions are not reported as taxable income on your federal W-2 statement at the end of the year. If you participate in the DCRA, IRS Form 2441 must be completed as part of your annual tax filing.

Disadvantages of Participating in the DCRA

The primary disadvantage of participating in the DCRA is the potential loss of any unused amounts in your account. By not paying FICA taxes, you will also be reducing your Social Security contributions.

“Use It or Lose It” Rule

Under this rule, you must use the money in your DCRA for eligible expenses incurred during the year in which the contributions are made. You have until May 31 of the following year to request your reimbursement for eligible expenses incurred before the end of the year by filing a Pay Me Back 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 Reimbursement Account after the deadline for requesting reimbursement, the IRS requires it to be forfeited.

Estimating Your Savings

To estimate your contributions for the DCRA, access the EVALUATE module of the FedEx Benefits Enrollment Website at fedex.ehr.com. Click on the “Estimate Dependent Care Expenses” button for the Dependent Care Reimbursement Account Estimator worksheet.

You may enter either your weekly or monthly payments for child or elder care costs and the calculator will estimate your annual DCRA contributions.

Once you have estimated your annual contributions you may select the “Tax Effect Estimator” which will provide you with the potential tax savings available through
your DCRA election. Don’t forget to deduct the cost of the weeks that you will not need child or elder care due to vacations, illness, etc.

Accessing Your Account
WageWorks administers the DCRA benefit for FedEx. You may request reimbursement of eligibility expenses through Pay Me Back or Pay My Provider. Regardless of the method of reimbursement you choose, you must save your detailed receipts for your records.

Pay Me Back
Some expenses are easier to pay for first and then receive reimbursement at a later date. The Pay Me Back method of reimbursement requires you to provide your detailed receipts to verify your reimbursement. The process to file your Pay Me Back reimbursement is:

Complete and Submit a Dependent Care Pay Me Back Claim Form with your eligible dependent care expense detailed receipt(s). You can download a form from the Print Forms page at www.wageworks.com. You can fax your completed form and proof of expenses (receipts, invoices, etc.) to 1-877-353-9236 (the number is also provided on the claim form) or mail your form and photocopies of your proof of expenses to: WageWorks, Inc., P.O. Box 14053, Lexington, KY 40512.

Claims may be filed any time you have eligible dependent care expenses of at least $5 except for your final claim for reimbursement. You can elect to receive your Pay Me Back reimbursement of your eligible DCRA expenses that you have paid for out-of-pocket by:

- Direct Deposit, or
- Check mailed to your home address via U.S. mail.

Direct Deposit — You can request Direct Deposit of your reimbursement of eligible expenses when you create your profile online at www.wageworks.com or call WageWorks Customer Service at 1-877-924-3967. You will need to provide your banking information to set up Direct Deposit. It is your responsibility to notify WageWorks immediately of any changes in the status of your bank account, such as a bank account closure or change in bank account number. Should you decide to cancel your Direct Deposit arrangement, reimbursement checks will be mailed to your home address once WageWorks receives and processes your reimbursement request.

The standard turnaround time for Direct Deposit reimbursement request is two business days from the time WageWorks transmits deposit authorization to your bank. You should verify that the deposit is made into your bank account before attempting to withdraw funds.

If you are a current participant in the DCRA with Direct Deposit and will participate in the DCRA in the new calendar year, WageWorks will automatically carry your Direct Deposit information forward.

Attach your Proof of Service. 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 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 DCRA Pay Me Back form to certify the amounts paid for services rendered are accurate.

*Keep a copy of your form and proof of expenses for your records.*

**Pay My Provider**

With the Pay My Provider option, you can pay your providers directly from your DCRA. If your DCRA expenses meet the following guidelines, Pay My Provider may be advantageous for you if:

- You have predictable dependent care expenses each month.
- Your dependent care provider does not require payment in advance.
- Your provider will accept monthly payments.

**Why you may prefer to use Pay My Provider:**

- No claim forms to file and no need to get reimbursement.
- Works like a bill pay service.
- Deducts automatically from your Dependent Care Reimbursement Account.
- Convenient method to pay for eligible dependent care services on a monthly basis.

**How to use Pay My Provider:**

2. Click on the “Dependent Care” tab.
3. Click “Request Pay My Provider.”
4. Confirm or enter your e-mail address.
5. Enter your provider information, dependent information and payment amount(s).
6. Scan and upload your detailed invoice, or other detailed support.
7. WageWorks will make the requested payment(s) from your DCRA account and mail it directly to your provider.
8. WageWorks will send you an e-mail each time a requested payment is made.

**NOTE:** Not all providers can be paid through Pay My Provider.

**WageWorks ONLINE @**

www.wageworks.com

As a DCRA participant, you can register at the WageWorks Website and have access to:

- Each contribution made to your account,
- Reimbursement claims you have filed, and
- Reimbursements that have been issued to you.

For more information, call WageWorks at 1-877-924-3967. The automated voice response system can assist you around the clock. Customer service representatives are available during normal business hours from 7:00 a.m. to 7:00 p.m. CST.
The IRS requires new elections for each calendar year. 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. See “Enroll by Web” in your enrollment packet for instructions on accessing the FedEx Benefits Enrollment Website at https://fedex.ehr.com.

The IRS requires that any unused amount left in your account as of May 31 of the following calendar year will be forfeited, for expenses incurred by December 31 of the year in which the contributions were made. This is a valuable benefit and it is not intended for you to forfeit money. So plan conservatively.

The money deposited to your DCRA is not subject to FICA tax. Your future Social Security benefits may be less than they would be otherwise because Social Security benefits are based partly on the amount of FICA taxable wages you earn. Your DCRA deposits may reduce your FICA taxable wages. However, the future Social Security benefits you may receive are generally impacted very little. If you have questions, you may wish to talk to your financial advisor, or check with the Social Security Administration.

If you plan to leave FedEx or downgrade to a casual or temporary position, consider whether or not you should participate in the DCRA. If you choose to participate and leave FedEx or downgrade prior to year-end, you can continue to submit claims for expenses incurred prior to your employment termination or downgrade date. You have until May 31 of the following calendar year to submit your eligible claims.

Send all reimbursement claims to: WageWorks, P.O. Box 14053, Lexington, KY 40512 or fax to: 1-877-353-9236.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you should contact WageWorks at 1-877-924-3967.

**Health Care Savings Account Plan for Pilots (HCSA)**

The Health Care Savings Account Plan for Pilots (HCSA) 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 options. Health plan options include medical, prescription drug, mental health/substance abuse, dental and vision expenses.

Please note that Benefits communications may sometimes refer to the Health Care Savings Account as the Health Care Spending Account (HCSA).

**What You Need To Do**

Access the FedEx Benefits Enrollment Website at [https://fedex.ehr.com](https://fedex.ehr.com).

Review the Information in the *Flexible Spending Accounts (FSA) Guide*.

From the main menu you can select the:

- **EDUCATE** module for additional information about the Flexible Spending Accounts.

- **EVALUATE** module for decision support tools to help you determine the best Health coverage option for you and your family. With the Medical Cost Estimator, you can estimate your family’s annual out-of-pocket expenses based on your expected use of health care services. Based on your expected expenses, the Flexible Spending Account Estimator will help you determine your appropriate contribution and estimated tax benefits from participation in the HCSA.

- **ENROLL** module to make your HCSA elections.

Make your HCSA enrollment elections.
Participation in the HCSA requires an annual election.

**Annual Benefits Enrollment** — Make your HCSA election during the Annual Benefits Enrollment period by going to the FedEx Benefits Enrollment Website at https://fedex.ehr.com. If you make your election by the deadline indicated in your Personalized Letter included in your packet, your enrollment becomes effective on January 1 of the following year.

**New Hire Enrollment** — You must enroll by the deadline indicated in your Personalized Letter provided in your New Hire Enrollment packet. The effective date is the date you make your election on the FedEx Benefits Enrollment Website at https://fedex.ehr.com.

**Eligibility & Enrollment**

**Who is Eligible to Enroll**

You are eligible to enroll if you are a pilot.

**Important**

You are not required to participate in FedEx Express Health coverage to participate in the HCSA. 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 HCSA).

**NOTE:** Pilots who live in Puerto Rico, Guam and Virgin Islands are not eligible to participate in the HCSA.

**Who Are Eligible Dependents**

Under the HCSA, eligible dependents include:

- Your Spouse (as defined by federal law)
- Your children (including stepchildren and adopted children) under the age of 27

**Who Should Enroll**

The HCSA is beneficial for anyone who has eligible out-of-pocket medical, prescription drug, mental health/substance abuse, dental or vision expenses beyond what their health plan options cover. See the “Flexible Spending Account Estimator” in the EVALUATE module of the FedEx Benefits Enrollment Website at https://fedex.ehr.com to help you determine if the HCSA will be a benefit to you. This tool will also help you calculate the contribution amount you may want to elect.

**When You Can Enroll**

**New Hire Enrollment** — If you are a pilot new hire, you must enroll by the deadline as specified in your Personalized Letter provided in your New Hire Enrollment packet. The effective date of coverage is the date you make your election by going to the FedEx Benefits Enrollment Website at https://fedex.ehr.com.

**Annual Benefits Enrollment** — You can enroll during the Annual Benefits Enrollment period by going to the FedEx Benefits Enrollment Website at https://fedex.ehr.com. If you make your election by the deadline, benefits become effective January 1 of the following year. Your payroll deductions will begin with the first pay period in the new tax year. FedEx cannot make a default HCSA election for you, if you wish to re-enroll you must make an active HCSA election each year. Participation in the HCSA requires an annual election.

If you fail to make your election by the specified deadline, you must wait until the next Annual Benefits Enrollment to enroll.

**Your Annual HCSA Contribution**

**New Hire Enrollment** — Your Personalized Letter provided in the New Hire Enrollment packet indicates the minimum and maximum monthly/annual contributions you are eligible to elect based on the remaining months in the calendar year.
Annual Benefits Enrollment — During the Annual Benefits Enrollment period, you may enroll based on the minimum and maximum amounts indicated below:

<table>
<thead>
<tr>
<th>Minimum Annual Contribution</th>
<th>Maximum Annual Contribution</th>
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</thead>
<tbody>
<tr>
<td>$250</td>
<td>Before January 1, 2013 – $5,000</td>
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<tr>
<td></td>
<td>Beginning January 1, 2013 – $2,500 (subject to indexing after 2013)</td>
</tr>
<tr>
<td>$20.83 per month for a 12-month election</td>
<td>Before January 1, 2013 – $416.66 per month for a 12-month election</td>
</tr>
<tr>
<td></td>
<td>Beginning January 1, 2013 – $208.33 per month for a 12-month election (subject to indexing after 2013)</td>
</tr>
</tbody>
</table>

To help you determine the amount you may want to contribute to the HCSA, you can access decision support tools on the FedEx Benefits Enrollment Website at https://fedex.ehr.com.

Changing your Election

Once you enroll in the HCSA, you cannot drop your coverage or increase or decrease your deduction amount for the remainder of the calendar year. However, in the event of your dependent’s death, you may change your elected amount within 31 days following your dependent’s death. Your coverage will end if you leave the Company or are no longer a pilot; however, you may still file claims for reimbursement of eligible health care expenses up until May 31 of the following calendar year. Any claims incurred after your coverage ends are not reimbursable, unless you elect to continue coverage under COBRA (see If You Terminate, Retire or Are No Longer Eligible to Participate in HCSA on page O-19).

Confirmation of Your Enrollment

Confirmation of your election will be mailed to your home address within two to three business days of the date of your election.

If You Are on a Leave of Absence After Your Coverage Becomes Effective

If you begin a leave of absence after your HCSA becomes effective, your deductions will accumulate for a maximum of 90 days from the date you go on leave. Once you return to work, your pre-tax HCSA deduction will begin—at a higher rate, however—until the deductions accumulated during your leave of absence are fully recovered. Any eligible HCSA expenses incurred after your effective date of coverage are reimbursable. If your leave of absence extends for more than 90 days, you will be billed for your contributions on an after-tax basis. If you continue to submit your monthly HCSA contribution, you are eligible to continue to receive reimbursement for eligible expenses incurred during your extended leave of absence.

If you fail to submit your HCSA contributions to Pilot Benefits Administration for a leave of absence that extends beyond 90 days, your coverage will terminate and you cannot re-enroll until the next Annual Benefits Enrollment period. Eligible HCSA expenses incurred after termination of your coverage are not reimbursable.

Eligible Expenses

Eligible health care expenses are defined by the IRS as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or
function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness. With this definition in mind, the health (including prescription drug and mental health/substance abuse), dental, and vision expenses that are not covered by your and your dependents’ health plan options are eligible for payment under the HCSA.

Over-The-Counter (OTC) medications require a prescription in order to be considered an eligible expense under the Health Care Spending Account. You can use your debit card to purchase OTC medications only when a doctor writes you a prescription and the pharmacy fills the OTC purchase by assigning a prescription number to the purchase. As always, you can purchase the medication and submit a manual claim with your prescription and receipt to WageWorks.

This rule does not apply to the following: insulin, other medical items, equipment, supplies or diagnostic devices, such as bandages, crutches or blood sugar test kits, obtained OTC. A prescription is not required for these items and you can use your Health Care Card when purchasing.

Listed below are many of the health expenses eligible for payment under the HCSA. This list is not meant to be all-inclusive. Other expenses not specifically mentioned may also qualify. For additional information, call WageWorks at 1-877-924-3967.

<table>
<thead>
<tr>
<th>Providers</th>
<th>Dental Services</th>
<th>Vision Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Allergist</td>
<td>• Crowns/Bridges</td>
<td>• Contact Lenses</td>
</tr>
<tr>
<td>• Chiropractor</td>
<td>• Dental X-rays</td>
<td>• Contact Lens Solution</td>
</tr>
<tr>
<td>• Christian Science Practitioner</td>
<td>• Dentures</td>
<td>• Eye Examinations</td>
</tr>
<tr>
<td>(for medical care)</td>
<td>• Exams/Teeth Cleaning</td>
<td>• Eyeglasses</td>
</tr>
<tr>
<td>• Dermatologist</td>
<td>• Extractions</td>
<td>• Laser Eye Surgeries</td>
</tr>
<tr>
<td>• Homeopath (for medical care)*</td>
<td>• Fillings</td>
<td>• Ophthalmologist</td>
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<tr>
<td>• Naturopath (for medical care)*</td>
<td>• Gum Treatment</td>
<td>• Optometrist</td>
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<tr>
<td>• Osteopath</td>
<td>• Oral Surgery</td>
<td>• Prescription Sunglasses</td>
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<tr>
<td>• Physician</td>
<td>• Orthodontia/Braces</td>
<td>• Radial Keratotomy/LASIK</td>
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<td>• Psychiatrist</td>
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<td>• Psychologist</td>
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<tr>
<th>Providers</th>
<th>Obstetric Service</th>
<th>Insurance Related Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Blood Tests</td>
<td>• Lamaze Class (instruction related to birth)</td>
<td>• Deductibles</td>
</tr>
<tr>
<td>• Cardiographs</td>
<td>• Midwife Expenses</td>
<td>• Copayments</td>
</tr>
<tr>
<td>• Diagnostic</td>
<td>• OB/GYN Exams</td>
<td>• Coinsurance Amounts</td>
</tr>
<tr>
<td>• Laboratory Fees</td>
<td>• OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)</td>
<td>• Pre-existing Condition Expenses (medical)</td>
</tr>
<tr>
<td>• Metabolism Tests</td>
<td>• Pre-Natal Treatment</td>
<td>• Private Hospital Room Differential</td>
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<tr>
<td>• Spinal Fluid Tests</td>
<td>• Post-Natal Treatment</td>
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<tr>
<td>• Urine/Stool Analyses</td>
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<tr>
<td>• X-rays</td>
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<tr>
<th>Providers</th>
<th>Lab Exams/Tests</th>
<th>Obstetric Service</th>
<th>Insurance Related Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Allergist</td>
<td>• Blood Tests</td>
<td>• Lamaze Class (instruction related to birth)</td>
<td>• Deductibles</td>
</tr>
<tr>
<td>• Chiropractor</td>
<td>• Cardiographs</td>
<td>• Midwife Expenses</td>
<td>• Copayments</td>
</tr>
<tr>
<td>• Christian Science Practitioner</td>
<td>• Diagnostic</td>
<td>• OB/GYN Exams</td>
<td>• Coinsurance Amounts</td>
</tr>
<tr>
<td>(for medical care)</td>
<td>• Laboratory Fees</td>
<td>• OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)</td>
<td>• Pre-existing Condition Expenses (medical)</td>
</tr>
<tr>
<td>• Dermatologist</td>
<td>• Metabolism Tests</td>
<td>• Pre-Natal Treatment</td>
<td>• Private Hospital Room Differential</td>
</tr>
<tr>
<td>• Homeopath (for medical care)*</td>
<td>• Spinal Fluid Tests</td>
<td>• Post-Natal Treatment</td>
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<tr>
<td>• Naturopath (for medical care)*</td>
<td>• Urine/Stool Analyses</td>
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<tr>
<td>• Osteopath</td>
<td>• X-rays</td>
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<td>• Physician</td>
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<td>• Psychiatrist</td>
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<tr>
<td>• Psychologist</td>
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<tr>
<td>Other Medical Treatment/Procedures</td>
<td>Other Medical Equipment, Supplies and Services</td>
<td>Medication</td>
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<tr>
<td>• Acupuncture</td>
<td>• Abdominal/Back Supports</td>
<td>• Insulin</td>
<td></td>
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<tr>
<td>• Alcoholism*</td>
<td>• Ambulance Services</td>
<td>• Prescribed Birth Control</td>
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</tr>
<tr>
<td>• Bio-feedback Therapy (in medically necessary situations)</td>
<td>• Arches/Orthopedic Shoes (cost in excess of regular shoes)</td>
<td>• Prescribed Vitamins (when a prescription is required for a medical condition)</td>
<td></td>
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<tr>
<td>• Reconstructive Surgery (if medically necessary due to a congenital defect or accident)</td>
<td>• Contraceptives</td>
<td>• Prescription Drugs</td>
<td></td>
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<tr>
<td>• Drug Addiction</td>
<td>• Counseling (for medical reasons)</td>
<td></td>
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<tr>
<td>• Hearing Exams</td>
<td>• Crutches</td>
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<tr>
<td>• Hospital Services</td>
<td>• Guide Dog (for visually/hearing impaired person)</td>
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<tr>
<td>• Infertility</td>
<td>• Hearing Aids and Batteries</td>
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<tr>
<td>• In-vitro Fertilization</td>
<td>• Hospital Bed</td>
<td></td>
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<tr>
<td>• Norplant Insertion or Removal</td>
<td>• Learning Disability (special school/teacher)</td>
<td></td>
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<tr>
<td>• Patterning Exercises*</td>
<td>• Lead Paint Removal (if not capital expense and incurred for a child poisoned)</td>
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<tr>
<td>• Physical Examination (not employment related)</td>
<td>• Medic Alert Bracelet or Necklace*</td>
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<tr>
<td>• Physical Therapy</td>
<td>• Oxygen Equipment</td>
<td></td>
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<tr>
<td>• Speech Therapy</td>
<td>• Prescribed Medical and Exercise Equipment*</td>
<td></td>
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<tr>
<td>• Sterilization</td>
<td>• Prosthesis</td>
<td></td>
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<tr>
<td>• Transplants (includes organ donor)</td>
<td>• Splints/Casts</td>
<td></td>
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<tr>
<td>• Vaccinations/Immunizations</td>
<td>• Support Hose*</td>
<td></td>
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<tr>
<td>• Vasectomy and Vasectomy Reversal</td>
<td>• Syringes</td>
<td></td>
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<tr>
<td>• Well-Baby Care</td>
<td>• Transportation Expenses (essential to medical care)</td>
<td></td>
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<tr>
<td></td>
<td>• Tuition Fee at Special School for Disabled Child</td>
<td></td>
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<tr>
<td></td>
<td>• Wheelchair</td>
<td></td>
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<tr>
<td></td>
<td>• Wigs (hair loss due to disease)**</td>
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</table>

*Eligible when prescribed by a physician for a specific medical condition.

