FedEx Express

2015 PILOT HEALTH ENROLLMENT GUIDE

NEW HIRE ENROLLMENT
ANNUAL BENEFITS ENROLLMENT

This *Health Enrollment Guide* provides easy-to-understand information about your Medical, Dental and Vision coverage choices.

This enrollment guide summarizes the key features of the FedEx Express health program for collectively-bargained pilots. It is not a summary plan description or part of a summary plan description. The details of the Plan can be found in the most current Plan document and summary plan description, the most current *Pilot Benefit Book*. If there are any discrepancies between the information in this guide and the official Plan documents, provisions of the Plan documents will govern.

The Plan Administrator believes the Federal Express Corporation Group Health Plan for Pilots (the "Plan") is 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. Being a grandfathered health plan means that the Plan may not include certain requirements of the Affordable Care Act that apply to other plans. 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 through the end of the month in which the child attains age 26, with no restrictions on marital status, support, residency or full-time student status.

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.

WHAT YOU NEED TO DO TO ENROLL

FedEx offers you a comprehensive health benefits package that includes a range of options to meet your health care and financial needs. This guide provides an overview of your Medical, Dental and Vision benefit options and information to help you make the best health enrollment decisions for you and your family.

New Hire Enrollment

Review the Personalized Letter in your enrollment packet. Your Personalized Letter indicates the:

- Medical, Dental and Vision benefit options available to you in 2015 and the cost for each option.
- Medical, Dental and Vision plan option and coverage tier you will automatically be enrolled in for 2015 if you do not make an enrollment election.

Review the information in this guide. This guide highlights the coverage available through each Medical Plan option and the Dental and Vision options. It also gives you important information to consider in making your health enrollment decisions. See "Medical Plan Options — Benefits at a Glance" on page 13.

You must make your elections by the deadline indicated in your Personalized Letter. If you do not make your elections by your deadline, you will be enrolled in the coverage indicated in your Personalized Letter.

Access FedEx Benefits Online at *fedex.ehr.com* to use the self-service tools and to make your elections. From the main menu, you can select the:

- **EDUCATE** section for information on the benefit plans and programs available to you and your family.
- **EVALUATE** section for online 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.
- **ENROLL** section to make your Medical, Dental, Vision and Flexible Spending Accounts enrollment elections for 2015, review your dependents' information and validate their benefits eligibility. You can also review your Life Insurance coverage and designate your Life Insurance beneficiaries.

Annual Benefits Enrollment

Access FedEx Benefits Online at *fedex.ehr.com*. This secure internet site provides you with self-service access to your benefits information. From the main menu, you can view your personal information, current benefit elections and select the:

- **EDUCATE** section for information on the benefit plans and programs available to you and your family.
- **EVALUATE** section for online 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.
- **ENROLL** section to make your Medical, Dental, Vision and Flexible Spending Accounts enrollment elections for 2015, review your dependents' information and validate their benefits eligibility. You can also review your Life Insurance coverage and designate or update your Life Insurance beneficiaries.

If you do not enroll or make necessary changes before the close of Annual Enrollment:

- You will be automatically re-enrolled for same Medical, Dental and/or Vision coverage as in 2014, with the same dependents. Contribution changes will apply starting with your first paycheck in January.
- If you elected to opt out of Medical, Dental and/or Vision coverage in 2014, and do not make an election during Annual Benefits Enrollment, you will remain as an opt out for 2015.
- You will not have a Health Care Spending Account and/or Dependent Care Reimbursement Account; elections for these accounts do not carry over from year to year.

After the enrollment deadline of November 5, 2014, you cannot change your election until:

- The next Annual Benefits Enrollment, or
- You have a Change in Family Status event. See page 4 for more information.

Make your enrollment elections to ensure you have the coverage you want for 2015.

IF YOU HAVE QUESTIONS

	For Information…	
	In This Guide / Packet	FedEx Benefits Online
What is my current Medical, Dental and Vision coverage?	Personalized Letter (new hires only)	ENROLL section — see "Enrollment Summary"
What are my Medical Plan options for 2015?	Personalized Letter (new hires only)	EVALUATE and ENROLL sections
What should I do to elect a Medical Plan option for 2015? • Compare the features of the plans offered. • Compare the total costs of each plan option. Consider the different types of medical services needed in the coming year and expected utilization of each.	*Health Enrollment Guide* — see page 8, "Compare FedEx Express Medical Plan Options"	EVALUATE section
How can I find out what providers participate in the Anthem network?	*Health Enrollment Guide* — see page 28, "How to Get More Information"	EDUCATE section — for link to Anthem Provider Directory
What happens if I don't make enrollment elections for Medical, Dental, Vision and the Flexible Spending Accounts?	Personalized Letter (new hires only)	ENROLL section
What are the monthly costs for Medical, Dental and/or Vision coverage in 2015?	Personalized Letter (new hires only) and *Health Enrollment Guide* page 31, "Monthly Cost — Medical, Dental, Vision"	ENROLL section
What are my additional out-of-pocket costs (for example, deductibles, copayments and coinsurance) for the Medical Plan option I choose?	*Health Enrollment Guide* — see page 8, "Compare FedEx Express Medical Plan Options"	EVALUATE section
Which members of my family are currently covered under my Medical, Dental and/or Vision coverage? • Is the information for my dependents (for example, names, Social Security Numbers, birthdates, addresses) correct?		ENROLL section
Do all of my covered dependents still meet the eligibility guidelines for health benefits?	*Health Enrollment Guide* — see page 4, "Covering Your Dependents"	ENROLL section
Is Dependent Eligibility Verification required for my dependent(s)?	*Health Enrollment Guide* — see page 6, "Dependent Eligibility Verification"	ENROLL section
What if I'm married to another employee who is eligible for FedEx Express benefits?	*Health Enrollment Guide* — see page 4, "Covering Your Dependents"	ENROLL section
Do I need to add or drop dependents from my Medical, Dental and/or Vision coverage? • Does my FedEx coverage duplicate the coverage of my Spouse's plans? • Are there family members who were not covered under my plan before who should be added now (for example, my toddler has teeth now and should have dental coverage)?	*Health Enrollment Guide* — see page 4, "Covering Your Dependents" and page 8, "Compare FedEx Express Medical Plan Options"	EVALUATE section
What if I have dependent children who are away at school or live at a different address?	*Health Enrollment Guide* — see page 21, "Medical Coverage for Dependents Who Are Away From Home"	ENROLL section
Will it be cost-effective for me to enroll in the Health Care Spending Account (Flexible Spending Account)?	*Flexible Spending Accounts* Guide	EVALUATE section
I'm receiving medical treatment. What happens if I am in a new Medical Plan option for 2015?	*Health Enrollment Guide* — see page 21, "If You Have Treatment in Progress"	
What do I have to do to opt out of FedEx benefits for 2015?	*Health Enrollment Guide* — see page 10, "Opt Out of FedEx Express Medical Coverage"	ENROLL section

COVERING YOUR DEPENDENTS — MEDICAL, DENTAL AND/OR VISION

As a pilot, you may enroll your eligible dependents in your FedEx Express Medical, Dental and/or Vision coverage. If you enroll for Pilot & Child(ren), Pilot & Spouse or Pilot & Family Medical, Dental and/or Vision coverage, you must list your dependents on FedEx Benefits Online at *fedex.ehr.com* and validate their eligibility. If you have no dependents listed, you will be automatically enrolled in Pilot Only coverage, and your dependents will not be enrolled for coverage. **Dependents must be listed on FedEx Benefits Online.**

Coverage Tiers

You have the choice to enroll your eligible dependents for Medical, Dental and/or Vision coverage. You can elect a different coverage tier for each benefit option. You have the choice of four coverage tiers.