**Eligible only with doctor's certification identifying the physical nature of the medical condition and length of treatment program.

**IMPORTANT**

You cannot receive a reimbursement from the HCSA that you also claim as a deduction on your federal income tax return or that is reimbursed from another plan.

**Ineligible Expenses**

The IRS does not allow the following expenses to be reimbursed under the HCSA. Expenses to promote general health are not eligible expenses unless prescribed by a physician for a specific medical condition. This is not an all-inclusive list.
**IMPORTANT**
Your pre-tax payroll deductions for health coverage are not eligible expenses for reimbursement.

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### Advantage of Participating in the HCSA

One important advantage of participating in the HCSA is that the amount you contribute to your HCSA and the amount you are reimbursed for eligible expenses are not subject to federal, Social Security and Medicare (FICA) taxes, and, in most locations, state and local income taxes. As a direct result of your personal tax savings, you will increase your spendable income. In addition, your contributions are not reported as taxable income on your federal W-2 statement at the end of the year.

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### Disadvantage of Participating in the HCSA

The primary disadvantage of participating in the HCSA is the potential loss of any unused amounts in your account. Generally speaking, there are no other disadvantages when you carefully plan your annual contribution. You should know, however, that when you reduce your FICA taxes, you will also be reducing your Social Security contribution.

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### GRACE PERIOD AND DEADLINE FOR FILING

The Health Care Spending Account (HCSA) has a grace period for incurring eligible expenses. The grace period will provide you additional time to incur eligible expenses that can be reimbursed from your HCSA account balance. You will have until March 15 of the next year to spend the money in your account. You will have until May 31 of the following year to file HCSA claims for expenses incurred from January 1st, of the previous year through March 15th of the next year. For example, you will have until May 31, 2013, to file HCSA claims for expenses incurred from January 1, 2012, through March 15, 2013.
“Use It Or Lose It” Rule

Under this rule, you must use the money in your HCSA for eligible expenses you incur during the calendar year and up to March 15 of the following calendar year, in which the contributions are made. You have until May 31 of the following calendar year to request your reimbursement by filing a Pay Me Back claim form. The Health Care Choice Card and Pay My Provider payment options cannot be used after the end of the calendar year. If you terminate during the year, you can only request reimbursement for expenses incurred through your termination date. If you have a balance left in your HCSA after the deadline for requesting reimbursement (May 31 of the following calendar year), the IRS requires it to be forfeited.

The tax savings you can expect will vary depending on your individual tax-filing situation. Before you elect to participate in the HCSA, be sure to consult your financial or tax advisor to determine if the HCSA is appropriate for your situation.

HCSA Decision Support Tools

The EVALUATE module of the FedEx Benefits Enrollment website has a number of online tools to help you determine the best coverage for you and your family. After comparing your Health coverage options, you can use the Medical Cost Estimator and Flexible Spending Account Estimator to help you decide if participation in the HCSA is right for you.

Medical Cost Estimator

With the Medical Cost Estimator, you can estimate your family’s annual out-of-pocket expenses based on your expected use of health care services. You indicate the number of health care services (e.g., physician visits, prescription drugs, maternity, etc.) you and each of your covered dependents expect to use. The Medical Cost Estimator then provides you with cost estimates based on the average cost of medical services in your region. Just click the “Continue to FSA Estimator” button to carry this information to the Health Care Spending Account Estimator.

Flexible Spending Account Estimator

With the Flexible Spending Account Estimator, you determine the amount you may want to contribute for the coming year and see the estimated tax effect based on your personal circumstances. If you used the Medical Cost Estimator, your results will display in the Health Care Spending Account Estimator tool. You can also enter amounts of other eligible expenses you and your eligible dependents expect to incur. Based on your entries, your contribution will be calculated subject to the plan’s maximum and minimum annual contributions. Once you have estimated your annual contributions, select the “Tax Effect Estimator,” which will provide you with the potential tax savings available through your HCSA election.

Accessing Your Account

You have three options to pay for eligible health care expenses from your HCSA:

Pay Me Back

- You are reimbursed for eligible expenses you have paid for out-of-pocket.
- You must submit a claim form and itemized proof of expenses to WageWorks via fax or mail.
- You are reimbursed for eligible expenses from your HCSA.

Pay My Provider

- An online bill pay service that sends payments from your HCSA directly to your providers.
- No claim forms to file.
- Convenient way to pay for most recurring eligible health care services.
- You will be able to select the date to make your payment.
Pay by Health Care Choice 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 HCSA.
- No claim forms to file.

Pay Me Back

Some expenses are easier to pay for first and then receive reimbursement at a later date. There are also providers that do not accept a debit card without a PIN as a payment method. This means you are either required to pay for these expenses out-of-pocket at the time of service or when you receive the bill. You should always save your detailed receipts to submit with your reimbursement request. IRS regulations require you to maintain documentation to verify your expenses.

This method of reimbursement requires you to complete a Pay Me Back Claim Form and submit it with your eligible health care expense receipts or invoices. You can download a form from the Print Forms page at www.wageworks.com. You can fax your completed form and proof of expenses (receipts, invoices, etc.) to 1-877-353-9236 (the number is also provided on the claim form) or mail your form and photocopies of your proof of expenses to:

WageWorks, Inc., P.O. Box 14053, Lexington, KY 40512

You can elect to receive reimbursement of your eligible HCSA expenses by:

- Direct Deposit, or
- Check mailed to your home address via U.S. mail.

Direct Deposit

You can request Direct Deposit of your reimbursement when you create your profile online at www.wageworks.com or you can call WageWorks Customer Service at 1-877-924-3967. You will need to provide your banking information to setup Direct Deposit. It is your responsibility to notify WageWorks immediately of any changes in the status of your bank account, such as a bank account closure or change in bank account number. Should you decide to cancel your Direct Deposit arrangement, reimbursement checks will be mailed to your home address once WageWorks receives and processes your reimbursement request.

The standard turnaround time for Direct Deposit reimbursement request is two business days from the time WageWorks transmits deposit authorization to your bank. You should verify that the deposit is made into your bank account before attempting to withdraw funds.

Pay My Provider

With the Pay My Provider option, you can pay your providers directly from your HCSA. It is a convenient way for you to pay for recurring or regularly scheduled eligible health care expenses such as orthodontic care or physical therapy. You can also use Pay My Provider to pay the balance of a bill your health plan doesn’t cover. The payment amount must be $20 or more.

How to Use Pay My Provider

2. Click on the “Health Care” tab.
3. Click “Request Pay My Provider.”
4. Confirm or enter your e-mail address.
5. Enter your provider information.
6. Enter patient information.
(7) Enter your payment amount(s).
(8) Scan and upload your detailed invoice, or other detailed support.
(9) WageWorks will make the requested payment(s) from your account and mail it directly to your provider.
(10) WageWorks will send you an e-mail each time a requested payment is made.

**NOTE:** There must be sufficient funds available in your account to remit the entire payment. No partial payments can be issued from the account.

### Pay By Health Care Choice Card

With the Health Care Choice Card, you can pay for eligible health care expenses at the time of service or point of sale. Simply swipe your card at the register (select “Credit” if asked) and funds are deducted automatically from your HCSA. When you use your Health Care Choice Card, there’s no need to submit a reimbursement claim form. However, for card usage that WageWorks is unable to substantiate, you will be required to submit a copy of the receipt to WageWorks.

**Important** — Always save your receipts in case they are needed to verify your expenses (with WageWorks or the IRS).

**New Hire** — Your card will be sent to your home address with Terms and Conditions for card usage within two to three weeks following the date of your enrollment in the HCSA.

**Annual Benefits Enrollment** — Your card will be sent to your home address with Terms and Conditions for card usage by mid-January of each plan year.

You may order up to two additional cards for use by your eligible dependents on the WageWorks Website at [www.wageworks.com](http://www.wageworks.com). The first two additional cards are provided at no charge. A fee of $5 is charged to your HCSA account for the third additional card.

Your HCSA spending card, has a three-year expiration date. If you enroll for the HCSA account in a future plan year, and your old card has not expired, your new election will be added to your current card.

### WageWorks ONLINE @ [www.wageworks.com](http://www.wageworks.com)

As an HCSA participant, you can register at the WageWorks Website and have access to:

- View your account activity and balance.
- Check the status of your claims and payments.
- Download claim forms.
- Request Pay My Provider payments.
- Order an additional Health Care Choice Card.

For more information, call WageWorks at 1-877-924-3967. The automated voice response system can assist you around the clock. Customer service representatives are available during normal business hours from 7:00 a.m. to 7:00 p.m. CST.

### Using the Health Care Choice Card

The Health Care Choice Card is a limited-use card; there are restrictions on where, when and how the card can be used for payment. These restrictions are applied to ensure the card is used only to pay for health care products and services eligible for payment from your Health Care Savings Account.

(1) **You must activate your card** before you use it. Call 1-866-363-4128 and enter the information requested. The Health Care Choice Card is a Visa® debit card that can be used at most merchants who sell eligible health care products or services and accept Visa debit cards without a PIN.
(2) **Use your card for eligible health care expenses only.** Log in to www.wageworks.com for a list of eligible expenses or review the list referenced in this section. This card can only be used at approved health care providers and merchants where health care products and services are likely to be sold (e.g., pharmacy, physician, medical facility, optician/optometrist, dentist, etc.).

(3) **Do not use your card to pay for past or future services.** Tax regulations prohibit you from using this card to pay for services you received before your current coverage period or those you plan to receive in the future.

(4) **Each time you use your card, you certify that you are paying for eligible expenses incurred by you or an eligible dependent during your current coverage period and that you have not and will not seek reimbursement for these expenses from any other health plan or source.**

(5) **Save all receipts that describe exactly what you paid for with your card.** These may be requested – by WageWorks or the IRS – to verify you used your account to pay for eligible products and services. Validate all card transactions where WageWorks is requesting additional support as all debit card transactions not validated will be included as taxable income on your W-2.

(6) **Debit or credit? Choose credit.** Even though this is not a credit card, choose the credit option. The card has no PIN.

(7) **Review your online Account Activity Statement.** They contain important information about your account, including if you are required to verify any purchases you made with the Health Care card.

(8) **You may be required to reimburse your account** in the amount of any card purchase if you cannot show the card was used for eligible health care products and services.

(9) **Card use is suspended** if the amount not verified is greater than or equal to 20% of your HCSA balance. Your card will remain suspended until you validate all unsubstantiated card transactions.

(10) **Payments received under the Pay Me Back option will be reduced by any amount shown in the “Action Needed” column on your online HCSA Account Activity statement.**

**When Coverage Ends**

Your coverage in the HCSA 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 15th of the next year to incur expenses. See “Grace Period and Deadline” for filing on page O-15 for more information.)
- You no longer meet the eligibility requirements to participate (e.g., cease to be a pilot). (Please see the below rules for filing claims and continuing participation in the HCSA in the event you cease to be a pilot.)
- You fail to pay billed monthly contributions during a leave of absence
- The Company terminates the plan
- You die

**If You Terminate, Retire or Are No Longer Eligible to Participate in HCSA**

Any eligible expenses incurred prior to the date you cease to be a pilot (e.g., retirement, termination from a FedEx company participating in FedEx Express benefits, death or a change from a permanent to a nonpermanent employment status) are eligible for reimbursement. You have, however, until May 31 of the following year to file your claims for expenses incurred between January 1 and the date you become ineligible to participate in the HCSA. You must file your claims for reimbursement by submitting a Pay Me Back Claim Form. The Health Care Choice Card and Pay My Provider payment options cannot be used after the end of the calendar year. If you terminate 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 as of May 31 will be forfeited.

Certainly, if you plan to leave the Company for any reason, you may wish to reconsider your choice to participate.

When you terminate, retire or become ineligible to participate, you are eligible to continue your participation in the HCSA under COBRA until the end of the plan year in which the qualifying event occurs. If you elect COBRA, you will make post-tax contributions to your account. COBRA continuation allows you to receive reimbursement of eligible expenses beyond the date you become ineligible. If you continue the HCSA under COBRA, you can file claims for eligible expenses incurred during the COBRA continuation period. Even though you would not have the tax advantages of pre-tax contributions, COBRA continuation may be a good strategy for you if the contributions remaining in your account when your coverage ends are significantly higher than the eligible expenses you have incurred prior to becoming ineligible. If you do not elect COBRA continuation, you cannot receive reimbursement for expenses incurred after the date you become ineligible to participate.

The IRS requires that you make new elections for each calendar year. Enrollment instructions are provided in your enrollment materials distributed for each Annual Benefits Enrollment period. 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.

An Explanation of Benefits statement often referred to as an EOB, will satisfy proof of a claim for you and your eligible dependents. An EOB is a statement received from the claims paying administrator that details benefits paid/not paid under the terms of the health plan. It is the unpaid benefits that may be eligible for reimbursement from the HCSA.

Monthly payroll deductions for group Health coverage are not eligible expenses.

IRS regulations require that you be able to show you used your Health Care Choice Card for eligible health care expenses. WageWorks may ask you to submit a photocopy of your receipt to show you used your card to pay for eligible health care products and services. **Even if your card transaction is automatically approved, you should keep your detailed receipts with your important tax records for the year.**

IRS regulations require that WageWorks verify each and every card transaction to ensure your account is used only to pay for eligible health care products and services. If WageWorks 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 transaction where WageWorks is requesting additional support as all debit card transactions not validated will be included as taxable income on your W-2.**

WageWorks will email you when you have a card transaction that needs to be validated. If you have not provided WageWorks with your email address, a notice will be mailed to you. The Card Use section shows all card transactions that are not verified and explains the options available to resolve them. If you have created an online account, you can log onto your WageWorks account at www.wageworks.com and review your Statement of Activity at any time; this statement identifies which card transaction needs verification.
The benefit derived from participation in the HCSA is tax savings. With regard to your taxes, they are your responsibility and involve much more than simply multiplying a tax rate times your wages. In order to maximize your tax savings from these accounts, and to ensure that they fit with your personal income tax situation, you are encouraged to consult with your tax advisor if you have specific questions or concerns prior to enrollment.

COBRA coverage under the Health Care Savings Account Plan will be offered to qualified beneficiaries losing coverage.

COBRA coverage will consist of the Health Care Savings Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The “use it or lose it” rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan year and COBRA coverage will terminate at the end of the Plan year.

Qualified beneficiaries may not enroll in the Health Care Savings Account Plan during the Annual Benefits Enrollment period.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you should contact WageWorks at 1-877-924-3967.

This description provides information about the Federal Express Corporation Health Reimbursement Arrangement for Retired Pilots (the “HRA Plan”). The benefits described in this description are offered to certain retired pilots. If you have any questions not answered in this description, contact FedEx Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in Memphis.

This description is the Summary Plan Description (“SPD”) for the HRA Plan, effective January 22, 2007. Subject to the Collective Bargaining Agreement, Federal Express Corporation reserves the right in its sole discretion to terminate, amend or modify the HRA Plan at any time and for any reason.

The content contained in this SPD provides highlights of important information about your participation in the HRA Plan. Complete details about the HRA Plan are contained in the legal HRA Plan documents that govern HRA Plan operation and administration. If there is a discrepancy between the information provided in the SPD and the provisions of the HRA Plan documents, the HRA Plan documents will govern.

Health Reimbursement Arrangement (HRA)

The Health Reimbursement Arrangement (HRA) is a tax-exempt health care arrangement that reimburses you and/or your eligible family members for eligible health care expenses (including retiree health care premiums). It is a cost-effective way to pay for such items as medical and dental deductibles, copayments, eligible health-related expenses that are not covered by your health plan options and health insurance premiums. “Health-related expenses” include medical, prescription drug, mental health/substance abuse, dental and vision expenses. Contributions and earnings in your HRA and reimbursements received from your HRA are not subject to federal income and employment taxes.

Once you become a Participant, the HRA Plan will maintain an “HRA Account” in your name to keep a record of the amounts available to you for the reimbursement of eligible health care expenses, as well as earnings and losses on such amounts and distributions.

Pursuant to the terms of Section 27.H.7. of the Collective Bargaining Agreement (“Agreement”) between Federal Express Corporation and Air Line Pilots Association, International, FedEx contributed a specified dollar amount to a trust to fund the HRA Plan for you and your covered dependents. No additional contributions will be made.
to the HRA Plan. The amount available for reimbursement of health care expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

After the end of the Plan Year, the unused amount (if any) in your HRA Account will remain available in the next Plan Year.

Who is Eligible
You are eligible to participate in the HRA Plan if you are a Retired Former Pilot or a Retired Pilot.

A Retired Former Pilot is a Pilot (as defined in the agreement between Federal Express Corporation and ALPA) who terminated employment with FedEx after May 31, 2004, but before August 26, 2006.

A Retired Pilot is a Pilot (as defined in the Agreement) who:
(i) has a seniority list number on August 25, 2006,
(ii) attained at least age 53 before January 1, 2007,
(iii) as of the attainment of age 60 or older, is expected to satisfy the age and service eligibility requirements for coverage under the Federal Express Corporation Retiree Group Health Plan, and
(iv) terminated employment with FedEx on or after August 26, 2006.

If you are a Retired Pilot, your HRA Account will be activated
(i) upon your retirement or your attainment of age 59, if later, or
(ii) your death.

Designating a Beneficiary
If you die and have a balance in your HRA Account, that balance is available for use by an eligible spouse (as defined by federal law) or eligible dependent, as defined in the Internal Revenue Code. You must complete a HRA Beneficiary Designation form and return the form to FedEx Express. If there are any changes to the form, you need to update FedEx Express with the changes by contacting FedEx Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area.

Who Are Eligible Dependents
Under the HRA, eligible dependents include:
- Your Spouse (as defined by federal law)
- Your children (including stepchildren and adopted children) under the age of 27

Eligible Expenses
Eligible health care expenses are defined by the Internal Revenue Service ("IRS") as amounts paid for the diagnosis, cure, mitigation, treatment or prevention of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness. With this definition in mind, health (including prescription drug and mental health and substance abuse), dental, and vision expenses that are not covered by your and your dependents’ health plan options are eligible for payment under the HRA. You and your eligible dependents do not have to be participants in the Federal Express Corporation Retiree Group Health Plan to receive reimbursement for eligible health care expenses. For example, health premiums and eligible health care expenses incurred while a participant in Tri-Care, an individual or group health insurance policy, or a long-term care policy can be reimbursed under your HRA. In addition, premiums for Medicare Parts B, C and D are eligible for reimbursement under your HRA.

Listed below are many of the health expenses eligible for payment under the HRA Plan. This list is not meant to be all-inclusive. Other expenses not specifically mentioned may also qualify. For additional information, call WageWorks at 1-877-924-3967 or go to www.wageworks.com and click on Eligible Expense and then click on HRA Health Care Eligible Expenses.
### Providers
- Allergist
- Chiropractor
- Christian Science Practitioner (for medical care)
- Dermatologist
- Homeopath (for medical care)*
- Naturopath (for medical care)*
- Osteopath
- Physician
- Psychiatrist
- Psychologist

### Dental Services
- Crowns/Bridges
- Dental X-rays
- Dentures
- Exams/Teeth Cleaning
- Extractions
- Fillings
- Gum Treatment
- Oral Surgery
- Orthodontia/Braces

### Vision Services
- Contact Lenses
- Contact Lens Solution
- Eye Examinations
- Eyeglasses
- Laser Eye Surgeries
- Ophthalmologist
- Optometrist
- Prescription Sunglasses
- Radial Keratotomy/LASIK

### Lab Exams/Tests
- Blood Tests
- Cardiographs
- Diagnostic
- Laboratory Fees
- Metabolism Tests
- Spinal Fluid Tests
- Urine/Stool Analyses
- X-rays

### Obstetric Service
- Lamaze Class (instruction related to birth)
- Midwife Expenses
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre-Natal Treatment
- Post-Natal Treatment

### Insurance Related Items
- Deductibles
- Copayments
- Coinsurance Amounts
- Pre-existing Condition Expenses (medical)
- Private Hospital Room Differential
### Other Medical Treatment/Procedures
- Acupuncture
- Alcoholism*
- Bio-feedback Therapy (in medically necessary situations)
- Reconstructive Surgery (if medically necessary due to a congenial defect or accident)
- Drug Addiction
- Hearing Exams
- Hospital Services
- Infertility
- In-vitro Fertilization
- Norplant Insertion or Removal
- Patterning Exercises*
- Physical Examination (not employment related)
- Physical Therapy
- Speech Therapy
- Sterilization
- Transplants (includes organ donor)
- Vaccinations/Immunizations
- Vasectomy and Vasectomy Reversal
- Well-Baby Care

### Other Medical Equipment, Supplies and Services
- Abdominal/Back Supports
- Ambulance Services
- Arches/Orthopedic Shoes (cost in excess of regular shoes)
- Contraceptives
- Counseling (for medical reasons)
- Crutches
- Diabetic Monitor
- Guide Dog (for visually/hearing impaired person)
- Hearing Aids and Batteries
- Hospital Bed
- Learning Disability (special school/teacher)
- Medic Alert Bracelet or Necklace*
- Oxygen Equipment
- Prescribed Medical and Exercise Equipment*
- Prosthesis
- Splints/Casts
- Support Hose*
- Syringes
- Transportation Expenses (essential to medical care)
- Tuition Fee at Special School for Disabled Child
- Wheelchair
- Wigs (hair loss due to disease)**

### Medication
- Insulin
- Prescribed Birth Control
- Prescribed Vitamins (when a prescription is required for a medical condition)
- Prescription Drugs

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*Eligible when prescribed by a physician for a specific medical condition.