- **Pilot Only**
- **Pilot & Child(ren)**
- **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," "Employee & Spouse," and so on.

The monthly cost for each Medical, Dental and Vision coverage tier is shown in your Personalized Letter (new hires only) and in the ENROLL section of FedEx Benefits Online.

It is important that you assess your family's health coverage situation and enroll in the benefit options that best meet your needs. For example, if your Spouse is eligible for medical coverage through his or her own employer, you may now decide it is more cost-effective to change to Pilot Only Medical coverage. Likewise, your dependent children may have other medical coverage but you want to enroll them for Dental or Vision coverage. You will not be able to change your coverage tier for Medical, Dental or Vision again until the next Annual Benefits Enrollment unless you have a Change in Family Status and make your election within 31 days following the event. Therefore, it is important that you carefully consider the best coverage for you and your family.

Changing Your Coverage Tier — Adding or Dropping Dependent Coverage

There are three situations in which you may request to change your Medical, Dental or Vision coverage tier — that is, add or drop coverage for your dependent(s). To make your coverage tier change, access FedEx Benefits Online at *fedex.ehr.com*, select ENROLL from the HOME page, then select the applicable event and follow the instructions.

- **When newly eligible for FedEx Express benefits.** If you wish to enroll your dependent(s) for Medical, Dental and/or Vision coverage, you must make your elections by the deadline indicated in your Personalized Letter (new hires only). Otherwise you will be enrolled in Pilot Only Medical, Dental and Vision coverage as indicated in your Personalized Letter (new hires only).
- **When you have a Change in Family Status.** If you experience a Change in Family Status event (for example, marriage, divorce, birth of a child, Spouse gains or loses other coverage) 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 Change in Family Status or Employment event from the ENROLL menu on FedEx Benefits Online. You are only permitted to make benefit coverage changes consistent with your event. For example, if you get married and select the Marriage event within 31 days following your marriage, you may add your Spouse, eligible children and/or stepchildren to your benefits.

  If your event occurred more than 31 days ago, you will not be allowed to change your coverage tier until the next Annual Benefits Enrollment or until you have another Change in Family Status or Employment event. Your current payroll deductions will not change. For example, if you access FedEx Benefits Online 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 or Vision coverage. Likewise, if you select the Divorce event more than 31 days following your divorce date and have Pilot & Spouse coverage, your Spouse's coverage will end. However, your coverage tier and monthly cost will not change.
- **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 Your Spouse or Child Is Also an Employee Eligible for FedEx Express Benefits

If both you and your Spouse, or you and your child, are employees at a FedEx company participating in FedEx Express benefits, review the following to help you make your enrollment elections:

- **If you and your (pilot or non-pilot) Spouse have no dependent children,** you must each make your own Medical, Dental and Vision elections. You cannot elect to cover your Spouse under your pilot plan.
- **If you and your pilot Spouse have children you wish to cover,** you must each make your own Medical, Dental and Vision elections. You cannot elect to cover each other, but one of you must elect Pilot & Child(ren) coverage for Medical, Dental and/or Vision. If any of your dependent children are eligible for FedEx Express benefits as a pilot or as a non-pilot permanent full-time or permanent part-time employee, they cannot be covered as both an employee and as a dependent under your Medical, Dental or Vision coverage.
- **If your Spouse is a non-pilot employee and you wish to cover the entire family unit** under your Medical, Dental and/or Vision coverage, you and your non-pilot Spouse must call Pilot Benefits Administration to make your enrollment election.
- **If your child is eligible for FedEx benefits as an employee,** you can continue to cover him/her as your dependent as long as he/she meets the eligibility requirements (that is to age 26 for Medical and to age 23 for Dental/Vision). However, your child cannot be covered as both an employee and as your dependent. If you cover your child as a dependent for Medical, Dental and/or Vision coverage, he/she must elect to Opt Out of the applicable benefit as an employee. Within 31 days following his/her 26th birthday for Medical, or 23rd birthday for Dental/Vision, your child should elect his/her own Medical and/or Dental/Vision coverage as an employee to remain covered under the FedEx Corporation Group Health Plan.