**Eligible only with doctor's certification identifying the physical nature of the medical condition and length of treatment program.

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**IMPORTANT**

You cannot receive a reimbursement from the HRA that you also claim as a deduction on your federal income tax return or that is reimbursed from another plan.

**Ineligible Expenses**

The IRS does not allow the following expenses to be reimbursed under the HRA Plan. Expenses to promote general health are not eligible expenses unless prescribed by a physician for a specific medical condition. This is not an all-inclusive list.
IMPORTANT

Unlike the Health Care Savings Account Plan for active pilots, there is no use-it or lose-it rule under the HRA Plan. Any unused amounts in your HRA after the end of the calendar year will be rolled over and available for use in the next Plan Year. You may not receive a cash-out from your HRA Account.

If you are reemployed after your HRA Account is activated, you will still have access to your HRA. However, if you become a participant in the Federal Express Corporation Health Care Savings Account Plan (the “HCSA”) for active pilots or the Federal Express Corporation Health Care Reimbursement Plan (the “HCRP”) for non-pilots, you must first file for reimbursement from the HCSA or the HCRP before you file for any benefits payable from the HRA Plan.

Forfeitures

Your HRA Account will be forfeited if money remains in the HRA Account following your death and the deaths of your surviving spouse and surviving eligible dependents (as defined in the Internal Revenue Code), if any.

Accessing Your Account

You have three options to pay for eligible health care expenses from your HRA:

Pay Me Back
- You are reimbursed for eligible expenses you have paid for out-of-pocket, including monthly health care premiums.
- You must submit a claim form and itemized proof of expenses to WageWorks via fax or mail.
- You are reimbursed for eligible expenses from your HRA.

Pay by Health Care Choice 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 HRA.
- No claim forms to file.
Pay My Provider

- An online bill pay service that sends payments from your HRA directly to your providers.
- No claim forms to file, but you upload your detailed invoice or other appropriate support.
- Convenient way to pay for most recurring eligible health care services.
- You will be able to select the date to make your payment.

Pay Me Back

Some expenses are easier to pay for first and then receive reimbursement at a later date. There are also providers that do not accept a debit card without a PIN as a payment method. This means you are either required to pay for these expenses out-of-pocket at the time of service or when you receive the bill. You should always save your detailed receipts to submit with your reimbursement request. IRS regulations require you to maintain documentation to verify your expenses.

This method of reimbursement requires you to complete a Pay Me Back Claim Form and submit it with your eligible health care expense receipts or invoices. You can download a form at www.wageworks.com “Need a claim form.” You can fax your completed form and proof of expenses (receipts, invoices, etc.) to 1-877-353-9236 (the number is also provided on the claim form) or mail your form and photocopies of your proof of expenses to:

WageWorks, Inc, P.O. Box 14053, Lexington, KY 40512

An Explanation of Benefits statement, often referred to as an EOB, will satisfy proof of a claim for you and your eligible dependents. An EOB is a statement received from the claims paying administrator that details benefits paid/not paid under the terms of the health plan. It is the unpaid benefits that may be eligible for reimbursement from the HRA. In order to receive reimbursement for your retiree health premiums, you must submit a copy of your cancelled check or a copy of your monthly pension check which shows the deduction for your monthly retiree health premium.

In addition to the above documents, you must submit a copy of your initial enrollment letter (and annual enrollment letters thereafter) which was included with your retiree health enrollment packet to WageWorks as proof of the amount of retiree health premiums. You may contact Pilot Benefits Administration if you need a duplicate copy of the initial enrollment letter.

You can elect to receive reimbursement of your eligible HRA expenses by:

- Direct Deposit, or
- Check mailed to your home address via U.S. mail.

Direct Deposit

You can request Direct Deposit of your reimbursement when you create your profile online at www.wageworks.com or you can call WageWorks Customer Service at 1-877-924-3967. You will need to provide your banking information to setup Direct Deposit. It is your responsibility to notify WageWorks immediately of any changes in the status of your bank account, such as a bank account closure or change in bank account number.

The standard turnaround time for Direct Deposit reimbursement request is two business days from the time WageWorks transmits deposit authorization to your bank. You should verify that the deposit is made into your bank account before attempting to withdraw funds.

Should you decide to cancel your Direct Deposit arrangement, reimbursement checks will be mailed to your home address once WageWorks receives and processes your cancellation request.
Pay By Health Care Choice Card

With the Health Care Choice Card, you can pay for eligible health care expenses at the time of service or point of sale. Simply swipe your card at the register (select “Credit” if asked) and funds are deducted automatically from your HRA. When you use your Health Care Choice Card, there’s no need to submit a reimbursement claim form. However, for card usage that WageWorks is unable to substantiate, you may be required to submit a copy of the receipt to WageWorks.

**Important** — Always save your receipts in case they are needed to verify your expenses (with WageWorks or the IRS). Be sure to validate all card transaction where WageWorks is requesting additional support as all debit card transactions not validated will be reported as taxable income to you.

**New Retiree** — Once you retire and meet the eligibility requirements on page O-11, your card will be sent to your home address with Terms and Conditions for card usage within two to three weeks following the date of your retirement.

Pay My Provider

With the Pay My Provider option, you can pay your provider directly from your HRA. It is a convenient way for you to pay for recurring or regularly scheduled eligible health care expenses such as orthodontic care or physical therapy. You can also use Pay My Provider to pay the balance of a bill your health plan does not cover. The payment amount must be $20 or more.

**How to Use Pay My Provider**

1. Log in to [www.wageworks.com](http://www.wageworks.com).
2. Click on the “Health Care” tab.
3. Click “Request Pay My Provider.”
4. Confirm or enter your e-mail address.
5. Enter your provider information.
6. Enter patient information.
7. Enter your payment amount(s).
8. Scan and upload your detailed invoice, or other detailed support.
9. WageWorks will make the requested payment(s) from your account and mail it directly to your provider.
10. WageWorks will send you an e-mail each time a requested payment is made.

**NOTE:** There must be sufficient funds available in your account to remit the entire payment. No partial payments can be issued from the account.

WageWorks ONLINE @
[www.wageworks.com](http://www.wageworks.com)

As an HRA participant, you can register at the WageWorks Website and have access to:

- View your account activity and balance.
- Check the status of your claims and payments.
- Download claim forms.
- Order an additional Health Care Choice Card.

For more information, call WageWorks at 1-877-924-3967. The automated voice response system can assist you around the clock. Customer service representatives are available during normal business hours from 7:00 a.m. to 7:00 p.m. CST.

WageWorks will send you a monthly statement reviewing all account activity since the last statement. The Card Use section shows all card transactions that are not verified and explains the options available to resolve them. If you have an e-mail address on record with WageWorks, you will be sent an e-mail each time a new
Using the Health Care Choice Card

(1) **You must activate your card** before you use it. Call 1-866-363-4128 and enter the information requested. The Health Care Choice Card is a Visa® debit card that can be used at most merchants who sell eligible health care products or services and accept Visa debit cards without a PIN.

(2) **Use your card for eligible health care expenses only.** Log in to www.wageworks.com for a list of eligible expenses or review the list referenced in this description. This card can only be used at approved health care providers and merchants where health care products and services are likely to be sold (e.g., pharmacy, physician, medical facility, optician/optometrist, dentist, etc.).

(3) **Do not use your card to pay for past or future services.** Tax regulations prohibit you from using this card to pay for services you received before your current coverage period or those you plan to receive in the future.

(4) **Each time you use your card, you certify that you are paying for eligible expenses incurred** by you or an eligible dependent during your current coverage period and that you have not and will not seek reimbursement for these expenses from any other health plan or source.

(5) **Save all receipts that describe exactly what you paid for with your card.** These may be requested – by WageWorks or the IRS – to verify you used your account to pay for eligible products and services. Be sure to validate all card transactions where WageWorks is requesting additional support as all debit card transactions not validated will be reported as taxable income to you on a W-2 from FedEx.

(6) **Debit or credit? Choose credit.** Even though this is not a credit card, choose the credit option. The card has no PIN.

(7) **Review the monthly statements** you will receive from WageWorks. They contain important information about your account, including if you are required to verify any purchases you made with the card.

(8) **You may be required to reimburse your account** in the amount of any card purchase if you cannot show the card was used for eligible health care products and services.

(9) **Card use is suspended** if the amount not verified is greater than or equal to 50% of your HRA Account balance and will remain suspended until all card transactions have been validated.

IRS regulations require that you be able to show you used your Health Care Choice Card for eligible health care expenses. WageWorks may ask you to submit a photocopy of your receipt to show you used your card to pay for eligible health care products and services. **Even if your card transaction is automatically approved, you should keep your detailed receipts with your important tax records for the year.**

IRS regulations require that WageWorks verify each and every card transaction to ensure your HRA Account is used only to pay for eligible health care products and services. If they are 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. If a card transaction cannot be verified, the unverified amount will be included in your taxable income.
When Coverage Ends  
Your coverage in the HRA ends when your HRA Account is exhausted or you forfeit your HRA Account as described on page O-25.

Overpayments or Errors  
If it is later determined that you and/or your dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement from the HRA. If you do not refund the overpayment or erroneous payment, the HRA and FedEx reserve the right to offset future reimbursement equal to the overpayment or erroneous payment.

Taxation  
The HRA Plan is intended to meet certain requirements of federal tax laws under which the benefits that you receive under the HRA Plan generally are not taxable to you. Because individual circumstances may produce different results, you are urged to contact your personal tax advisor.

Administration  
The HRA Plan requires several vendors for its administration:

1. **Mercer HR Services.** The assets in the VEBA trust are invested in the “Vanguard Money Market Fund Institutional Shares.” In order to allocate interest to each pilot, each pilot has a separate sub-account in the VEBA trust. Putnam (now Mercer HR Services) sent each pilot/Retired Pilot a welcome letter explaining how to access their account. Since Mercer is investing any unused money each day, pilots/Retired Pilots will receive their account balances from Mercer. Mercer will e-mail each pilot/Retired Pilot a quarterly statement detailing account activity, including interest earned, and their account balance. In addition, pilots/Retired Pilots can contact Mercer at 1-877-864-6644 between the hours of 8:00 a.m. and 10:00 p.m. ET for their balances; pilots/Retired Pilots can use the Internet at anytime to access their account at [www.ibenefitcenter.com](http://www.ibenefitcenter.com).

2. **WageWorks Inc.** WageWorks is the company that administers active HRA Accounts by processing any HRA reimbursement request as well as managing the HRA debit card feature. WageWorks will send a welcome kit and a HRA debit card to eligible Retired Pilots who are at least 59 years old and to any eligible Retired Former Pilot who retired prior to August 26, 2006. The welcome kit will explain how to use the HRA Account. All Retired Pilots and Retired Former Pilots with an active HRA Account will receive monthly statements from WageWorks that details monthly activity for their HRA Account or they can call WageWorks at 1-877-924-3967 between the hours of 8:00 a.m. and 8:00 p.m. ET or they can use the Internet at anytime to access their HRA Account activity at [www.wageworks.com](http://www.wageworks.com). WageWorks' monthly statements will not include HRA Account balances for Retired Pilots and Retired Former Pilots with active HRA Accounts; the statement will only include claims processed for the month. At 4:00 p.m. ET (1:00 PT) each day, WageWorks requests funding from the VEBA trust/Mercer for claims processed up until that time. Mercer uses this funding deadline in order to comply with the Security Exchange Commission’s late trading rules which are based on Eastern Time. However, since WageWorks processes and reports on Pacific Time, it continues to process claims for the remainder of the business day. WageWorks reporting is based on what was processed during the business day, which it measures according to Pacific Time. Accordingly the monthly balances reported by WageWorks will not agree to the balances reported by Mercer and the balances are thus not reported on the monthly WageWorks statements.

Funding and Plan Assets  
The cost of the HRA Plan is paid by Federal Express Corporation. All assets are held in a trust (“VEBA”). HRA Plan assets are held for the exclusive benefit of HRA Plan participants.
Employee Reduced-rate Shipping

As an active or retired pilot, you may take advantage of Employee Reduced-rate shipping using the services and products of FedEx. This benefit is offered on a space-available basis according to a few simple guidelines, as outlined below.

Eligibility

You, your spouse and your dependent children are eligible. In designated COMAIL codes in San Francisco and SFO, registered Domestic Partners (registered with any governmental body pursuant to state or local law authorizing such registration) and their dependents are included. Unfortunately, the Company cannot extend discounted shipping to brothers, sisters, parents, grandparents, other family members or temporary pilots.

There may be only one discount shipping account number per family. So, if you are married to another FedEx employee and you both have account numbers, one account number must be deleted.

Services and Shipping Rates

For most products, base charges are discounted by a specific percentage. On some products, a flat rate is charged based on the service and weight. Up-to-date information on current rates and products can be found by going online at the FedEx portal and then selecting the Life page.

Delivery and tracing are included for domestic and international products. Traces should not be requested until at least 48 hours after you made your shipment and after the delivery commitment time. Since all employee reduced-rate shipments are moved on a space-available basis, there are no expedites, credits or refunds for delays. Also, the 30-minute response or refund does not apply.

Restrictions

There are restrictions on picking up and dropping off packages. These restrictions are based on eligibility, payment and season. If you do not follow these restrictions, you could lose your shipping privileges, or disciplinary action could be taken, including dismissal. For example, some areas such as Memphis have limited access to service centers for discount shipment drop-off during peak season so that priority is given to customers. Also, packages may not be dropped off at unstaffed FedEx locations (such as drop boxes) unless the packages are being billed to an employee account number.

The following restrictions apply:

- Do not use your discount for business or for activities for which you or your family are reimbursed.
- Do not give your account number to someone other than your spouse or dependent children. Don't even give it to another employee.
- Do not use nonrevenue account numbers for personal shipments. (For example, don't ask Global Travel Services to return personal tickets on an airbill using a nonrevenue number.)
- Know proper shipping procedures and educate other family members. No adjustments will be honored if you or a family member complete the airbill incorrectly.
- Do not request refunds, credits or invoice adjustments for errors you could have prevented. You are responsible for your mistakes.
- Do not use another employee's, family member's or friend's credit card number to establish an employee account number.

Steps to Take to Apply for an Account Number

1. Read Reduced Shipping Policy by going online at the FedEx portal and then selecting the Life page. Follow instructions for an account number.
2. Keep FedEx employee account number up-to-date by going online at the FedEx portal and then selecting the Life page or by notifying Revenue Services at 1-800-622-1147 of credit card expiration date or when card number changes.
Steps to Take to Make Payments and Drop-offs

(1) **Use Employee Reduced-rate Shipping** for personal shipments only.

(2) **Read Employee Reduced Rate Shipping Policy** in *The People Manual* and educate eligible family members in proper shipping procedure.

(3) **Check the FedEx Service Guide** or COSMOS ISQS for up-to-date information on international restrictions (e.g., paperwork requirements, acceptable package contents, destination served) before shipping. Any duties and taxes assessed by customers on international shipments are not discounted. Alaska and Hawaii surcharges are discounted 75 percent.

(4) **Complete airbill or air waybill properly.** Write legibly, or type the paperwork when possible. Keep airbill copies and receipts.

(5) When possible, **route all shipments “Hold at Location”** to a service center or station during peak season.

(6) When possible, **sign the signature release section** (on U.S. domestic airbills) to allow couriers to leave packages at the destination without a recipient signature.

(7) **Identify yourself immediately** as a FedEx pilot when talking with FedEx agents on the phone or at a counter.

(8) **Present valid FedEx ID** at time of shipment and list employee ID number in reference section of airbill or air waybill. Family members must present their personal identification along with your FedEx ID or a photocopy of your FedEx ID. Registered domestic partners of pilots in designated COMAIL codes in San Francisco and SFO must also present a completed copy of the Domestic Partner Identification Form.

(9) **Pay** with cash, personal check, cashier's check, money order, credit card (American Express, Visa, MasterCard, Discover or Diner's Club) or valid FedEx employee account number when shipping in person. (Overdrawn checks and charge returns by credit card companies are subject to a penalty fee.)

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you should log into the FedEx portal and then select the Life page.

**Employee Stock Purchase Plan (ESPP)**

The FedEx Corporation Employee Stock Purchase Plan (ESPP) offers eligible pilots the opportunity to purchase FedEx Corporation common stock through payroll deductions without having to pay any transaction fees on the purchase. Computershare administers the ESPP for participating pilots.

You are eligible to participate in the ESPP if you have attained the age of majority in the state in which you reside and you are a full-time or permanent part-time employee of FedEx Corporation or one of its subsidiaries and you are not a managing director (or its equivalent) or an officer of FedEx Corporation or one of its subsidiaries or a member of the FedEx Corporation Board of Directors. Pilots who reside outside of the United States and Puerto Rico are not eligible to participate in the ESPP.

As a participant, you authorize payroll deductions of 1 percent to 10 percent of your 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)
Other Benefits and Services

- 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
- Amounts distributed from the Pilots' Retirement Saving 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
- Vacation buybacks

Eligible earnings include pay prior to deductions for pre-tax health care, dependent care, and PRSP 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 Pre-tax/401(k) Employer Matching contributions
- PRSP Employer Sick Bank Account contributions
- PMPPP contributions
- Excess Life Premiums
- Earnings above the IRS compensation limit
- Reimbursed expenses

Your ESPP deductions accumulate until the end of the month. FedEx Corporation stock is purchased at the end of each month at market price and then allocated to each participant's account at Computershare. You may change your payroll deductions or withdraw from the ESPP at any time. You may sell your stock through Computershare, but are responsible for the transaction fee or commission on each sale of stock.

To enroll in or withdraw from the ESPP, or to change your payroll deduction, you should contact Computershare either online, at www.computershare.com/employee/us, or by phone, through Computershare’s Interactive Voice Response (IVR) system at 1-800-326-6150. You will need your social security number and Personal Identification Number (PIN) to access either automated system. If you do not yet have a PIN, your PIN will initially be set as the last five digits of your social security number. If you do not remember your PIN, please call Computershare at 1-800-326-6150 to reset your number.

If you wish to speak with a Computershare service representative about your ESPP account, please call Monday through Friday between 8:00 a.m. and 7:00 p.m., Eastern Time.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. The terms of the ESPP are outlined in the Employee Stock Purchase Plan Booklet, which you can download on the FedEx Intranet home.
Global Travel

FedEx Express offers eligible employees discount privileges for both business and personal travel. These discounts are offered through Global Travel on those airlines, which have reciprocal agreements with FedEx Express. (Agreements may be changed or canceled by either FedEx or the airline.) The Global Travel Department provides you with business airline arrangements, regardless of location or passenger airline. Global Travel also provides all discount personal ticketing for you, your spouse and your dependent children up to their 21st birthday.

Do not discuss the corporate travel benefit with other passengers while traveling at a reduced rate.

Eligibility

As an active pilot, you and your eligible dependents may travel at discounted rates. All airlines require you be a permanent FedEx Express pilot with a minimum of six months of uninterrupted service. Required length of service and employment status is subject to the contract with the individual airline. Refer to the FedEx Express Intranet site (keyword: global travel for contact information for the airline directory and eligibility requirements by airline including those for your family members.

Retirees do not have access to the website. They must call Global Travel at (901) 395-7000 and follow the prompts for “Personal Travel.” Then they must advise the agent that they are a FedEx retiree and need a fare quote.

You are not eligible for interline discount travel during a leave of absence, starting with the first day of leave. Exceptions may be made in critical situations such as medical and death-related travel requirements with a written request and approval from your Systems Chief Pilot to the manager of Global Travel Services.

Listing of Discounts

Information related to interline air discounts, tours and cruises is located in the FedEx Express Intranet site (keyword: global travel). Procedures and eligibility requirements are also listed there.

Submitting Ticket Requests

Personal travel requests must be processed through Global Travel. All discount travel requests must be made with the proper Request for Travel Form.

All personal travel tickets issued by FedEx Global Travel to pilots and/or their eligible family members will be assessed a non-refundable, $18-per-ticket service fee. Credit cards (American Express, Visa or Master Card) issued in the pilot's name are now also accepted when paying for a personal travel ticket issued by Global Travel.

Personal discounted standby tickets are for space-available seating only. Travelers must contact the airlines directly for flight schedules, availability and to list as a STAND BY passenger. Please contact the airline during non-peak hours (7:00 p.m. to 6:00 a.m.). Refer to the Global Travel website for eligibility rules and listing guidelines by airline. Any attempt to reserve a seat in the pilot's own name or another name to hold space for standby tickets is immediate cause for disciplinary action. The airline may charge a standby passenger full fare if this occurs and report it to FedEx Express.

Tickets can be held for pickup at the Crew-Global Travel office located at Flight Operations-AOC or sent to a non-FedEx location (pilot is to pay for shipping to non-FedEx locations).

Rules

FedEx discounted personal travel policies can be found on the Global Travel website. Review this information before you request discount personal interline travel. You are responsible for notifying your dependents of interline travel policies and regulations. Abuse of privileges may jeopardize discount benefits for your fellow pilots. Therefore, misconduct while using travel benefits is grounds for disciplinary action—even termination.
The most recent incidents leading to suspension of personal travel privileges are:

- Wearing sweats or a jogging suit
- No FedEx ID
- Being argumentative with airline staff
- Not following airline instructions

Please refer to the Global Travel website and the Personal Travel Certification Form located at the bottom of your personal travel ticket request form. The Certification Form covers 15 rules of proper dress and conduct for stand-by travel.

The following special dress code must be observed:

- **Male adults** – Casual slacks with collared shirt (no jeans or T-shirts). Casual shoes with socks (no athletic shoes). Coat and tie are not required except for first-class travel.
- **Female adults** – Dress, pantsuit or slacks/skirt with coordinating blouse. Casual shoes with hosiery (no athletic shoes).
- **Children** – Well-groomed and well-dressed in clothing suitable for travel. Children over the age of 12 are considered adults by airlines and must meet adult dress standards.

**Unacceptable clothing:** Tennis/athletic shoes, ski/all-weather jackets, denim fabrics (including jeans), shirts with no collar, T-shirts, tank tops, sweats, jogging suits, shorts, cutoffs, miniskirts, sandals, thongs, and sheer, strapless or spaghetti strap tops or dresses.

You or any family member will be denied boarding if the dress code is not observed. As members of the airline family and representatives of FedEx Express, pilots and their dependents are to conduct themselves according to the highest standards during all discounted transactions.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you should log into the Global Travel website.

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**Group Legal Services Plan for Federal Express Corporation and Affiliated Employers (GLSP)**

Pilots and retirees may purchase the Group Legal Services Plan (GLSP), administered by Hyatt Legal Plans, a MetLife Company. Hyatt has contracted with more than 11,000 attorneys across the United States to provide legal services for Plan participants.

The Plan provides you and your eligible dependents with a wide range of legal services including:

- Purchase, sale or refinancing of primary residence
- Wills and estate planning
- Deed preparation
- Debt matters
- Defense of civil lawsuits
- Unlimited telephone advice and office consultations on many personal legal matters (business and employment related matters excluded)

**Eligibility**

Eligible active pilots include any U.S.-based, Puerto Rico-based or domestic pilot of any FedEx company participating in the Federal Express Group Health Plan and who has satisfied the eligibility requirements for that Plan. Participating employers in the
Group Legal Services for Federal Express Corporation and Affiliated Employers Plan include: Federal Express Corporation; FedEx Corporation; FedEx Trade Networks Transport & Brokerage, Inc.; FedEx Trade Networks Trade Services, Inc.; World Tariff, Ltd.; FedEx Corporate Services, Inc.; FedEx Trade Networks, Inc.; FedEx TechConnect, Inc.; and FedEx Freight Corporation. Employees of Federal Express Virgin Islands, Inc. and pilots domiciled in Guam are not eligible to participate.

Dependents are eligible as outlined below:

- Your spouse is a legally married spouse (as defined by federal law, which is a person of the opposite sex who is a husband or wife with who you have entered into a marriage (a legal union between one man and one woman as husband and wife).

- An eligible child, adopted child, stepchild, or any other child who is dependent upon you by virtue of a legal decree such as adoption, guardianship or administrative procedure sanctioned by the state in which an adoption will occur and who is: (a) dependent on you for over half of his or her financial support, (b) unmarried and (c) under 19 years of age or, if a full-time student, under 23 years of age.

Eligible former pilots include any U.S.-based, Puerto Rico-based or domestic former pilot of a participating employer who terminated employment and (i) is eligible for Retiree Health coverage, or (ii) after reaching age 55 and had completed five years of employment. Participating employers in the Group Legal Services for Federal Express Corporation and Affiliated Employers Plan include: Federal Express Corporation; FedEx Corporation; FedEx TechConnect, Inc.; FedEx Trade Networks Transport & Brokerage, Inc.; FedEx Trade Networks Trade Services, Inc.; World Tariff, Ltd.; FedEx Corporate Services, Inc.; FedEx Trade Networks, Inc.; and FedEx Freight Corporation. Former employees of Federal Express Virgin Islands, Inc. and former pilots domiciled in Guam are not eligible to participate.

Dependents are eligible if they meet the definition of dependent as outlined above under the Federal Express Corporation Retiree Group Health Plan and are a dependent of a former pilot of a participating employer listed above.

**Enrollment**

Permanent new hires must enroll within the first 90 days of becoming eligible for the FedEx Express benefit programs or wait until the next annual enrollment period. During the annual enrollment, you will be given the opportunity to enroll in GLSP for the next calendar year. **After you enroll in the GLSP, you will automatically be reenrolled each year unless you disenroll during the annual enrollment.** The disenrollment will become effective on December 31 of that calendar year.

You may also enroll or disenroll within 31 days of a family status change, which includes but is not limited to:

- Birth or adoption of a child
- Marriage or divorce
- Death of a spouse or eligible dependent
- Spouse's gain or loss of employment
- Unpaid leave of absence by you or your spouse
- Change by you or your spouse from permanent full-time to permanent part-time or vice versa
- Legal custody or guardianship of a child

Once enrolled, you must stay in the GLSP through the Plan Year (January 1 through December 31), unless you have a family status change as described above.
To request an enrollment kit or enroll in the GLSP, call 1 800 GET-MET8 (1-800-438-6388), Monday through Friday 8:00 a.m. to 7:00 p.m., Eastern Time. Hearing impaired individuals can call MetLife’s TDD number at 1-800-426-5718. You may also visit the MetLife website at www.metlife.com/mybenefits.

**Premiums**

The monthly premium of $17 is automatically deducted from and is equally divided between your paychecks.

**Selecting an Attorney**

You can use one of the attorneys in Hyatt’s network, or you can use your own attorney. Here are the differences:

**In-Network Attorney**

- All covered services are paid in full.
- No claim forms are required.

**Out-of-Network Attorney**

- All covered services are reimbursed according to a set fee schedule.
- You are responsible for paying the difference between the attorney’s fee and the GLSP fee schedule.
- Claim forms are required.

**Using the Plan**

To receive benefits, Plan participants must obtain an authorization number via MetLife’s website or MetLife’s Client Service Center.

You must obtain an authorization number for services as described below, prior to contacting any attorney, whether in-network or out-of-network. No benefits will be paid for services incurred before you have received an authorization number.

**To use the MetLife Website**

Logon to the website at www.metlife.com/mybenefits. You will be taken to a secure site where you will be asked to enter your last four digits of your Social Security number. You will see a variety of options, including:

- Attorney
- Coverage
- Authorize

**NOTE:** When you click on “Authorize” you will be issued an authorization number. Once you have the authorization number, call your attorney and schedule an appointment.

**To use MetLife’s Client Service Center**

Call 1 800 GET-MET8 (1-800-438-6388), Monday through Friday 8:00 a.m. to 7:00 p.m., Eastern Time. Identify yourself as a participant in the FedEx Group Legal Services Plan and provide the last four digits of your Social Security number. If you are a spouse or an eligible dependent child of a participating pilot, you will need the pilot’s Social Security number.

The Client Service Representative who answers your call will:

- Verify eligibility for services.
- Make an initial determination as to whether and to what extent your case is covered if using an in-network attorney; however, no predetermination of benefits can be made for out-of-network services.
- Provide an authorization number. (A new authorization number is needed for each new case you have.)
Supply the telephone number of the Plan Attorney most convenient to you.

Send you a fee reimbursement schedule and claim forms, if you choose to use an out-of-network attorney.

Answer questions about the Group Legal Services Plan.

Once you have the authorization number, call your attorney and schedule an appointment.

If there are no in-network attorneys available to you or you choose to use an out-of-network attorney, you will be reimbursed based on the set fee schedule for out-of-network attorneys.

**A preauthorization number is not a guarantee of benefits or reimbursement when using an out-of-network attorney.**

### Covered Legal Services

The following benefits are available to you, your spouse and eligible dependent children, unless otherwise noted.

| Advice and Consultation, Including Telephone Advice | Provides the opportunity to discuss with an attorney any personal legal problems not specifically excluded. The Plan attorney will explain your rights, his or her opinions and recommend a course of action. The Plan attorney will identify any further coverage available and agree to represent you, if you agree. If representation is covered by the Plan, you will not be charged for the Plan attorney’s services. If representation is NOT covered by the Plan, the Plan attorney will provide you with a written fee statement in advance so you can chose whether to retain the Plan attorney at your own expense, find another attorney or do nothing. There are no restrictions on the number of times per year you can use this service. However, for a non-covered matter, this service is not intended to provide you with continuing access to a Plan attorney to seek advice that would allow you to represent yourself. |
| **Wills and Estate Matters** | **Trusts**—preparation of your revocable or irrevocable living trust.  
*Does not include*—financial or tax planning or services associated with funding the trust after it is created.  
**Living Wills**—preparation of your living will.  
**Wills and Codicils**—preparation of your will, including creation of any testamentary trust and preparation of codicils or will amendments.  
**Power of Attorney**—preparation of any power of attorney when you are granting the power.  
**Probate (10% In-Network Attorney Discount)**—subject to applicable law and court rules, Plan attorney will handle probate matters at a fee that is 10% less than the normal fee charged by that Plan attorney. You are responsible for this fee and all costs charged by the Plan attorney. |
| Defense of Civil Lawsuit | Administrative Hearing | representation for you in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission, including the hearing before an administrative board or agency over an adverse governmental action.  

*Does not include*—services and representation provided by virtue of an insurance policy or family law matters, post judgment matters or litigation of a job-related incident.

**Civil Litigation Defense**—representation for you in defense of an arbitration or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. Does not include - services and representation provided by virtue of an insurance policy or family law matters, post-judgment matters or litigation of a job-related incident or bringing counter, cross or third-party claims.

**Incompetency Defense**—representation for you in defense of incompetency action, including court hearings when there is a proceeding to find you incompetent.

| Document Preparation | Affidavits | preparation of an Affidavit where you are the person making the statement. An Affidavit is a sworn written statement generally witnessed by a notary public.

**Deeds**—preparation of any Deed for which you are either the grantor or grantee.

**Demand Letters**—preparation of letters for you demanding money, property or some other property interest of yours (except interest that is an excluded service), mailing letters to the addressee and forwarding and explaining any response to you. Does not include - negotiations and representation in litigation.

**Document Review**—review of any personal legal document of yours, such as letters, leases or purchase agreements.

**Mortgages**—preparation of a mortgage or deed of trust where you are the mortgagor.

*Does not include*—documents pertaining to business, commercial or rental property.

**Notes**—preparation of a promissory note where you are the payor or payee.
| Family Law | **Name Change**—all necessary pleadings and court hearings for your legal name change.  
**Prenuptial Agreement**—preparation of an agreement for you and your fiancé(e)/partner before marriage or legal union (where allowed by law) outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to the employee. The fiancé(e)/partner must have separate attorney or waive representation by an attorney.  
**Contested and Uncontested Adoption and Legitimization**—all legal services and court work (state or federal court) for contested and uncontested adoption and legitimization for you and your spouse.  
**Uncontested Guardianship or Conservatorship**—establishment of an uncontested guardianship or conservatorship over a person and his/her estate when you or your spouse is appointed guardian or conservator. Includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing paperwork, attending the hearing and preparing the initial accounting.  
**Services not covered**—if the proceeding becomes contested, you and/or your spouse are responsible for all additional legal fees.  
**Does not include**—representation of the person over whom guardianship or conservatorship is sought, or any annual accounting after preparation of the initial accounting.  
**Elder Law Matters**—counseling via phone or in the office on any personal issues relating to your parents which affect you, including reviewing parents' documents. Documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. Also includes preparing deeds involving the parents when you are either the grantor or grantee; and preparing promissory notes involving the parents when you are the payor or payee.  
**Protection from Domestic Violence**—covers the employee only, not the spouse or dependents, as the victim of domestic violence. It provides the employee with representation to obtain a protective order including all required paperwork and attendance at all court appearances. This service does not include representation in suits for damages, defense of any action, or representation for the offender. |
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<td>Immigration</td>
<td><strong>Immigration Assistance</strong>—advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping you prepare for hearings.</td>
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| Traffic and Criminal Matters | **Juvenile Court Defense**—representation for you and dependent child in juvenile court matter.  
**Does not cover**—representation will be provided only to you if a conflict of interest exists between you and your child, including services for parental responsibility.  
**Restoration of Driving Privileges**—representation for you in proceedings to restore your driving license.  
**Traffic Ticket Defense**—representation for you in defense of a traffic ticket, including court hearings, negotiation with prosecutor and trial.  
**Does not include**—representation for defense of driving under the influence (DUI) or vehicular homicide. |
| **Real Estate** | **Eviction and Tenant Problems (primary residence as a tenant only)** — assistance to you as a tenant for matters involving leases, security deposits or disputes with a residential landlord, including eviction defense, up to and including trial, if necessary.  
*Does not include* — representation in disputes with other tenants or as plaintiff in lawsuit against the landlord, including action for a return of a security deposit.  
**Home Equity Loan (primary residence)** — review or preparation of a home equity loan on your primary residence.  
**Home Refinancing (primary residence)** — review and preparation by Plan attorney of relevant documents which are involved in refinancing or obtaining a home equity loan on your primary residence, including mortgage, deed and documents pertaining to title, insurance, recordation and taxation. This also includes obtaining a permanent mortgage on a newly constructed home.  
*Does not include* — services that represent a lending institution or title company; refinancing a second home, vacation property, rental property or property held for business or investment.  
**Home Sale or Purchase (primary residence)** — review and preparation of relevant documents that are involved in the purchase or sale of your primary residence or vacant property to be used for building a primary residence, including construction documents, purchase agreement, mortgage and deed, documents pertaining to title, insurance, recordation and taxation and attorney representation at closing.  
*Does not include* — sale or purchase of second home, vacation property, rental property, property held for business or investment or lease with an option to buy, boundary or title dispute, property tax assessment or zoning application.  
**Security Deposit Assistance (primary resident as a tenant only)** — counseling for you as a tenant in recovering a security deposit from your residential landlord for your primary residence; reviewing the lease and other relevant documents; preparing demand letter to landlord for return of deposit; assisting you in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; preparing you for small claims trial.  
*Does not include* — attendance or representation at small claims trial, collection activities after a judgment or any services relating to post-judgment actions.  
**Boundary or Title Disputes (primary residence)** — covers negotiations and litigation arising from boundary or title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies.  
**Property Tax Assessment (primary residence)** — covers the Participant for review and advice on a property tax assessment on the Participant’s primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.  
**Zoning Applications** — provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning. |
| **Tax Audit** | **Tax Audit** — reviewing tax returns and answering questions the IRS, or state or local taxing authority has concerning your tax return; negotiating with the agency; advising you on necessary documentation; and attending an IRS, or state or local taxing authority audit.  
*Does not include* — prosecuting a claim for the return of overpaid taxes or for the preparation of any tax return. |
| Consumer Protection Matters | Consumer Protection Matters—representation for you as a Plaintiff, including trial, for disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing.  

*Does not include*—disputes over real estate, construction, insurance or collection activities after a judgment.  

**Small Claims Assistance**—counseling you on prosecuting a small claims action; helping you prepare documents; advising you on evidence, documentation and witnesses; and preparation for trial.  

*Does not include*—Plan attorney's attendance or representation at small claims trial, collection activities after a judgment, or any services relating to post-judgment actions.  

**Personal Property Protection**—counseling you over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements, and pursuing or defending small claims actions. This service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters. |
| Debt Matters | Debt Collection Defense—services to negotiate with creditors for repayment schedule, limit creditor harassment, representation in defense of action for personal debt collection, foreclosure, repossession or garnishment up to and including trial, if necessary.  

*Does not include*—vacating a judgment; counter, cross or third-party claims; bankruptcy; actions arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with FedEx or MetLife.  

**Identity Theft Defense**—consultations with Plan attorney for potential creditor actions from identity theft; attorney services needed to contact creditors, credit bureaus and financial institutions; defense services for specific creditor actions over disputed accounts which include limiting creditor harassment, representation in defense of action arising from identity theft such as foreclosure, repossession or garnishment, up to and including trial, if necessary. Also provides online help and information about identity theft and prevention.  

*Does not include*—counter, cross or third-party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with FedEx or MetLife. |
| Personal Bankruptcy | Personal Bankruptcy or Wage Earner Plan—pre-bankruptcy planning, preparation and filings for you and your spouse, including representation at court hearings and trials.  

*Does not include*—any services if the creditor is affiliated with FedEx or MetLife, even if you or your spouse choose to reaffirm that specific debt. |
| Personal Injury (25% In-Network Maximum) | Personal Injury Cases—Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the participant's responsibility to pay this fee and all costs. |
What Is Not Covered

The GLSP does not cover:

- Any matter which would otherwise be covered if it involves your Employer or any of its affiliates as an adverse party; any pilot benefit or benefit plan established by your Employer; any employment-related matter; or any matter involving Hyatt Legal Plans, Metropolitan Life Insurance Company or either of its Affiliates, or any Plan Attorney as an adverse party.

- Appeals, class actions, interventions, amicus curiae filings or derivative actions; agricultural, commercial or business transactions (including transactions involving rental property); matters related to admiralty, patent, trademark, or copyright law; tax return preparation; unemployment compensation or workers’ compensation matters.

- Any matter for which you retained an attorney prior to being enrolled in the Plan.

- Any matter for which you retained an attorney before calling the Hyatt's Client Service Center for an authorization number.

- Any matter arising outside the United States, its territories or possessions.

- Amounts due third parties such as court costs, filing fees, fines, judgments, witness fees, transcripts, recording fees, penalties or orders of restitution ordered by any court.

Telephone or office consultations related to the above matters are not eligible for reimbursement.

Other Legal Matters

For all other personal legal matters, an advice and consultation benefit is provided. During the consultation, the attorney will explain the participant's rights, point out options, and if needed, recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the participant so requests.

If representation is covered by the Plan, the participant will not be charged for the Plan Attorney's services. Additional representation is also included for certain matters. If a matter involves a participating pilot and a covered dependent as an adversary, coverage will be provided for the participating pilot only. There is no obligation to provide legal services benefits in any matter deemed to be frivolous, harassing, or in contravention of the rules of ethical conduct governing attorneys.