CHANGE IN FAMILY STATUS AND EMPLOYMENT EVENTS

Some of the most common Change in Family Status and Employment events include:

- Birth or adoption of a child
- Marriage or divorce
- Commencement or termination of domestic partnership (California residents only)
- Dependent child loses eligibility for Medical, Dental and Vision coverage (for example, child is age 26 and is no longer eligible for Medical coverage, or age 23 and no longer eligible for Dental or Vision coverage)
- Death of Spouse or dependent child
- Spouse gains or loses employment or for Medical, Dental and/or Vision coverage through their employer
- Spouse has a significant change (for example, cost or benefits) in Medical, Dental and/or Vision coverage under their employer's plan
- You or your Spouse begin or return from a leave of absence

You are required to verify benefits eligibility of any newly added dependents. See Dependent Eligibility Verification on page 6.

Additional information can be found in the most current *Pilot Benefit Book*.

FOR INFORMATION...

REVIEW THE BENEFIT DESCRIPTIONS OF YOUR AVAILABLE MEDICAL OPTIONS TO DETERMINE THE BEST FIT FOR YOU AND YOUR FAMILY.

Who's Eligible?

You are able to cover your eligible children under your Medical Plan until midnight on the the last day of the month in which the child attains age 26, and until midnight on the last day of the month in which the child attains age 23 for Dental and Vision benefits, with no restrictions.

Dependents **ELIGIBLE** to be covered under your FedEx Express Medical, Dental and/or Vision coverage include your:

- Spouse:
  - — Legally Married Opposite-Sex Spouse
  - — Legally Married Same-Sex Spouse (for tax implications, see page 6)
  - — Common-Law Spouse (as defined by the state where Common-Law status is established)
- In California only, a Domestic Partner registered with the State of California
- Eligible child

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
- — In California only, your Domestic Partner's child

** Legal documents must be provided.*

Provided your child meets the eligibility requirements, you can cover them (until midnight on the last day of the month in which the child attains age 26 for Medical; until midnight on the last day of the month in which the child attains age 23 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
- — 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, your Spouse or, in California only, your Domestic Partner.)

Medical coverage ends automatically at midnight on the last day of the month in which the child attains age 26 and Dental and Vision coverage end automatically at midnight on the last day of the month in which the child attains age 23 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 the coverage. See the *Pilot Benefit Book* for details.

Your Spouse/Domestic Partner (in California only) cannot be covered as an eligible dependent if he or she is on active duty in the armed forces of any country.

Dependent Eligibility Verification

FedEx requires you to submit proof of benefits eligibility for all dependents you add for Medical, Dental and/or Vision coverage. See "Dependent Eligibility Verification," beginning on page 6, for details.

Once your dependents are approved for coverage, you will be required to confirm each dependent's eligibility annually when making your online benefit elections. If you are covering an individual who does not meet the definition of an eligible dependent, you should indicate that the dependent is not eligible during the online dependent confirmation process. 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.

Covering Your Same-Sex Spouse

You can cover your eligible Same-Sex Spouse and your Spouse's eligible children for health (Medical, Dental and Vision) and Flexible Spending Accounts benefits. If you are married under the laws of a state where same-sex marriage is recognized, health benefits for your Spouse and your Spouse's children are not considered part of your taxable income for federal tax purposes and your paycheck contributions will be made on a pre-tax basis, no matter where you currently reside. However, state tax implications for health benefits may be different based on the state where you reside.

DEPENDENT ELIGIBILITY VERIFICATION

Adding Dependents to Medical, Dental and/or Vision Coverage

You may access FedEx Benefits Online at *fedex.ehr.com* to add your eligible dependent(s) or add coverage for an existing eligible dependent(s). If you add Medical, Dental and/or Vision coverage for an eligible dependent(s), you are required to submit acceptable documentation within 45 days to verify the covered dependent(s) is eligible for health benefits.

Dependent Verification Packet

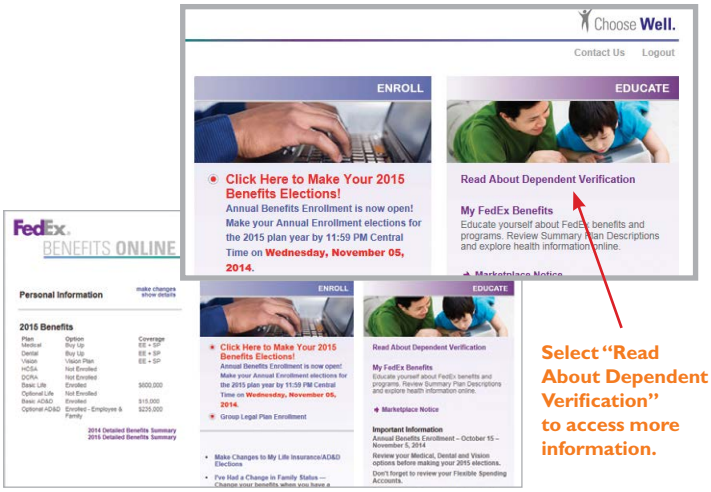
Once you have added Medical, Dental and/or Vision coverage for your eligible dependent(s), you will receive a personalized Dependent Verification packet at your home address as reflected in PRISM. This packet will include a Personalized Letter, an Acceptable Documentation list, Definition of Eligible Dependents, Frequently Asked Questions and Dependent Verification Cover Sheet (barcoded). You can upload your documentation online (see Upload Acceptable Documents) or mail or fax them. It is important that if you are mailing or faxing your acceptable documentation to the Dependent Verification Center, you include the barcoded Dependent Verification Cover Sheet so that your documentation can be linked to your covered dependent(s). If the cover sheet is not sent with your documentation that is mailed or faxed and your documentation cannot be identified, your covered dependent(s) will be dropped from Medical, Dental and/or Vision coverage.

If you lose your Dependent Verification Coverage Sheet, you may call the **Dependent Verification Center at 1.800.953.5393** to request this document.

FedEx Benefits Online at fedex.ehr.com

You can access information about the Dependent Verification process at FedEx Benefits Online prior to receiving your packet by selecting "About Dependent Verification" from the EDUCATE section of the HOME page. Here you will find links to Acceptable Documentation, Definition of Dependent Eligibility and Frequently Asked Questions.

Once you have submitted acceptable documentation that has been reviewed and approved, you will be required to annually validate your covered dependent in FedEx Benefits Online.