Non-Covered Services

If representation is recommended on a non-covered matter, your Plan Attorney will give you a written fee agreement in advance. You may choose whether to retain the Plan Attorney at your own expense, seek outside counsel, or do nothing.

If your legal matter is not listed as covered or excluded, your initial advice and consultation are covered.

Continuing Coverage

When you retire, you may have the option to continue your GLSP coverage without interruption. Since payroll deduction is no longer an option, you will be required to pay the full annual premium in advance.

Upon termination of employment or your death, GLSP coverage can be continued for 30 months provided you or your surviving spouse pay the full premium in advance. After the 30-month period, GLSP coverage ends.

Participants who begin a leave of absence (for example, disability, unpaid medical, personal or military leave) or a suspension may continue the coverage by converting to MetLife's home billing. MetLife's automated billing system will send a payment request for the missed premiums to your home address. Call MetLife at 1 800 GET-MET8 (1-800-438-6388) if you have any questions.
For details, please see the appropriate life events description in “What to Do When,” page W-1.

When the Pilot contacts MetLife to obtain a case number, the appropriate fee will be communicated.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you should log into the MetLife website at www.metlife.com/mybenefits.

The WorkLife® Balance Program is a work/life resource and referral service through LifeCare®. LifeCare® services are paid for by FedEx and free to you and your household members.

Trying to manage daily responsibilities and life events can be a real challenge at times. Fortunately, there's LifeCare®. Offering comprehensive work and life services, LifeCare® gives you the valuable and timely knowledge you need to manage your daily life—from prenatal information to adult care...from summer camps to child care services...from pet care to health and wellness... and much more.

Assistance around the clock, whenever you need assistance with a work and life issue or a referral to a provider, WorkLife Balance is always there for you, 24 hours a day, 7 days a week.

To access LifeCare® by phone... Call 1-877-LIFE-FDX (1-877-543-3339) (or TDD/TTY 1-800-873-1322).

To access LifeCare® on the web...

1. Enter the following URL in your browser: http://lcc.30.lifecare.com.
2. New users: click “NEW USERS CLICK HERE” link at the top right of the page in the Member Login box.
3. When prompted for a Registration Code, please enter: fedex.
4. When prompted for a Member ID, please enter: Your FedEx employee number (Member ID is a 10 digit number, if your employee number is less than 10 digits please add leading zeroes).
5. Follow the on-screen instructions to complete the one-time registration form.

If you have difficulty accessing the site, contact the help desk at 1-888-604-9565.

The LifeCare® Website offers rich content, extensive search features, and a variety of interactive tools. Highlights include:

Online provider searches and referrals

- Instantly access information on providers and resources (child care, adult care, schools, fitness centers, etc.) nationwide
- Request personalized referrals from a specialist via our interactive forms
- Confidentially view and retrieve information and referrals via your own Message Center
- Access a history of your requests and transactions via your Account Activity Center

Best in class content

Read or download the extensive library of materials available in printable html, PDF, and hard copy, including:

- Parenting information from experts
- Extensive content for seniors and caregivers on aging issues
• State regulations on child care centers and family day care homes nationwide
• Health content including an A-Z index of health articles, a Drug Database, a Symptom Checker, a Diagnosis Lookup, etc.
• Consumer articles on everyday issues such as choosing cleaning services, personal safety and home improvement

Interactive tools and features
• Medical animations that illustrate human anatomy, medical conditions, and other scientific topics
• Interactive quizzes on topics such as anger, anxiety, depression, lifestyle, patience, self-esteem and more
• Live virtual seminars and audio tips

Exciting Perks from LifeCare®
• Expecting a baby? You may be eligible to receive a Prenatal Kit containing free products and information to promote a healthy pregnancy—and baby.
• Caring for a child under three? Ask about the Child Safety Kit containing free products and information to keep your child safe.
• Have a college bound child? Inquire about the College Kit which can be sent directly to students to help them manage the transition to college.
• Caring for an older loved one? Inquire about the Adult Care Kit containing free products and information to assist caregivers with their responsibilities.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you can call LifeCare® at 1-877-LIFE-FDX (1-877-543-3339) (or TDD/TTY 1-800-873-1322) or on the web at http://lcc.30.lifecare.com.

Group Long-Term Care Insurance (LTCI)

Effective 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. If you need assistance with everyday activities, such as getting out of bed, eating, or taking a shower because of a disability, a chronic illness or as a result of the aging process, long-term care insurance helps pay for these services.

Some of the program features include:
• Covered Services: Nursing homes, Alzheimer’s facilities, assisted living facilities, inpatient hospice, licensed home care, adult day care and outpatient hospice care.
• When Benefits Begin: To receive a benefit, the participant must be unable to perform 2 of the following 6 daily activities of living: bathing, dressing, toileting, transferring (moving about a residence), continence and eating. After a 90-day waiting period, benefits are paid for the cost of a covered service up to the daily benefit amount.
• Daily Benefit Amount (DBA): Participants selected one of the following DBA options: $100, $150, $200, or $250.
• Lifetime Maximum: Participants selected one of the following lifetime maximum options: DBA for 3 years or DBA for 5 years.
Participants
Participants include any U.S.-based, Puerto Rico-based or domestic active pilot of any FedEx company participating in the Federal Express Corporation Group Health Plan and who satisfied the eligibility requirements for that Plan (see page H-2). Participating employers in the Federal Express Corporation Group Long-term Care Insurance Plan include: Federal Express Corporation; FedEx Corporation; FedEx Trade Networks Transport & Brokerage, Inc.; FedEx TechConnect, Inc.; FedEx Trade Networks Trade Services, Inc.; World Tariff, Ltd.; FedEx Corporate Services, Inc.; FedEx Trade Networks, Inc. and FedEx Freight Corporation. Employees of Federal Express Virgin Islands, Inc. and pilots domiciled in Guam are not eligible to participate.

Participating former pilots include any U.S.-based, Puerto Rico-based or domestic former pilot of a participating employer who terminated employment after reaching age 55 and completed five years of employment. Participating employers in the Federal Express Corporation Group Long-term Care Insurance Plan include: Federal Express Corporation; FedEx Corporation; FedEx Trade Networks Transport & Brokerage, Inc.; FedEx Trade Networks Trade Services, Inc.; FedEx TechConnect, Inc.; World Tariff, Ltd.; FedEx Corporate Services, Inc.; FedEx Trade Networks, Inc.; and FedEx Freight Corporation. Former employees of Federal Express Virgin Islands, Inc. and former pilots domiciled in Guam are not eligible to participate.

Your spouse, surviving spouse, parents, parents-in-law, grandparents and grandparents-in-law may also be participants in this program.

Premiums
MetLife has guaranteed their LTCI rates through December 31, 2011. The monthly premiums are based on the participant’s age at entry and will remain level for the original amount of coverage selected. Should a participant elect to increase coverage levels, the monthly premium will increase based on the additional coverage and participant’s age at the time such changes are elected. Each participant will pay the full cost of coverage. MetLife has filed for rate increase which is subject to regulatory approval. This increase could be effective as early as January 1, 2013.

There are several options for paying premiums, including payroll deduction and ExpressItSM checking account deduction. Under these two options, payments are deducted directly from your paycheck or personal checking account. There are no interest charges or service fees. Home billing is also an option.

Return of Contributions
If you are covered by the LTCI plan on the date of your death, your contributions that were paid up to your 65th birthday will be refunded as follows:

- **If you die before age 65**: all contributions less any benefits paid to you or on your behalf under the plan
- **If you die on or after age 65 but before age 75**: all contributions due and paid up to your 65th birthday—reduced by 1/120 of that amount for each full month you were covered after your 65th birthday—less any benefits paid to you or on your behalf under the plan
- **Contributions that were due and paid after your 65th birthday will not be refunded**
- **Contributions will not be refunded**: if you die on or after age 75; or if nonforfeiture coverage (see below) was being provided on the date of your death

If coverage ends because of your death, any additional contributions paid for any period beyond the date of your death will be refunded to your estate. The time limit for submitting proof of claim to MetLife for a refund of contributions is 90 days after the date of the covered person’s death.
To ensure that you receive Nonforfeiture Coverage, you must have made contributions for at least 3 years. If you elect to receive this benefit and it is shown in your personalized Schedule of Benefits, you will be eligible for Nonforfeiture Coverage. "Paid Contributions" include charges for Nonforfeiture Coverage and any month for which payment of your contribution was waived. Nonforfeiture Coverage takes effect on the Nonforfeiture Date, which is the 1st day following the end of the period covered by your last paid contribution.

Once you receive Nonforfeiture Coverage, you cannot change your benefits. The total benefits paid prior to and after the Nonforfeiture Date will not exceed the Total Lifetime Benefit in effect immediately prior to the Nonforfeiture Date.

Exclusions

The LTCI plan does not provide benefits for any of the following:

- Care in a facility that provides services primarily for detoxification of or rehabilitation for alcoholism or drug addiction (chemical dependency), except drug addiction sustained at the hands of or while being treated by a physician for an injury or sickness
- Illness, treatment or medical condition arising out of:
  - War or act of war (whether declared or undeclared);
  - Participation in a felony, riot or insurrection;
  - Service in the armed forces or auxiliary units;
  - Attempted suicide (while sane or insane) or intentionally self-inflicted injury.
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital that is licensed as a nursing home or hospice
- Any service provided by your immediate family
- Any service or supply if the expenses are reimbursable under Medicare, or would be reimbursable for the application of a deductible or coinsurance or copayment amount. This exclusion will not apply when Medicare is determined to be secondary payer under applicable law
- Services for which no charge is normally made in the absence of insurance

Continuing Coverage

When you retire, terminate employment, begin a leave of absence (disability, unpaid medical, personal or military, etc.), or are on suspension, you have the option to continue your long-term care insurance at the same premium rate without interruption. Since payroll deduction is no longer an option, you may convert to ExpressItSM (monthly checking account deduction) or home billing. Other family members who are enrolled in LTCI may continue their coverage by making premium payments directly to MetLife. For details, please see the appropriate life events description in “What to Do When,” page W-1.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, call MetLife at 1 800 GET-MET8 (1-800-438-6388).
Eligible crew members and former employees may purchase personal property insurance through the METPAY℠ Program at special group rates (available in most states to those who qualify). The program is offered by MetLife® Auto and Home, and features benefits and conveniences that are not available to individual policyholders. METPAY℠ advantages include:

- Special group rates (available in most states to those who qualify)
- Money saving discounts
- Convenient payment options such as payroll deduction
- Personalized service with 24-hour claim reporting

There are a variety of coverages available through METPAY℠, including:

- Automobile
- Homeowners
- Renters
- Condominium
- Boat Owners
- Mobile Home
- Recreational Vehicle
- Personal Excess Liability

**Eligibility**

Eligible active pilots include any U.S.-based or domestic pilot of any FedEx company participating in the Federal Express Group Health Plan and who has satisfied the eligibility requirements for that Plan (see page H-2). Participating employers in the METPAY℠ Program include: Federal Express Corporation; FedEx Corporation; FedEx Trade Networks Transport & Brokerage, Inc.; FedEx TechConnect, Inc.; FedEx Trade Networks Trade Services, Inc.; World Tariff, Ltd.; FedEx Corporate Services, Inc.; FedEx Trade Networks, Inc.; and FedEx Freight Corporation. Employees of Federal Express Virgin Islands, Inc. and pilots domiciled in Puerto Rico or Guam are not eligible to participate.

Eligible former pilots include any U.S.-based or domestic former pilot of a participating employer who terminated employment and after reaching age 55 and completed five years of employment. Participating employers in the METPAY℠ Program include: Federal Express Corporation; FedEx Corporation; FedEx TechConnect, Inc.; FedEx Trade Networks Transport & Brokerage, Inc.; FedEx Trade Networks Trade Services, Inc.; World Tariff, Ltd.; FedEx Corporate Services, Inc.; FedEx Trade Networks, Inc.; and FedEx Freight Corporation. Former employees of Federal Express Virgin Islands, Inc. and former pilots domiciled in Puerto Rico or Guam are not eligible to participate.

**Application for coverage**

For a free insurance review and no-obligation premium quote, call MetLife at 1 800 GET-MET8 (1-800-438-6388), Monday through Friday 8:00 a.m. to 11:00 p.m., and Saturday 9:00 a.m. to 5:00 p.m., Eastern Time. Hearing impaired pilots can call MetLife’s TDD number at 1-800-426-5718. If you choose, you can even enroll in the program while you are on the phone. For the most accurate comparison, please have your current policies with you when you call. You may also visit the MetLife website at www.metlife.com/mybenefits.
If you are not enrolled in \textsc{metpay}$^\text{SM}$ at the time of your retirement, you may apply for coverage at any time.

### Premiums

You are eligible for special group rates (available in most states to those who qualify) that are designed to save you money. Additionally, there are a variety of discounts available that could save you even more (available in most states to those who qualify) including:

#### Auto
- Anti-theft device
- Passive restraint (e.g., air bags)
- Superior driver

#### Homeowners
- Home security system
- New home

There are several options for the payment of premiums, including payroll deduction and \textsc{expressit}$^\text{SM}$ monthly checking account deduction. With these methods, the premium is spread over the policy term. Payments are deducted directly from your paycheck or personal checking account. There are no interest charges or service fees. Home billing is also an option, and mortgage-lender billing is available for homeowners insurance. In some instances, a down payment may be required from pilots who decline to pay premiums by payroll deduction.

If you alter your policy in a way that requires a change to the amount of your payroll deduction, there is no need to contact the Pilot Benefits Department. \textsc{metpay}$^\text{SM}$ will take care of the adjustment automatically.

### Report a Claim

Claims can be reported 24 hours a day, 7 days a week by calling MetLife at \texttt{1 800 \textasciitilde GET-MET8} (1-800-438-6388).

### Continuing Coverage

When you retire, terminate employment, begin a leave of absence (disability, unpaid medical, personal or military, etc.), or if you are on suspension, you have the option to continue your coverage without interruption. Since payroll deduction is no longer an option, you may convert to \textsc{expressit}$^\text{SM}$ (monthly checking account deduction) or home billing. In some instances, a down payment may be required when the home billing option is selected. Your surviving spouse may also continue the coverage without interruption following your death. For details, please see the appropriate life events description in “What to Do When,” page W-1.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, you should log into the MetLife website at \url{www.metlife.com/mybenefits} or call MetLife at \texttt{1 800 \textasciitilde GET-MET8} (1-800-438-6388).

### Recognition of Significant Family Events

The Company may provide recognition, as appropriate, to any pilot and their immediate families in the event of a marriage, birth of a child, adoption, hospitalization, or death. Immediate family includes spouse, children, parents and guardians. In designated \textsc{comail} codes in San Francisco and at SFO, registered domestic partners (registered with any governmental body pursuant to state or local law authorizing such registration) and their dependents are included. This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. Please see your Assistant Chief Pilot for additional information.
Service and Retirement Awards Program

Service Awards
Pilots with 5, 10, 15, 20, 25, 30 and 35 years of permanent full-time service are eligible to receive a service award. Three months prior to your anniversary milestone, you will receive a service award packet that includes an order form and a full-color catalog of the service award collection. You may select a service award from the award collection offered for your years of service or from one of the previous recognition levels. You may order your award by completing the order form and returning it in the envelope provided, calling the toll-free number included in the packet or accessing the service award website at http://awards.mtmrecognition.com/fedexexpress. Your employee number is your password. The award should be ordered within 10 days of receiving the service award packet, to ensure the award is shipped to you prior to the anniversary date. If your award is not received by your anniversary date, please contact the Employee Service Award Administrator at 1-800-882-5120.

Retirement Awards
Pilots retiring at age 55 or older with 5 or more years of permanent service are eligible for a retirement award. You will automatically be sent a retirement award packet that includes an order form and full-color catalog of the retirement award collection, once your retirement date is input in PRISM. You may select an award from the award collection offered for your years of service or from one of the previous recognition levels. You may order your award by completing the order form and returning it in the envelope provided, calling the toll-free number included in the packet or accessing the service award website at http://awards.mtmrecognition.com/fedexexpress. Your employee number is your password. The award should be ordered within 30 days of receiving the retirement award packet, to ensure the award is shipped to you in a timely manner.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company. For the most current information, please contact the Employee Service Award Administrator at 1-800-882-5120.

Tuition Assistance Program
The Tuition Assistance Program, formerly known as the Tuition Refund Program, encourages you to get additional education and training to enhance your career development at FedEx.

Eligibility
Permanent full-time and permanent part-time pilots are eligible for Tuition Assistance benefits for courses beginning on or after the pilot’s most recent date of hire as a permanent full-time or permanent part-time pilot. Pilots must have continuous permanent full-time or part-time status in order to be eligible for Tuition Assistance benefits. No other classification of pilots is eligible for benefits. Assistant Chief Pilots may verify the pilot’s classification by checking the JOB screen in PRISM. The Assistant Chief Pilot can verify the pilot’s eligibility, as well as the particular school’s eligibility, by using the TRINQ screen in PRISM.

Tuition reimbursements are not provided to pilots who are in an ineligible category of employment at any time during the course.

Reimbursement Amounts
Tuition Assistance benefits have been administered on a calendar year basis (January 1 through December 31) since January 1, 2001. If you are a permanent full-time or permanent part-time pilot of FedEx Express, you may get a refund of up to $3,000. If you are receiving educational benefits from the Veterans Administration or any other external reimbursement or financial aid programs (e.g., grants, scholarships or waivers) that do not require repayment, your reimbursement will be reduced by the amount of the external benefit. Student loans that must be paid back do not affect your benefit amount.
If any portion of the financial aid you receive is actually a reimbursement of amounts contributed from your personal funds, such amounts will not reduce your Tuition Assistance reimbursement.

Appropriate documentation of your personal contributions must be provided along with the Tuition Assistance Application Form.

Reimbursement is applied toward the calendar year in which the course is completed. (For example, if a course starts November 2011 (CY2011) and ends in February 2012 (CY2012), reimbursement is applied toward the CY2012 maximum.) Calendar years run from January 1 to December 31.

Taxes on Reimbursements
Tuition Assistance benefits may be subject to taxes based on current state and federal guidelines. Currently, Tuition Assistance benefits are not subject to tax up to $3,000 per calendar year.

Scheduling Requirements
Your courses must be scheduled so that:

- They do not interfere with your normal work hours. Your regular schedule cannot be changed to allow you time off the job for courses offered during work hours.

- Your courses must not interfere with changes made in your work schedule or with scheduled overtime, even if your changed work schedule means you fail to complete the course and become ineligible for reimbursement.

- You are advised not to take more than three courses per semester or quarter. If you wish to apply for more than three courses, you should get approval from your Assistant Chief Pilot before registration.

Leave of Absence
Leaves of absence are not given for study or sabbatical, except as described in the FedEx Express (USA) Personnel Policy and Procedure Manual, Policy 7-5. Tuition reimbursements are not provided to pilots who are on personal leaves of absence at any time during the course.

If you are on long term disability (LTD), family, military or medical leave of absence, you may be eligible to receive reimbursement for classes that either begin or end while you are on leave, but not for any class that both begins and ends during the period(s) you are on leave. You are not eligible for reimbursement if you are on leave during the entire course.

Suspension
If you are on an investigative suspension with pay, you may be eligible to receive reimbursement for courses that either begin or end while you are on suspension with pay.

If you are on a disciplinary suspension without pay at any time during your course, you are not eligible for reimbursement.

Termination of Employment
If your employment ends before the approved course is completed, you are not eligible for reimbursement.

Overpayments
If you receive reimbursement funds in error, you will be ineligible for additional reimbursement benefits under the Tuition Assistance Program until the funds are repaid or repayment arrangements have been made with Payroll. You must repay the funds as required by the FedEx Express (USA) Personnel Policy and Procedure Manual, Policy 2-85 Personal Financial Responsibility. Please see the Tuition Assistance website on the FedEx Intranet (keyword: tuition).

Eligible Fees
The Tuition Assistance Program covers tuition and standard mandatory fees. Standard mandatory fees may include matriculation, registration, activity, maintenance, enrollment, library usage, laboratory, technology and other instructional fees. For fees
that do not qualify for reimbursement, see the Ineligible Courses/Programs and Expenses section.