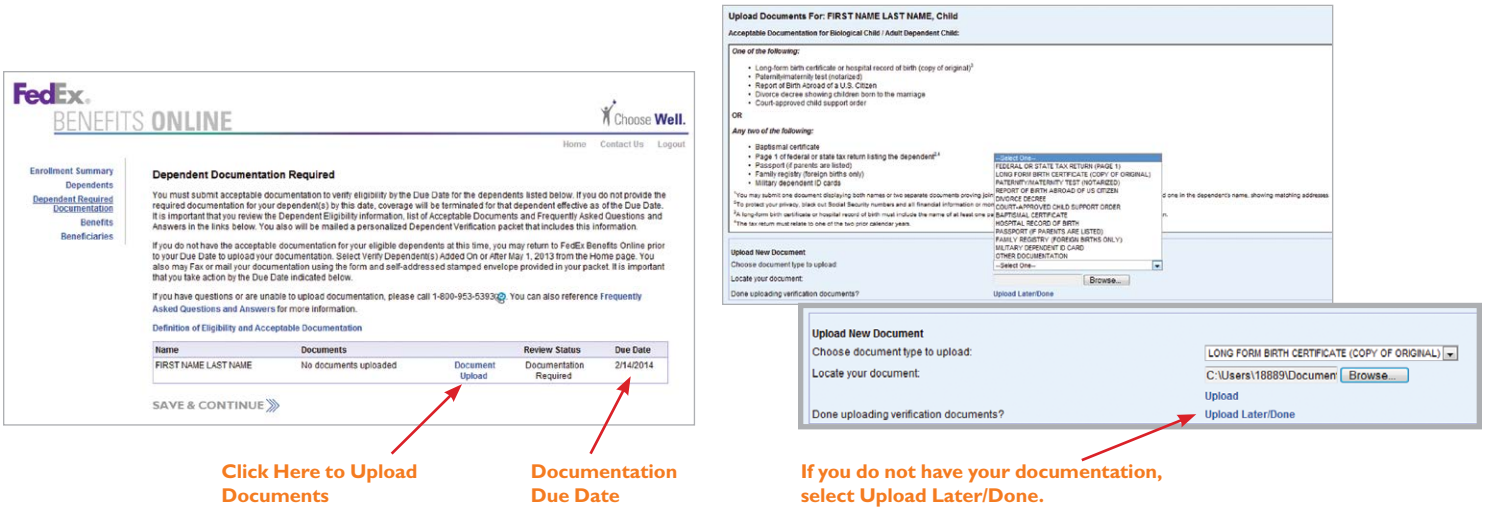


Upload Acceptable Documents

You may upload your acceptable documentation in FedEx Benefits Online. This is a quick and easy process assuming you have the documentation available when adding your dependent(s) or electing coverage for an existing dependent. Once you have added your eligible dependents to Medical, Dental and/or Vision coverage and completed the Dependent Affidavit process, the **Dependent Documentation Required** screen allows you to upload your documents (such as PDFs, JPEGs, and so on).

Each dependent type (such as Spouse, stepchild, biological child) has its own list of acceptable documentation that may be submitted to validate the dependent. Simply choose the document type to load and select **Upload** if you have your acceptable documents for that dependent or **Upload Later** if you do not have acceptable documentation available at that time.

- If you do not have your acceptable documents as you are going through the Dependent Documentation Required process, you may return to this screen at a later date but must upload your documents by your due date as indicated on FedEx Benefits Online and in the Personalized Letter.
- After this due date, you may provide documentation via U.S. Mail or fax, however, you must provide the Dependent Verification Cover Sheet (barcoded) to link your documents to your dependent(s). Documentation sent without this barcoded sheet, will not be processed.



Failure to Provide Acceptable Documentation

If you fail to provide acceptable documentation by the required due date, your dependent's Medical, Dental and/or Vision coverage will be terminated. Before your dependent's Medical, Dental and/or Vision coverage is terminated, you will receive a termination letter with the termination date, dependent name and your appeal rights. If you submit acceptable documentation during the appeal period, coverage will be reinstated to the termination date.

Otherwise, you will not be able to add your dependent back to your Medical, Dental and/or Vision coverage until the next Annual Enrollment or unless you have a Change in Family Status and make an election within your 31-day election period. You will still be required to provide acceptable documentation within 45 days of adding your eligible dependents during either of these situations.

Under the Patient Protection and Affordable Care Act (PPACA), employees who do not have access to affordable, minimum value health care coverage through their employer may purchase health insurance from the new health insurance marketplaces established in each state. If the employer's plan is not affordable or does not meet the minimum value standard, the employee may be eligible for tax incentives to offset part of the cost of insurance purchased through these marketplaces, depending upon the employee's family income.

PPACA requires employers to provide their employees with a written notice about the health insurance options available through the health insurance marketplace and whether the employer's plan meets the minimum value and affordability tests. FedEx has determined that its plan offerings are both affordable and are of minimum value as defined. Therefore, no tax incentives will be available for employees who are eligible for FedEx coverage.

COMPARE FEDEX EXPRESS MEDICAL PLAN OPTIONS

The FedEx Express Medical Plan options provide comprehensive medical benefits. However, the plans vary in the amount you contribute to participate, your out-of-pocket expenses (for example, annual deductible, copayments and coinsurance) and the level of covered services. See your Personalized Letter (new hires only) or EVALUATE and ENROLL sections on FedEx Benefits Online, for your available Medical Plan options. Review your options carefully before choosing a Medical Plan.

Base Plan

Buy Up Plan

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, 7 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 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, 7 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, 7 days a week
- Easy access to an international PPO network when you travel

When you use in-network providers, you must meet an annual deductible before benefits are payable in the Base Plan only. 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. Preventive care is not subject to the in-network deductible.

When you use out-of-network providers, you are responsible for your annual deductible, applicable coinsurance and expenses above FAIR Health Rates or National Care Network (NCN) limits. Amounts over the FAIR Health Rates or NCN limits are not considered covered charges and are not counted toward the annual out-of-pocket limit.

Your annual deductible, coinsurance and the limit on how much you pay annually are less when you use the PPO network than when you go out-of-network. For a list of network providers in your area or another part of the country, you can access the Provider Directory at *www.anthem.com/ca*, link to the directory from the EDUCATE section on FedEx Benefits Online, or call Anthem Customer Service at 1.866.406.0982.

With the Base and Buy Up Plans, the Plan also includes coverage for prescription drugs, Employee Assistance Program (EAP) and mental health/substance abuse.

Prescription Drug Benefits

Anthem's pharmacy benefit program provides both retail and mail order coverage administered by Express Scripts. For more information, refer to "Benefits at a Glance" on pages 14 and 15. You can also access information through *www.anthem.com/ca*.

NEW for 2015! Effective January 1, 2015, if you (or your eligible dependent) are taking a brand-name drug or had a brand-name drug filled within the last six months and that drug is on the GenericSelect list, if your doctor agrees that you can switch to a GenericSelect drug, you will receive the first generic prescription at no cost. If you begin your medication therapy with a GenericSelect drug, you also will receive your first prescription at no cost. This applies to your first fill for a 30-day supply at retail or 90-day supply through home delivery. You will be required to pay the generic copayment for all future refills of the GenericSelect drug.

You are not eligible for this copay waiver for drugs on the GenericSelect list that you have already tried. There will not be a penalty if you choose to continue with your brand-name drug. You will simply pay the brand copayment.

If you have questions regarding this program, your pharmacy benefits or to receive the GenericSelect drug list call Anthem Customer Service at 1.866.406.0982 or Anthem's pharmacy service, supported by Express Scripts, directly at 1.800.700.2541.

Your EAP and Mental Health/Substance Abuse Benefits

If you participate in the Base Plan or Buy Up Plan, your EAP and Mental Health/Substance Abuse benefits are both administered by Anthem. If you participate in the International Plan, your Mental Health and Substance Abuse benefits are administered by GeoBlue and EAP benefits are administered by Anthem. For more information, refer to "Benefits at a Glance" starting on page 15. When in the U.S., you can access the EAP through *www.anthemEAP.com* or by calling 1.866.621.0130.

Anthem EAP has partnered with Workplace Options (WPO) to provide EAP services outside the U.S. Effective January 1, 2015, EAP services for FDA pilots, members of your household and pilots traveling outside the U.S. will be provided through WPOs global network of providers.

You can access EAP benefits or locate participating providers at *www.anthemEAP.com* or by calling the new international phone number at 44.20.8987.6230.

BEFORE RECEIVING IN-NETWORK OR OUT-OF-NETWORK MEDICAL SERVICES

If you participate in the Base Plan or Buy Up Plan, it is recommended that you call Anthem at the number shown on your ID card before receiving certain medical services.