**Eligible Courses**

Courses must be taken from colleges or universities, or from business, technical, trade or distance learning schools accredited by an organization recognized by the U.S. Department of Education. For schools not listed in the PRISM Tuition Assistance school database, you must submit proof of accreditation to the Tuition Assistance Department for review. Please see the FedEx Express Intranet site (keyword: tuition) for contact information.

Many types of courses qualify for reimbursement. Examples are:

- Courses leading to a first associate’s degree. Courses leading to a second/additional associate’s degree must be relevant to FedEx operations and continued growth.*

- Courses leading to a first bachelor’s degree. Courses leading to a second/additional undergraduate degree (either an associate’s or bachelor’s) must be relevant to FedEx operations and continued growth.*

- Courses leading to a graduate degree if the degree’s area of study is relevant to FedEx operations and continued growth.*

- Noncredit/continuing education courses which directly relate to your current job. This relationship must be documented and approved by your Assistant Chief Pilot before enrollment occurs.

- Courses taken for college credit and courses taken as part of a defined program leading to a professional license or certification that provides knowledge or skills for career development at FedEx are eligible when approved by your Assistant Chief Pilot prior to enrollment. A list of eligible professional certifications may be found on the Tuition Assistance website on the FedEx Intranet (keyword: tuition). See the “Flight Training” section of this guide for flight license and certification eligibility information.

- Review courses leading to an approved professional certification. For a list of currently approved professional certifications, see the Tuition Assistance website on the FedEx Intranet (keyword: tuition).

*For a list of currently approved second undergraduate and graduate fields of study, see the Tuition Assistance website on the FedEx Intranet (keyword: tuition). It is suggested that your Assistant Chief Pilot approve all courses before enrollment occurs.

**Eligible Aircraft Maintenance Training**

Courses must be certified by Federal Aviation Regulations (FAR), Part 147.

**Flight Training**

Pilots are not eligible for reimbursement under the flight training portion of the Tuition Assistance Program.

**Eligible Aircraft Dispatcher Training**

Training must be certified under Part 65 of the FAR.

**Ineligible Courses/Programs and Expenses**

Not all types of instruction, training or fees are covered by the Tuition Assistance Program. The following courses and expenses are not reimbursed:

- Private pilot instruction and certification

- Rotary wings, sea plane, or type-ratings on aircraft not applicable to FedEx operations

- Solo flight time

- Books, supplies and other equipment
- Renewal or reinstatement of licenses or certificates
- Audited courses
- Seminars, conferences, workshops, lectures or forums
- Review courses in preparation for educational program admissions testing (e.g., LSAT, GMAT, GRE, MAT)
- Exam fees [except for the one-time examination fee for CPS rating (Parts I-III), Airline Transport Pilot (ATP) written exam and Flight Engineer written exam]
- Transportation expenses, including parking fees
- Review or evaluation fees associated with obtaining credits for work or life experiences, as well as prior learning credit (including portfolio fees)
- Tutoring fees
- Travel, meals and lodging
- Financing or installment service charges
- Reinstatement, late registration, finance charges, course change fees, withdrawal fees, parking fees and fines, library fines, insurance fees and health/medical fees
- Fees charged to maintain an active student status during a term in which the pilot does not attend.
- Previously reimbursed courses

**How to Check for Course Approval**

If you are unsure whether a course you wish to take qualifies under this program, complete a Tuition Assistance Application Form and submit it to your Assistant Chief Pilot at least three weeks before registration. Your Assistant Chief Pilot will determine whether or not the course meets all Tuition Assistance Program guidelines to confirm its eligibility prior to your enrollment. See “Steps to Take to Check for Course Approval” in the following table.

Blanket approvals are not given for an entire degree or license program or for any program lasting more than one semester.

The Tuition Assistance Office is the final judge of course qualification under the Tuition Assistance Program. You should not commit to any course of study you want covered by the Tuition Assistance Program until your Assistant Chief Pilot determines that it meets eligibility requirements for Tuition Assistance.

Although courses may be approved, the amount of reimbursement is still subject to the annual plan maximum that applies to you. Check with your Assistant Chief Pilot to confirm the annual maximum rate before committing to a course of study. This is done by accessing the TRINQ screen in PRISM.

Some accredited colleges and universities allow their classrooms to be used for nonaccredited instruction. Approval is based on the accreditation of the institution that provides the instruction, not the institution that provides the facilities.
### Steps to Take to Check for Course Approval

<table>
<thead>
<tr>
<th>Person or Department</th>
<th>Action</th>
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</table>
| Pilot                | (1) Completes a Tuition Assistance Application Form (LOGOS Part 111150 Rev. 1/06 or later). Form is available from Assistant Chief Pilot or form can be downloaded from the FedEx Express Intranet site (keyword: tuition).  
(2) At least three weeks before class registration, asks Assistant Chief Pilot to review pilot's TRINQ screen in PRISM to verify eligibility for Tuition Assistance, including course, school and pilot eligibility. TRINQ is a view-only screen and does not create a record. |
| Assistant Chief Pilot | (3) Enters application data on TRINQ screen in PRISM to determine if pilot and school are eligible, and benefit amount available for pilot. If the school is not in the database, sends proof of the school’s accreditation by an agency recognized by the U.S. Department of Education to Tuition Assistance Department for addition.  
(4) Reviews courses to ensure they meet Tuition Assistance Program guidelines as described in Eligible Courses. Contacts Tuition Assistance Office by e-mailing tuition.assistance@fedex.com if further assistance is needed in determining eligibility.  
(5) Approves/disapproves application within 10 working days. If application is denied, provides explanation in writing to pilot. Retains copy of written denial for Tuition Assistance personnel records.  
(6) Returns application to pilot to hold until course is completed, if all eligibility requirements and guidelines are met. |

### Procedures/Conditions for Reimbursement

You must complete the course(s) successfully with a grade of “C minus” or above for undergraduate courses and graded certificate/diploma/license courses, “B minus” or above for graduate courses, and “Pass” or “Satisfactory” for noncredit courses. Professional license and certification classes require that you receive the license or certificate before applying for reimbursement. However, eligible professional license and certification programs composed of courses with predetermined begin and end dates may be approved on a course-by-course basis. You should apply for reimbursement no later than **90 days** after the course ends. You must contact your Assistant Chief Pilot within the 90-day application period to discuss any circumstances that will prohibit you from receiving the materials necessary to file for reimbursement (e.g., late grades or deferred payment receipts). If your application cannot be processed within the 90-day limit, your Assistant Chief Pilot may approve an extension not to exceed 365 days from the course end date. Any applications for reimbursement submitted more than 365 days after the course has been completed are not eligible.

For additional information about processing reimbursements, see the “Quick Job Aid” on the Tuition Assistance website on the FedEx Intranet (keyword: tuition).

### Forfeiture of Tuition Assistance Benefits

If there are any instances of fraudulent activity or falsification of any information or documents pertaining to the Tuition Assistance Program, you will no longer be eligible to participate in the program and may be subject to discipline up to and including termination.
Other Benefits and Services

January 2013

Steps to Take to Apply for Reimbursement

<table>
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<tr>
<th>Person or Department</th>
<th>Action</th>
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</table>
| Pilot                | (1) Within 90 days after completing the approved course(s), provides the following to the Assistant Chief Pilot:  
  - Completed Tuition Assistance Application Form (LOGOS Part 111150 version 1/06 or later)  
  - Final grade(s), license or certificate showing “C minus” or above for undergraduate courses and graded certificate, license, diploma courses, “B minus” or above for graduate courses, and “Pass” or “Satisfactory” for noncredit courses  
  - Proof of payment and amount charged. Examples include: official receipt, front and back of canceled check, credit card receipt, copy of promissory note, loan agreement, receipt of financial aid and student account statements. (See Reimbursement Amounts if pilot receives financial aid)  
  - Fee schedule that shows cost of tuition and mandatory fees for term in which course(s) is taken.  
    **NOTE:** Proof of payment should show that tuition and fees have been paid in full or that the terms of the promissory note, deferment agreement, or enrollment agreement are being met. Proof of payment should also include method of payment.  
  
| Assistant Chief Pilot | (2) Reviews application, grade report, proof of payment and fee schedule to make sure all requirements have been met, and signs application indicating approval.  
(3) Enters application data on the TRAPPR screen in PRISM. If needed, views “Quick Job Aid” letter on the Tuition Assistance website on the FedEx Intranet (keyword: tuition) for additional information about this step.  
(4) Verifies and approves final amount for refund payment on the TRAPPR screen.  
(5) Keeps all related documentation in the pilot’s local personnel file for at least three years.  
    **NOTE:** Reimbursement checks are distributed during the pilot’s regular payroll cycle, usually within 30 days of the TRAPPR screen entry date. Please refer to the Tuition Assistance website on the FedEx Intranet (keyword: tuition). |
| Tuition Assistance Appeals | To appeal a Tuition Assistance request or eligibility request that was denied, explain in writing within 60 business days from the date the request was denied by the Assistant Chief Pilot, giving your justification for having the reimbursement paid. Your written appeal, accompanied by the Assistant Chief Pilot’s written denial and all other related paperwork (e.g., application form, proof of payment and grade report) should be submitted to the Tuition Assistance Department. Your appeal will be reviewed by the Tuition Assistance Department, and you will receive a written response within 60 business days. The ruling by the Tuition Assistance Department is the final decision within FedEx.  
FedEx Express reserves the right to amend or terminate the Tuition Assistance Plan at any time.
Wellness Programs

**Fitness**  FedEx has three on-site Wellness Programs Fitness Centers in Memphis. FedEx also has Wellness Center locations in Colorado Springs and Dallas. The Wellness Centers may be utilized by active and retired pilots for a fee. Please call 1-901-434-9365 for details. Additional information can also be found on the intranet using keyword: wellness.

Additional information on wellness and fitness membership discounts can be found at https://worklifebalance.lifecare.com under Wellness Resources and in LifeMart Discounts under Health & Wellness, “Fitness Club.” See LifeCare for additional information on first time user registration.

This program is available to pilots on the same terms and conditions as it is available to other employees of the Company.

**Smoking Cessation**  Anthem 360 Health nurses provide members with information and resources to assist in tobacco and smoking cessation. The Health nurses will also make referrals to appropriate local and online resources, highlight any discount programs that may be available and provide educational guidance as needed.
What to Do When

Various life events affect your continuing coverage under the benefit plans described in this book.

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<th>The information you need...</th>
<th>begins on page...</th>
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<td>Continuing Coverage After Transfer to a Non-Crew Position</td>
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<td>Continuing Coverage After Retirement</td>
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<td>Continuing Coverage for Your Survivors If You Die While an Active FedEx Express Pilot</td>
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<td>Continuing Coverage for Your Survivors If You Die After You Retire from FedEx Express</td>
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<td>Coverage During a Paid Leave of Absence (Disability or Workers’ Compensation)</td>
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<td>Coverage During an Unpaid Leave of Absence (Personal, Medical, etc.)</td>
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<td>Coverage During a Military Leave of Absence (MLOA)</td>
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<tr>
<td>Coverage During an Unpaid Suspension</td>
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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 you terminate employment and do not meet the age and service requirements for Retiree Health Coverage, your coverage under most plans ends. These provisions are described under each plan, but some key points are also mentioned here. If you meet the age and service requirements for Retiree Health Coverage, see “Continuing Coverage After Retirement,” page W-6.

<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit, includes mental health/substance abuse and prescription drugs</td>
<td>Coverage ends and payroll deductions stop. If you meet the age and service requirements for Retiree Health Coverage, you can elect Retiree Health Coverage under the Federal Express Corporation Retiree Group Health Plan for Pilots for yourself and your eligible spouse and dependent children who are Pre-65 or elect Medical coverage under the Federal Express Corporation Group Health Plan for Pilots through COBRA. See “Retiree Health Coverage” in the “Health” section starting on page H-65 for more Retiree Health information. See “COBRA—Continuation of Coverage” in the “Health Care—General information” section starting on page H-17 for more for more Retiree Health information. See “COBRA—Continuation of Coverage” in the “Health Care—General information” section starting on page H-17 for more COBRA information. If you meet the age and service requirements for Retiree Health Coverage and you or your spouse are age 65 or older, you or your spouse can participate in the ALPA sponsored FedEx Pilots Post-Medicare Retiree Health Plan. If you do not meet the age and service requirements to elect Retiree Health Coverage under the Federal Express Corporation Retiree Group Health Plan for Pilots for yourself and your eligible spouse and dependent children who are Pre-65, you can elect Medical coverage under the Federal Express Corporation Group Health Plan for Pilots through COBRA. See “COBRA—Continuation of Coverage” in the “Health Care—General Information” section starting on page H-17 for more COBRA information.</td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Vision Benefit and Advantage Eye Care Program</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Long Term Disability (LTD), includes Supplementary Disability Benefit</td>
<td>Coverage ends.</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Coverage ends. Conversion available. 31-day election grace period. See “Rules Applicable to All Insurance Plans” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>Coverage ends. Portability and conversion options available. 31-day election grace period. See “Rules Applicable to All Insurance Plans” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Plan or Program</td>
<td>Coverage</td>
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</tr>
<tr>
<td>Basic Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage ends. Conversion to an individual policy available. 31-day election grace period. See “Rules Applicable to All Insurance Plans” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Optional Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage ends. Conversion to an individual policy available. 31-day election grace period. See “Rules Applicable to All Insurance Plans” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Coverage ends.</td>
</tr>
<tr>
<td>Pension Plan</td>
<td>If vested, may receive monthly benefits as early as age 55 (reduction for early benefit commencement). See “Making Application for Benefits and When Payments Commence” starting on page R-22 for more details.</td>
</tr>
<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)</td>
<td>Distributions available or generally can be deferred until age 70. See “When Payment Can Be Made” starting on page R-93 for more details.</td>
</tr>
<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)</td>
<td>Distributions available or generally can be deferred until April 1st of the year following the year that you turn age 70½. See “When Payment Can Be Made” starting on page R-93 for more details.</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account (DCRA)</td>
<td>Payroll deductions stop. Reimbursement for eligible expenses incurred prior to termination must be filed by May 31 of the following year. See “Dependent Care Reimbursement Account DCRA” information in the “Other Benefit Plans, Programs and Services” section starting on page O-3 for more details.</td>
</tr>
<tr>
<td>Health Care Savings Account (HCSA)</td>
<td>Payroll deductions stop. Reimbursement for eligible expenses incurred prior to termination must be filed by May 31 of the following year or you can elect to continue participation through COBRA. See “Health Care Savings Account (HCSA)” information in the “Other Benefit Plans, Programs and Services” section starting on page O-10 for more details.</td>
</tr>
<tr>
<td>Health Reimbursement Arrangement (HRA) for Retired Pilots</td>
<td>If you met the eligible requirements, you will be eligible to receive reimbursement of eligible health care expenses on the later of your termination date or age 59. See “HRA” information in the “Other Benefit Plans, Programs and Services” section starting on page O-21 for more details.</td>
</tr>
<tr>
<td>Credit Association</td>
<td>Contact Credit Association for more information. See “Who to Call” section for the contact information.</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan (ESPP)</td>
<td>Payroll deductions stop. Retain ownership of shares already purchased. See “ESPP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>Global Travel</td>
<td>Privileges end.</td>
</tr>
<tr>
<td>Employee Reduced-rate Shipping</td>
<td>Privileges end.</td>
</tr>
<tr>
<td>METPAYSM Program (Voluntary Personal Property Insurance)</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “METPAY” information in the “Other Benefit Plans, Programs and Services” section starting on page O-47 for more details.</td>
</tr>
</tbody>
</table>
If you contemplate returning to work at FedEx Express or another FedEx Company you should take the following steps:

1. You should promptly contact Vanguard 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, s/he may not be able to receive distributions/benefits until a subsequent termination of employment.

2. Pilots eligible for Retiree Health Coverage must elect coverage within the appropriate time-frame. Retiree Health Coverage can be deferred if the pilot is eligible for coverage as an active employee under a FedEx health plan, but Retiree Health Coverage must be elected timely.

<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Coverage</th>
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<tbody>
<tr>
<td>Group Long-Term Care Insurance (LTCI)</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “LTCI” information in the “Other Benefit Plans, Programs and Services” section starting on page O-44 for more details.</td>
</tr>
<tr>
<td>Group Legal Services Plan (GLSP)</td>
<td>Payroll deductions stop. Coverage can be continued for 30 months provided you or your surviving spouse pay the full annual premium in advance. After the 30-month period, GLSP coverage ends. See “GLSP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-34 for more details.</td>
</tr>
<tr>
<td>Tuition Assistance Program</td>
<td>Privileges end (unless course completed prior to termination). See “Tuition Assistance Program” information in the “Other Benefit Plans, Programs and Services” section starting on page O-49 for more details.</td>
</tr>
</tbody>
</table>
Continuing Coverage After Transfer to a Non-Pilot Position

If you transfer to a non-pilot position within FedEx Express on or after February 28, 2011, 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 for non-pilots for a full discussion of benefits available to non-pilot personnel. If you transfer to a non-pilot position within FedEx Express on or after February 28, 2011, and your participation in FedEx Express benefit plans is provided under the terms of the Agreement, your participation will continue as described in this book.
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 do not meet the age and service requirements for a particular retiree benefit, see “Continuing Coverage After Employment Termination,” page W-2. Here are some key points about retiree benefits:

<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit, includes mental health/substance abuse and prescription drugs</td>
<td>Payroll deductions stop. If you meet age and service requirements for Retiree Health Coverage, you can elect Retiree Health Coverage under the Federal Express Corporation Retiree Group Health Plan for Pilots for yourself and your eligible spouse and dependent children who are Pre-65 or elect Medical coverage under the Federal Express Corporation Group Health Plan for Pilots through COBRA. See “Retiree Health Coverage” in the “Health” section starting on page H-65 and see “COBRA Continuation of Coverage” in the “Health Care General Information” starting on page H-17 for more coverage information. If you meet the age and service requirements for Retiree Health Coverage and you or your spouse are age 65 or older, you or your spouse can participate in the ALPA sponsored FedEx Pilots Post-Medicare Retiree Health Plan. If you do not meet age and service requirements for Retiree Health Coverage under the Federal Express Corporation Retiree Group Health Plan for Pilots for yourself and your eligible spouse and dependent children who are Pre-65, you can elect Medical coverage under the Federal Express Corporation Group Health Plan for Pilots through COBRA. See “COBRA Continuation of Coverage” in the “Health Care General Information” starting on page H-17 for more COBRA information.</td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Vision Benefit and Advantage Eye Care Program</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Long Term Disability (LTD), includes Supplementary Disability Benefit</td>
<td>Coverage ends.</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Coverage ends. Conversion available. 31-day election grace period. See “Rules Applicable to All Insurance Plans” starting on page L-2.</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>Coverage ends. Retiree Optional Life and conversion are available. 31-day election grace period. See “Rules Applicable to All Insurance Plans” starting on page L-2.</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage ends. Conversion available. 31-day election grace period. See “Rules Applicable to All Insurance Plans” starting on page L-2.</td>
</tr>
<tr>
<td>Optional Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage ends. Conversion available. 31-day election grace period. See “Rules Applicable to All Insurance Plans” starting on page L-2.</td>
</tr>
<tr>
<td>Plan or Program</td>
<td>Coverage</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Coverage ends.</td>
</tr>
<tr>
<td>Pension Plan</td>
<td>If vested, may receive monthly benefits as early as age 55 (reduction for early benefit commencement). See “Making Application for Benefits and When Payments Commence” starting on page R-22 for more details.</td>
</tr>
<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)</td>
<td>Distributions available or generally can be deferred until age 70. See “When Payment Can Be Made” starting on page R-93 for more details.</td>
</tr>
<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)</td>
<td>Distributions available or generally can be deferred until April 1st of the year following the year that you turn age 70½. See “When Payment Can Be Made” starting on page R-93 for more details.</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account (DCRA)</td>
<td>Payroll deductions stop. Reimbursement for eligible expenses incurred prior to retirement must be filed by May 31 of the following year. See “Dependent Care Reimbursement Account (DCRA)” information in the “Other Benefit Plans, Programs and Services” section starting on O-3 for more details.</td>
</tr>
<tr>
<td>Health Care Savings Account (HCSA) for Pilots</td>
<td>Payroll deductions stop. Reimbursement for eligible expenses incurred prior to your retirement must be filed by May 31 of the following year or you can elect to continue participation for the remainder of the year through COBRA. See “Health Care Savings Account (HCSA)” information in the “Other Benefit Plans, Programs and Services” section starting on page O-10 for more details.</td>
</tr>
<tr>
<td>Health Reimbursement Arrangement (HRA) for Retired Pilots</td>
<td>If you met the eligible requirements, you will be eligible to receive reimbursement of eligible health care expenses on the later of your termination date or age 59. See “HRA” information in the “Other Benefit Plans, Programs and Services” section starting on page O-21 for more details.</td>
</tr>
<tr>
<td>Credit Association</td>
<td>Membership continues. Contact Credit Association for more information. See “Who to Call” section for the contact information.</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan (ESPP)</td>
<td>Payroll deductions stop. Retain ownership of shares already purchased. See “ESPP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>Global Travel</td>
<td>Privileges limited.</td>
</tr>
<tr>
<td>Employee Reduced-rate Shipping</td>
<td>Privileges continue.</td>
</tr>
<tr>
<td>METPAY℠ Program (Voluntary Personal Property Insurance)</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “METPAY” information in the “Other Benefit Plans, Programs and Services” section starting on page O-47 for more details.</td>
</tr>
<tr>
<td>Group Long-Term Care Insurance (LTCI) [Effective 1/1/2013, this Plan is closed to new enrollees]</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “LTCI” information in the “Other Benefit Plans, Programs and Services” section starting on page O-44 for more details.</td>
</tr>
</tbody>
</table>
Continuing Coverage After Retirement

Pilot Benefit Book

W-8

January 2013

**IMPORTANT INFORMATION TO UNDERSTAND PRIOR TO RETIREMENT**

- **Eligibility**
  One month prior to your retirement, call Pilot Benefits Administration at 1-866-795-6353 or in the Memphis area at 1-901-434-6353 to discuss Retiree Health Coverage eligibility/information with a representative.

- **Prescriptions**
  Prior to your retirement date, you should ensure routine prescription(s) are filled for you and your covered dependents to accommodate at least 2 to 3 weeks after retirement. This will provide you adequate time to receive your Retiree Health Coverage packet, make your election and remit your premium payment.

- **Assigned a Medical, Dental and/or Vision Plan Option**
  Within 3 to 5 days after your management enters your retirement date in PRISM, eligible retired pilots and/or eligible dependents are assigned a Medical, Dental and/or Vision plan option and a coverage tier based on your current coverage tier. The assigned Medical, Dental and/or Vision plan option and coverage tier will be in effect the day after your retirement date.

- **Retiree Health Coverage Packet**
  Your Retiree Health Coverage packet will be sent via US Mail delivery to the PRISM home address. This packet will contain a Personalized Letter advising you of the Medical, Dental and/or Vision plan option and coverage tier that you have been assigned and any Medical, Dental and/or Vision plan options and costs available in your home ZIP code location.

- **Deadline for Enrollment**
  If you fail to make an election before the deadline as indicated in your Personalized Letter, Retiree Health Coverage will be terminated retroactive to the day after your retirement.

- **Change of Address**
  Call Pilot Benefits Administration at 1-866-795-6353 or in the Memphis area at 1-901-434-6353 if you have a change of your address within the first 31 days following your date of retirement to ensure you are assigned to the correct Medical, Dental and/or Vision plan option. Based on your new ZIP code location, you may have new health plan options to choose from.

- **Medicare Age**
  If you and/or your spouse are Medicare Age (65) on your date of retirement, the individual who is 65 or older will not be eligible for Retiree Health Coverage but may participate in the ALPA sponsored FedEx Pilots Post-Medicare Retiree Health Plan, if you meet the eligibility requirements for that plan. Refer to the Retiree Health Coverage information in the Health section starting on page H-65 for more details.

<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Legal Services Plan (GLSP)</td>
<td>Payroll deductions stop. May continue coverage by lump sum payment of all remaining premiums through end of calendar year. Thereafter, must pay entire annual rate (12 months of premiums) in advance. See “GLSP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-34 for more details.</td>
</tr>
<tr>
<td>Tuition Assistance Program</td>
<td>Coverage ends at retirement (unless course completed prior to retirement). See “Tuition Assistance Program” information in the “Other Benefit Plans, Programs and Services” section starting on page O-49 for more details.</td>
</tr>
</tbody>
</table>
• **Defer Retiree Health Coverage**
  If you elect to defer your Retiree Health Coverage as defined in your Retiree Health packet, you must still notify Pilot Benefits Administration by your deadline that you wish to defer your Retiree Health Coverage.

• **Vacation**
  If you go on vacation immediately after your retirement, you should make arrangements to have your Retiree Health packet forwarded to you, so you can make your election and remit your premiums by your enrollment deadline.

• **COBRA**
  You will receive a COBRA packet, separate from your Retiree Health Coverage packet, 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 under the Federal Express Corporation Retiree Group Health Plan for Pilots, you can defer your Retiree Health Coverage and elect COBRA coverage for up to 18 months by paying the full cost, plus 2% or you can choose to elect Retiree Health Coverage. If you are going to elect to participate in Retiree Health, you do not need to take any action on COBRA. See “Retiree Health Coverage” in the “Health” section starting on page H-65 and see “COBRA Continuation of Coverage” in the “Health Care General Information” starting on page H-17 for more details on continuing coverage after your retirement.

• **Retiree Health Coverage Cancellation**
  If you elect Retiree Health Coverage, you can cancel it at any time. If you do cancel your Retiree Health Coverage, you will not have the opportunity to enroll in FedEx Retiree Health Coverage again and will not be eligible to participate in the ALPA sponsored FedEx Pilots Post-Medicare Retiree Health Plan.

**If you contemplate returning to work at FedEx Express or another FedEx Company you should take the following steps:**

1. You should promptly contact Vanguard 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, s/he may not be able to receive distributions/benefits until a subsequent termination of employment. See the “Retirement” section for further details.

2. Pilots eligible for Retiree Health Coverage must elect coverage within the appropriate time-frame. Retiree Health Coverage can be deferred if the pilot is eligible for coverage as an active employee under a FedEx health plan, but Retiree Health Coverage must be elected timely.
Continuing Coverage for Your Survivors

If You Die While an Active Pilot

If you die while you're still an active FedEx Express pilot, your eligible survivors may be entitled to continue some of your benefits. Some key provisions are mentioned below.

<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Coverage</th>
</tr>
</thead>
</table>
| Medical Benefit, includes mental health/substance abuse and prescription drugs | Dependent coverage can be continued under either:  
- Retiree Health Coverage. If eligibility requirements are met, see “Retiree Health Continuation of Coverage” in the “Health” section starting on page H-65 and “COBRA Continuation of Coverage” in the “Health” section starting on page H-17 for more details or  
- The Federal Express Corporation Group Health Plan for Pilots. If Retiree Health eligibility is not met, see “Continuing Health Coverage for your Survivors—If you die while an Active Pilot” in the “Health” section starting on page H-63 and “COBRA Continuation of Coverage” in the “Health” section” starting on page H-17 for more details. |
<p>| Dental Benefit | Same as medical benefit. |
| Vision Benefit and Advantage Eye Care Program | Same as medical benefit. |
| Optional Life Insurance | Coverage ends. 31-day election grace period for dependents to elect portability or conversion coverage. See “Rules Applicable to All Insurance Plans” starting on page L-2. |
| Optional Accidental Death and Dismemberment (AD&amp;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. See Rules Applicable to All Insurance Plans starting on page L-2. |
| 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. See “Survivor Benefits” starting on page R-24 for more details. |
| FTL Fixed Pension Plan |
| FTL Variable Annuity Pension Plan for Pilots | Surviving spouse of a former FTL Pilot may be eligible for a death benefit from the Plans. For more information, contact the FedEx Retirement Service Center at 1-866-303-0556. |
| Pilots’ Retirement Savings Plan (PRSP) | Distributions available to beneficiary(ies). See “Death” under “When Payment Can Be Made” starting on page R-95 for more details. |
| Pilots’ Money Purchase Pension Plan (PMPPP) | Distributions available to beneficiary(ies). See “Pre-Retirement Death Benefit” under “Death” starting on page R-95 for more details. |
| Dependent Care Reimbursement Account (DCRA) | Reimbursement for eligible expenses incurred prior to pilot's death must be filed by May 31 of the year following pilot's death. See “Dependent Care Reimbursement Account (DCRA)” information in the “Other Benefit Plans, Programs and Services” section starting on page O-3 for more details. |
| Health Care Savings Account (HCSA) | Reimbursement for eligible expenses incurred prior to pilot's death must be filed by May 31 of the following year or you can elect to continue participation for the remainder of the year through COBRA. See “Health Care Savings Account (HCSA)” information in the “Other Benefit Plans, Programs and Services” section starting on page O-10 for more details. |</p>
<table>
<thead>
<tr>
<th>Plan or Program</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Health Reimbursement Arrangement (HRA) for Retired Pilots</td>
<td>The ownership of any remaining balance is changed to the designated beneficiary. The HRA is activated upon the active pilot’s death and a new welcome kit will automatically be mailed to the primary beneficiary. See “HRA” information in the “Other Benefit Plans, Programs and Services” section starting on page O-21 for more details.</td>
</tr>
<tr>
<td>Credit Association</td>
<td>Dependent membership can continue. Contact Credit Association for more information. See “Who to Call” section for the contact information.</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan (ESPP)</td>
<td>Surviving dependents should contact the FedEx Corporate Finance Department. See “ESPP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>Global Travel</td>
<td>Privileges end.</td>
</tr>
<tr>
<td>Employee Reduced-rate Shipping</td>
<td>Privileges end.</td>
</tr>
<tr>
<td>METPAY&lt;sup&gt;SM&lt;/sup&gt; Program (Voluntary Personal Property Insurance)</td>
<td>Spouse may continue coverage by contacting MetLife and making required premium payments. See “METPAY” information in the “Other Benefit Plans, Programs and Services” section starting on page O-47 for more details.</td>
</tr>
<tr>
<td>Group Long-Term Care Insurance (LTCI)</td>
<td>Other enrolled family members may continue coverage by making premium payments directly to MetLife. See “LTCI” information in the “Other Benefit Plans, Programs and Services” section starting on page O-44 for more details.</td>
</tr>
<tr>
<td>Group Legal Services Plan (GLSP)</td>
<td>Spouse may continue coverage for 12 months by lump sum payment of entire annual premium in advance. See “GLSP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-34 for more details.</td>
</tr>
</tbody>
</table>
### 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. Some key provisions are mentioned below.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit (includes mental health/substance abuse and prescription drugs)</td>
<td>If the retiree was covered under the Federal Express Corporation Retiree Group Health Plan for Pilots, dependent coverage continues under Retiree Health Coverage. See “Continuing Retiree Health for Your Survivors if you die after you Retire” starting on page H-117 in the “Health” section for more details.</td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Vision Benefit and Advantage Eye Care Program</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Retiree Optional Life Insurance</td>
<td>Covered dependents eligible for conversion benefits. See Retiree Optional Life Insurance in the Life Insurance section starting on page L-22.</td>
</tr>
<tr>
<td>Pension Plan</td>
<td>If selected at retirement, beneficiary(ies) receive benefits in accordance with the specific provisions of the form of payment. See page R-4 for more details.</td>
</tr>
<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)</td>
<td>Distribution available to beneficiary in any one of the forms of payment described on page R-76. If benefits commenced or were elected prior to the death of the pilot, then the benefit will be based on the payment option elected. See “Death” under “When Payments Can Be Made” starting on page R-95 for more details.</td>
</tr>
<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)</td>
<td>Distribution available to beneficiary in any one of the forms of payment described on page R-76. If benefits commenced or were elected prior to the death of the pilot, then the benefit will be based on the payment option you elected. See “Post Retirement Death Benefit” under “Death” starting on page R-95 for more details.</td>
</tr>
<tr>
<td>Health Reimbursement Arrangement (HRA) for Retired Pilots</td>
<td>The ownership of any remaining balance is changed to the designated beneficiary. See “HRA” information in the “Other Benefit Plans, Programs and Services” section starting on page O-21 for more details.</td>
</tr>
<tr>
<td>Credit Association</td>
<td>Dependent membership can continue. Contact Credit Association for more information. See “Who to Call” section for the contact information.</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan (ESPP)</td>
<td>Surviving dependents should contact the FedEx Corporate Finance Department. See “ESPP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>Global Travel</td>
<td>Privileges end.</td>
</tr>
<tr>
<td>Employee Reduced-rate Shipping</td>
<td>Privileges end.</td>
</tr>
<tr>
<td>METPAY℠ Program (Voluntary Personal Property Insurance)</td>
<td>Spouse may continue coverage by contacting MetLife and making required premium payments. See “METPAY” information in the “Other Benefit Plans, Programs and Services” section starting on page O-47 for more details.</td>
</tr>
<tr>
<td>Group Long-Term Care Insurance (LTCI)</td>
<td>Other enrolled family members may continue coverage by making premium payments directly to MetLife. See “LTCI” information in the “Other Benefit Plans, Programs and Services” section starting on page O-44 for more details.</td>
</tr>
<tr>
<td>Group Legal Services Plan (GLSP)</td>
<td>Spouse may continue coverage for 12 months by lump sum payment of entire annual premium in advance. See “GLSP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-34 for more details.</td>
</tr>
</tbody>
</table>
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 “Disability,” page D-3. The effect of a paid leave of absence on your benefit plan participation is described here.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit, includes mental health/</td>
<td>If you are enrolled in a Medical, Dental and/or Vision plan option, coverage will continue in your current Medical, Dental and/or Vision plan option and coverage tier as long as the required monthly Medical, Dental and/or Vision contributions are paid. If you are on an approved leave of absence (LOA), 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, deductions will be taken.) If you remain on leave for more than 90 days, Pilot Benefits Administration will send a billing statement to your PRISM home address notifying you of the cost to continue your Medical, Dental and/or Vision coverage beyond the 90-day period. You may elect to opt out of Medical, Dental and/or Vision if your request is within 31 days following the date your leave begins. See “Coverage During a Leave of Absence – Medical, Nonmedical or Military” in the “Health” section starting on page H-14 for more details.</td>
</tr>
<tr>
<td>substance abuse and prescription drugs</td>
<td></td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Vision Benefit and Advantage Eye Care</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Program</td>
<td></td>
</tr>
<tr>
<td>Long Term Disability (LTD)</td>
<td>If eligible, coverage may continue, see “Disability,” starting on page D-3. for more details.</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Coverage continues. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>Coverage continues: Pilot cost accumulates for the first 90 days; thereafter, cost is payable monthly. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment</td>
<td>Coverage continues. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>(AD&amp;D)</td>
<td></td>
</tr>
<tr>
<td>Optional Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage continues: Pilot cost accumulates for the first 90 days; thereafter, cost is payable monthly. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Coverage ends, but is reinstated when you return to active employment status. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Plan</td>
<td>Coverage</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pension Plan</td>
<td>You may continue to earn service during paid leaves, see “Hours of Service” on page R-7 for more details.</td>
</tr>
<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)</td>
<td>Distributions available on total disability. Participants may be eligible for suspension of loan repayments while on leave, see “Loan Rules,” page R-74 for more details.</td>
</tr>
<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)</td>
<td>Distributions not available. See “When Payment Can Be Made” starting on page R-93 for more details.</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account (DCRA)</td>
<td>Payroll deductions stop. You may continue to send eligible claims for dependent care expenses directly to WageWorks in accordance with Plan rules. When you return to work, if you do not reenroll 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. See “DCRA” in the “Other Benefit Plans, Programs and Services” section starting on page O-3 for more details.</td>
</tr>
<tr>
<td>Health Care Savings Account (HCSA) for Pilots</td>
<td>Payroll deductions stop. You may continue to send eligible claims for health care expenses directly to WageWorks in accordance with Plan rules. Your HCSA contributions will automatically accrue for the first 90 days of your approved leave of absence. A billing statement will be sent to your PRISM home address after the first 90 days giving you an opportunity to continue HCSA participation. You must remit your HCSA contributions to Pilot Benefits Administration to continue to file eligible expenses after the first 90 day period. If your HCSA payment is not received by your deadline, this benefit will end and you cannot reenroll until the next annual enrollment period. 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 percentage basis. See “HCSA” in the “Other Benefit Plans, Programs and Services” section starting on page O-10 for more details.</td>
</tr>
<tr>
<td>Credit Association</td>
<td>Membership continues. Contact Credit Association for information on account. See “Who to Call” section for the contact information.</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan (ESPP)</td>
<td>Payroll deductions stop. Deductions begin again when you return to work. See “ESPP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>Global Travel</td>
<td>Privileges suspended. See “Global Travel” information in the “Other Benefit Plans, Programs and Services” section starting on page O-33 for more details.</td>
</tr>
<tr>
<td>Employee Reduced-rate Shipping</td>
<td>Privileges continue. See “Employee Reduced-rate Shipping” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>METPAY℠ Program (Voluntary Personal Property Insurance)</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “METPAY” information in the “Other Benefit Plans, Programs and Services” section starting on page O-47 for more details.</td>
</tr>
<tr>
<td>Group Long-Term Care Insurance (LTCI) [Effective 1/1/2013, this Plan is closed to new enrollees]</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “LTCI” information in the “Other Benefit Plans, Programs and Services” section starting on page O-44 for more details.</td>
</tr>
<tr>
<td>Plan</td>
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</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Group Legal Services Plan (GLSP)</td>
<td>Payroll deductions stop. May continue coverage by converting to home billing. See “GLSP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-34 for more details.</td>
</tr>
<tr>
<td>Tuition Assistance Program</td>
<td>Coverage may continue for eligible courses, see “Tuition Assistance Program” section, “Other Benefits and Services” starting on page O-49 for more details.</td>
</tr>
</tbody>
</table>

Important Note: If termination or death occurs while on a leave of absence, see “Continuing Coverage After Employment Termination,” page W-2 or “Continuing Coverage for Your Survivors if You Die While an Active Pilot,” page W-10.
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.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit, includes mental health/substance abuse and prescription drugs</td>
<td>If you are enrolled in a Medical, Dental and/or Vision plan option, coverage will continue in your current Medical, Dental and/or Vision plan option and coverage tier as long as the required monthly Medical, Dental and/or Vision contributions are paid. If you are on an approved leave of absence (LOA), 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, deductions will be taken.) If you remain on leave for more than 90 days, Pilot Benefits Administration will send a statement to your PRISM home address notifying you of the cost to continue your Medical, Dental and/or Vision coverage beyond the 90-day period. You may elect to opt out of Medical, Dental and/or Vision if your request is within 31 days following the date when your leave begins. See “Coverage During a Leave of Absence—Medical, Nonmedical or Military” in the “Health” section starting on page H-14 for more details.</td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Vision Benefit and Advantage Eye Care Program</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Long Term Disability (LTD), includes Supplementary Disability Benefit</td>
<td>Coverage ends but is reinstated when you return to active employment status. See “Disability,” starting on page D-3, for more details.</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Coverage continues. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>Coverage continues: Pilot cost accumulates for the first 90 days; thereafter, cost is payable monthly. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage continues. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Optional Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage continues: Pilot cost accumulates for the first 90 days; thereafter, cost is payable monthly. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Coverage ends but is reinstated when you return to active employment status. See “Rules Applicable to All Insurance Plans – For Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Pension Plan</td>
<td>Years of credited service generally do not include periods of unpaid leaves of absence. See “Hours of Service” starting on page R-7.</td>
</tr>
<tr>
<td>Plan</td>
<td>Coverage</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)</td>
<td>Participants may be eligible for suspension of loan repayments while on leave, see “Loan Rules,” page R-74. Hardship or in-service withdrawals may be available. Loans and distributions are not available.</td>
</tr>
<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)</td>
<td>Distributions not available. See “When Payment Can Be Made” starting on page R-93.</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account (DCRA)</td>
<td>Payroll deductions stop. You may continue to send eligible claims for dependent care expenses directly to WageWorks in accordance with Plan rules. When you return to work, if you do not reenroll 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. See “DCRA” in the “Other Benefit Plans, Programs and Services” section starting on page O-3 for more details.</td>
</tr>
<tr>
<td>Health Care Savings Account (HCSA) for Pilots</td>
<td>Payroll deductions stop. You may continue to send eligible claims for health care expenses directly to WageWorks in accordance with Plan rules. Your HCSA contributions will automatically accrue for the first 90 days of your approved leave of absence. A billing statement will be sent to your PRISM home address after the first 90 days giving you an opportunity to continue HCSA participation. You must remit your HCSA contributions to Pilot Benefits Administration to continue to file eligible expenses after the first 90 day period. If your HCSA payment is not received by your deadline, this benefit will end and you cannot reenroll until the next annual enrollment period. 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 percentage basis. See “HCSA” in the “Other Benefit Plans, Programs and Services” section starting on page O-10 for more details.</td>
</tr>
<tr>
<td>Credit Association</td>
<td>Membership continues. Contact Credit Association for information on account. See “Who to Call” section for the contact information.</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan (ESPP)</td>
<td>Payroll deductions stop. Deductions begin again when you return to work. See “ESPP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>Global Travel</td>
<td>Privileges suspended. See “Global Travel” information in the “Other Benefit Plans, Programs and Services” section starting on page O-33 for more details.</td>
</tr>
<tr>
<td>Employee Reduced-rate Shipping</td>
<td>Privileges continue. See “Employee Reduced-rate Shipping” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>METPAY℠ Program (Voluntary Personal Property Insurance)</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “METPAY℠” information in the “Other Benefit Plans, Programs and Services” section starting on page O-47 for more details.</td>
</tr>
<tr>
<td>Group Long-Term Care Insurance (LTCI) [Effective 1/1/2013, this Plan is closed to new enrollees]</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “LTCI” information in the “Other Benefit Plans, Programs and Services” section starting on page O-44 for more details.</td>
</tr>
<tr>
<td>Group Legal Services Plan (GLSP)</td>
<td>Payroll deductions stop. May continue coverage by converting to home billing. See “GLSP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-34 for more details.</td>
</tr>
<tr>
<td>Tuition Assistance Program</td>
<td>Coverage ends, see the “Tuition Assistance Program” section in “Other Benefits and Services” chapter, starting on page O-49 for more details.</td>
</tr>
</tbody>
</table>
**Important Note:** If termination or death occurs while on a leave of absence, see “Continuing Coverage After Employment Termination,” page W-2, or “Continuing Coverage for Your Survivors if You Die While an Active Pilot,” page W-10.
Coverage During a Military Leave of Absence

If you are on an approved military leave of absence, some of your FedEx Express benefits can be continued. The effect of a military leave of absence on your benefit plans is described here.

The effective date of active military service is the date of military leave of absence (MLOA) as shown in PRISM. The end of active military service is that date provided under USERRA.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health (includes Medical, Dental, Vision, Prescription Drug, Mental Health/Substance Abuse Benefits)</td>
<td>If you are enrolled in a Medical, Dental and/or Vision plan option and on MLOA, coverage will continue in your current Medical, Dental and/or Vision plan option and coverage tier as long as the required monthly contributions are paid. 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. <strong>NOTE:</strong> If, while on MLOA, you receive a Payroll generated check, deductions will be taken. If you remain on leave for more than 90 days, a letter will be sent to your PRISM home address explaining your benefits and 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 the following: • Your dependents’ Medical, Dental and/or Vision coverage will end. • You will be enrolled in the Base Plan and your Dental and Vision coverage, if applicable, will be canceled. You will not be able to change your Medical plan option until the next Annual Benefits Enrollment or until you have a Qualified Change in Family Status (Return from MLOA is a Qualified Change in Family Status). • During your MLOA, you will be eligible to add dependent Medical, Dental and/or Vision coverage only during the Annual Benefits Enrollment or if you have a Change in Family Status. • When you return from MLOA, 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. You may elect to opt out of Medical, Dental and/or Vision coverage if your request is within 31 days following the date your MLOA begins. MLOA 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 leave. You can access the FedEx Benefits Enrollment Web site within 31 days of beginning your MLOA to make your coverage tier elections. If a Change in Family Status occurs while you are on MLOA (for example, birth of a child, marriage, divorce, etc.), you have 31 days from the date of the event to add or drop dependent Medical, Dental and/or Vision coverage consistent with the Change in Family Status event. The cost of the new Medical, Dental and/or Vision 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 Medical, Dental and/or Vision coverage tier elections within 31 days following your return date.</td>
</tr>
</tbody>
</table>
Coverage During a Military Leave of Absence

<table>
<thead>
<tr>
<th>Health (includes Medical, Dental, Vision, Prescription Drug, Mental Health/Substance Abuse Benefits) (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If you take leave to perform service in the uniformed services, FedEx will continue to maintain your Medical, Dental and/or Vision coverage provided that you continue to pay the pilot portion of the premium during your military leave.</td>
</tr>
<tr>
<td>- Charges incurred in connection with an illness or injury resulting from service in the armed forces are covered under TRICARE and excluded under FedEx Express coverage. FedEx Express coverage applies for nonmilitary-related illnesses or injuries not covered by the military.</td>
</tr>
</tbody>
</table>

**Dependent Coverage:**

FedEx Express coverage continues as long as the required Medical, Dental and/or Vision premium is paid. This cost is the same as when you were active at work. The cost automatically accrues for the first 90 days. Thereafter, a billing statement will be sent to your PRISM home address and 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. If you do not wish to continue Medical, Dental and/or Vision dependent coverage, notify Pilot Benefits Administration at 1-866-795-6353 or 1-901-434-6353 in the Memphis area within 31 days following your MLOA. Upon your return to employment, you will have 31 days to re-elect dependent Medical, Dental and/or Vision coverage. If you do not cancel within the 31 days and your monthly premiums are not received, your dependent Medical, Dental and/or Vision coverage will end.

When you return from MLOA you will be placed in the same coverage tier you were enrolled in prior to your leave. You will have 31 days following the date you return from leave to change your coverage tier.

MLOA is considered a Qualified Change in Family Status which allows you to add or drop dependent Medical, Dental and/or Vision coverage within 31 days following the start or end of the MLOA.

A dependent spouse in active military service of any country is not an eligible dependent. If your covered spouse is on active duty, Medical, Dental and/or Vision coverage for this dependent ends. You may wish to drop this dependent's coverage during his/her active duty to avoid paying additional premiums. Notify Pilot Benefits Administration within 31 days following your spouse’s start of or return from active duty.

See “Coverage During a Leave of Absence – Medical, Nonmedical or Military” in the “Health” section starting on page H-14 for more details.

<table>
<thead>
<tr>
<th>Retiree Health Coverage (eligibility)</th>
<th>Your MLOA will be included in determining your years of continuous service for Retiree Health Coverage eligibility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Disability (LTD), includes Supplementary Disability Benefit</td>
<td>Coverage ends effective the date of MLOA as shown in PRISM. Coverage will be reinstated upon your return to active work. See “Disability,” starting on page D-3 for more details.</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Coverage continues at no cost. No exclusions. See “Rules Applicable to All Insurance Plans–For Military Leave of Absence” starting on page L-2 for more details.</td>
</tr>
<tr>
<td>Plan</td>
<td>Coverage</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>Coverage continues with no exclusions 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 billing statement will be sent to your PRISM home address and 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. If monthly premiums are not received, your and your dependents' coverage, if applicable, will end. If you wish to reenroll when you return to active work, you must enroll within 31 days after you return to active work or Proof of Insurability forms and evidence satisfactory to Prudential will be required. If you are not presently enrolled in Optional Life and wish to enroll, there will be no prejudice due to your activation status, however, the approval process, which could require a request for medical records and a physical exam, 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 dependent in active military service, notify Pilot Benefits Administration.</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment (AD&amp;D)</td>
<td>You continue to participate in the plan at no cost. Death or injury while on active service in the military is not covered. However, in the event of death or injury during the first 60 days of active service in the National Guard or a Reserve Unit, your loss 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. See “Rules Applicable to All Insurance Plans – For Military Leave of Absence” starting on page L-2 for more details.</td>
</tr>
</tbody>
</table>
| Optional Accidental Death and Dismemberment (AD&D) | Coverage continues as long as the required premium is paid. The same policy provisions stated above in Basic AD&D also apply to Optional AD&D for the Pilot. **Dependent coverage** continues as long as the required Pilot & Dependent premium is paid. This cost is the same as when you were active at work. The cost automatically accrues for the first 90 days. Thereafter, a billing statement will be sent to your PRISM home address and 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. If monthly premiums are not received, your and your dependents’ coverage will end. If you wish 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 wish to enroll, coverage will begin on the first day of the month following your request as long as you are not on a leave of absence on the effective date. The following exclusions apply to continued dependent coverage:  
  • A dependent spouse or child on active military service of any country is not an eligible dependent. If covering a dependent on active military service, notify Pilot Benefits Administration.  
  • Declared or undeclared war or an act of either within the geographic limits, territorial waters or the airspace above the United States. See “Rules Applicable to All Insurance Plans – For Military Leave of Absence” starting on page L-2 for more details. |
<p>| Business Travel Accident                   | Losses caused by or resulting from injuries sustained while serving in the armed forces are excluded. See “Rules Applicable to All Insurance Plans – For Military Leave of Absence” starting on page L-2 for more details. |</p>
<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
</table>
| 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 the Uniformed Services Employment and Reemployment Rights Act (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 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.  
See “Crediting Hours During Active Military Service” starting on page R-9 for more details. |
| Pilots’ Retirement Savings Plan (PRSP)    | If you return to employment and have satisfied the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA) within the period specified after you are released from active duty, you may make-up any missed Pre-tax/401(k), After-tax, and if eligible, Catch-up contributions. Make-up contributions are calculated using the average of your 12 months eligible earnings (or all if less than 12 months) immediately prior to the MLOA. Any missed Employer Matching contributions on your Pre-tax/401(k) contributions will be credited monthly as you make up contributions. 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 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.  
See “Benefits upon Return from a Military Leave of Absence (MLOA),” starting on page R-58, and “Loan Default Rules” starting on Page R-75 for more details. |
If you return to employment and have satisfied the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA) within the period specified after you are released from active duty, PMPPP contributions will reflect the period of your military service. In the event of death during your MLOA, any contributions missed during your MLOA up to the date of your death will be credited to your account.

If applicable, any contributions missed during your MLOA will be made by using the average of your 12 months eligible earnings (or all if less than 12 months) immediately prior to your MLOA.

MLOA make-up contributions 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 PRISM.

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 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.

See “Benefits upon Return from a Military Leave of Absence (MLOA),” starting on page R-58 for more details.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pilots’ Money Purchase Pension Plan (PMPPP)</strong></td>
<td>If you return to employment and have satisfied the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA) within the period specified after you are released from active duty, PMPPP contributions will reflect the period of your military service. In the event of death during your MLOA, any contributions missed during your MLOA up to the date of your death will be credited to your account. If applicable, any contributions missed during your MLOA will be made by using the average of your 12 months eligible earnings (or all if less than 12 months) immediately prior to your MLOA. MLOA make-up contributions 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 PRISM. 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 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. See “Benefits upon Return from a Military Leave of Absence (MLOA),” starting on page R-58 for more details.</td>
</tr>
<tr>
<td><strong>Dependent Care Reimbursement Account (DCRA)</strong></td>
<td>Payroll deductions stop. You may continue to send eligible claims for dependent care expenses directly to WageWorks in accordance with Plan rules. When you return to work, please call Pilot Benefits Administration (PBA) to start your DCRA payroll deductions again. See “DCRA” in the “Other Benefit Plans, Programs and Services” section starting on page O-3 for more details.</td>
</tr>
<tr>
<td><strong>Health Care Savings Account (HCSA) for Pilots</strong></td>
<td>Payroll deductions stop. You may continue to send eligible claims for health care expenses directly to WageWorks in accordance with Plan rules. Your HCSA contributions will automatically accrue for the first 90 days of your military leave. A billing statement will be sent to your PRISM home address after the first 90 days giving you an opportunity to continue HCSA participation. You must remit your HCSA contributions to Pilot Benefits Administration to continue to file eligible expenses after the first 90 day period. If your HCSA contributions are not received by the deadline given in your billing statement, your participation will end and you cannot reenroll until the next annual enrollment period. 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 percentage basis. See “HCSA” in the “Other Benefit Plans, Programs and Services” section starting on page O-10 for more details.</td>
</tr>
<tr>
<td><strong>Credit Association</strong></td>
<td>Contact Credit Association for information on account. See “Who to Call” section for the contact information.</td>
</tr>
</tbody>
</table>
NOTE: Please make certain that you or your family notify FedEx Express Pilot Benefits Administration at 1-866-795-6353, or 1-901-434-6353 in the Memphis area of any address change during your 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 5 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 8 hours for transportation from the place of military service to the employee’s residence);
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 a Military Leave of Absence**

January 2013

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Stock Purchase Plan</td>
<td>Payroll deductions stop. Deductions begin again when you return to work. See “ESPP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>Global Travel</td>
<td>Privileges suspended. See “Global Travel” information in the “Other Benefit Plans, Programs and Services” section starting on page O-33 for more details.</td>
</tr>
<tr>
<td>Employee Reduced-rate Shipping</td>
<td>Privileges continue. See “Employee Reduced-rate Shipping” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>METPAY℠ Program (Voluntary Personal Property Insurance)</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “METPAY” information in the “Other Benefit Plans, Programs and Services” section starting on page O-47 for more details.</td>
</tr>
<tr>
<td>Group Long-Term Care Insurance (LTCI) [Effective 1/1/2013, this Plan is closed to new enrollees]</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “LTCI” information in the “Other Benefit Plans, Programs and Services” section starting on page O-44 for more details.</td>
</tr>
<tr>
<td>Group Legal Services Plan (GLSP)</td>
<td>Payroll deductions stop. May continue coverage by converting to home billing. See “GLSP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-34 for more details.</td>
</tr>
<tr>
<td>Tuition Assistance Program</td>
<td>Coverage ends, see the “Tuition Assistance Program” section in “Other Benefits and Services,” starting on page O-49 for more details. 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.</td>
</tr>
</tbody>
</table>
# 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.

## Plan Coverage

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit, includes mental health/substance abuse and prescription drugs</td>
<td>If you are enrolled in a Medical, Dental and/or Vision plan option, coverage will continue in your current Medical, Dental and/or Vision plan option and coverage tier as long as you pay the full cost monthly from the first day of suspension. A billing statement will be sent to your PRISM home address providing your cost to continue Medical, Dental and/or Vision coverage (Company cost plus pilot cost). If your Medical, Dental and/or Vision payments are not received by Pilot Benefits Administration by the deadline given in your billing statement you and your covered dependent(s) Medical, Dental and/or Vision coverage will end. See “Your Coverage During an Unpaid Suspension” in the “Health” section starting on page H-15 for more details.</td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Vision Benefit and Advantage Eye Care Program</td>
<td>Same as medical benefit.</td>
</tr>
<tr>
<td>Long Term Disability (LTD), includes Supplementary Disability Benefit</td>
<td>Coverage ends but is reinstated when you return to active employment status. See “Disability,” starting on page D-3 for more details.</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Coverage continues if you pay the full cost monthly from the first day of suspension. See “Rules Applicable to All Insurance Plans – For Suspension” starting on page L-6 for more details.</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>Coverage continues if you pay the full cost monthly from the first day of suspension. See “Rules Applicable to All Insurance Plans – For Suspension” starting on page L-6 for more details.</td>
</tr>
<tr>
<td>Basic Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage continues if you pay the full cost monthly from the first day of suspension. See “Rules Applicable to All Insurance Plans – For Suspension” starting on page L-6 for more details.</td>
</tr>
<tr>
<td>Optional Accidental Death and Dismemberment (AD&amp;D)</td>
<td>Coverage continues if you pay the full cost monthly from the first day of suspension. See “Rules Applicable to All Insurance Plans – For Suspension” starting on page L-6 for more details.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Coverage ends, but is reinstated when you return to active employment status. See “Rules Applicable to All Insurance Plans – For Suspension” starting on page L-6 for more details.</td>
</tr>
<tr>
<td>Pension Plan</td>
<td>Years of credited service generally do not include periods of unpaid suspension. See “Hours of Service” starting on page R-7 for more details.</td>
</tr>
<tr>
<td>Pilots’ Retirement Savings Plan (PRSP)</td>
<td>You do not accrue hours of service during your unpaid suspension. Distributions from the Pilots’ Retirement Savings Plan are not available until you terminate, retire or meet the disability eligibility as defined under the provisions of the Pilots’ Retirement Savings Plan. 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. See “Hours of Service,” starting on page R-48 for more details.</td>
</tr>
<tr>
<td>Pilots’ Money Purchase Pension Plan (PMPPP)</td>
<td>You do not accrue hours of credited service during your unpaid suspension. Distributions are not available from the PMPPP until you retire or terminate. See “Hours of Service,” starting on page R-80, and “When Payment Can Be Made” starting on page R-93 for more details.</td>
</tr>
<tr>
<td>Plan</td>
<td>Coverage</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account (DCRA)</td>
<td>Payroll deductions stop. Reimbursement for eligible expenses incurred prior to suspension must be filed by May 31 of the following year. See “DCRA” in the “Other Benefit Plans, Programs and Services” section starting on page O-3 for more details.</td>
</tr>
<tr>
<td>Health Care Savings Account (HCSA) for Pilots</td>
<td>Payroll deductions stop. Reimbursement for eligible expenses incurred prior to suspension must be filed by May 31 of the following year. A billing statement will be sent to your PRISM home address within 14 days of your suspension date giving your cost to continue HCSA participation. You must remit your HCSA contributions to Pilot Benefits Administration to continue to file eligible expenses after the date of your suspension. If your HCSA contributions are not received by the deadline given in your billing statement, your participation ends. See “HCSA” in the “Other Benefit Plans, Programs and Services” section starting on page O-10 for more details.</td>
</tr>
<tr>
<td>Credit Association</td>
<td>Membership continues. Contact Credit Association for information. See “Who to Call” section for the contact information.</td>
</tr>
<tr>
<td>Employee Stock Purchase Plan (ESPP)</td>
<td>Payroll deductions stop. Deductions begin again when you return to work. See “ESPP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>Global Travel</td>
<td>Privileges suspended. See “Global Travel” information in the “Other Benefit Plans, Programs and Services” section starting on page O-33 for more details.</td>
</tr>
<tr>
<td>Employee Reduced-rate Shipping</td>
<td>Privileges suspended. See “Employee Reduced-rate Shipping” information in the “Other Benefit Plans, Programs and Services” section starting on page O-31 for more details.</td>
</tr>
<tr>
<td>METPAY℠ Program (Voluntary Personal Property Insurance)</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “METPAY℠” information in the “Other Benefit Plans, Programs and Services” section starting on page O-47 for more details.</td>
</tr>
<tr>
<td>Group Long-Term Care Insurance (LTCI)</td>
<td>Payroll deductions stop. May continue coverage by converting to monthly checking account deductions or home billing. See “LTCI” information in the “Other Benefit Plans, Programs and Services” section starting on page O-44 for more details.</td>
</tr>
<tr>
<td>Group Legal Services Plan (GLSP)</td>
<td>Payroll deductions stop. May continue coverage by converting to home billing. See “GLSP” information in the “Other Benefit Plans, Programs and Services” section starting on page O-34 for more details.</td>
</tr>
<tr>
<td>Tuition Assistance Program</td>
<td>If you are on an investigative suspension with pay, you may be eligible to receive reimbursement for courses that either begin or end while you are on suspension with pay. If you are on a disciplinary suspension without pay at any time during your course, you are not eligible for reimbursement. See “Tuition Assistance Program” information in the “Other Benefit Plans, Programs and Services” section starting on page O-49 for more details.</td>
</tr>
</tbody>
</table>

**Important Note:** If termination or death occurs while on suspension, see “Continuing Coverage After Employment Termination,” page W-2, or “Continuing Coverage for Your Survivors if You Die While an Active Pilot,” page W-10.
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