Preauthorization is recommended for the following services:

- All inpatient hospitalization including acute rehabilitation and long-term acute care, Cardiac/Pulmonary/Vestibular Rehab
- All inpatient mental health and substance abuse covered services (inpatient includes inpatient hospitalization, partial hospitalization, residential treatment center and intensive outpatient program)
- 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/provider/f1/s0/t0/pw_a092321.pdf* 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 required preauthorization of specific services 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
- Mastectomy and lymph node dissection

This process helps to ensure that medical services you receive are appropriate and meet the medical necessity guidelines. **If you do not call for preauthorization of the above services, your benefits may be denied if the treatment you receive is found not to be medically necessary.**

Remember, when accessing medical services, it is **your** responsibility to obtain the recommended preauthorization.

NOTE: Even when a preauthorization is not recommended, the claim must still meet medical necessity. Refer to page 29 for a definition of "medically necessary."

24-HOUR HEALTH INFORMATION LINE

ANTHEM: 1.866.406.0982

If you are enrolled in any of the Anthem-administered Medical Plan options, you also have access to a 24-hour Health Information Line that offers support 24 hours a day, 7 days a week. If you need urgent care, a nurse will direct you to the nearest provider. If your condition does not require immediate care, a nurse will give you self-care tips to use until you see your doctor.

International Plan — Administered by GeoBlue

(Available to Internationally-based Pilots only)

Internationally-based pilots and their covered family members who are remaining in the U.S. or living abroad will have medical, pharmacy and behavioral coverage through GeoBlue, Anthem's worldwide partner for international coverage. GeoBlue provides a full range of services to assist with accessing health care needs overseas and in the U.S. Here are a few specifics about what GeoBlue coverage will include:

1. GeoBlue has carefully selected and contracted with over 6,000 Western-trained, English-speaking doctors in 200 countries.The contracts call for the doctor to respond the same day to an appointment request, and if the appointment is made through GeoBlue, the doctor has agreed to direct billing.
2. GeoBlue has built elaborate profiles of these doctors, ranging from where the doctor went to medical school to professional honors and personal interests. GeoBlue has a team that regularly updates these profiles to assure that all of the key information is up-to-date and accurate.
3. GeoBlue helps its members identify, access and pay for the best health care, no matter where they are in the world.
4. GeoBlue has 150 regional Physician Advisors. These individuals are leaders in their medical specialties, as well as their geographic territories. These key leaders are available to meet with members to discuss options in the face of an unexpected medical condition.
5. The GeoBlue program includes powerful health and security information on over 1,000 international cities. GeoBlue helps its members prepare for safe and healthy travel.
6. The online appointment scheduling process received a U.S. patent.
7. GeoBlue provides members with a number of valuable online translation databases, one for medical terms, another for medical phrases and one with names, preparation and availability of 350 brand name drugs in 24 countries.
8. Members can create personal online profiles based on family needs, languages and assignment locations.
9. Members can sign up for valuable daily health and security alerts. If these alerts elicit questions, members have 24-hour access to personal consults.
10. Most of the resources are now available to members on web-enabled hand-held devices. Everything that is available on the web or a hand-held device is also and always available through the GeoBlue 24-hour call center.
11. To obtain further information about GeoBlue and their available web tools, you can access their website at *www.geo-blue.com* and select "Take a Tour" of the online tools in the lower right.
12. When you use providers in the United States, you pay 10% of the covered expense — your coinsurance — up to a specified dollar amount annually. When you reach this annual limit, your out-of-pocket expense, GeoBlue pays 100% of covered expenses for the rest of the calendar year.

HMSA — Preferred Provider Plan

(Available to Hawaii employees only)

This Medical Plan option gives you access to HMSA's Preferred Provider Network. You can choose from a list of providers inside the PPO network or go outside the PPO network. When you receive services from an in-network provider, you do not have to file a claim. Outside the PPO network, you pay for care at the time of service, then file a claim for reimbursement. You will pay any difference between the actual charge and the eligible charge. You are responsible for obtaining pre-certification approvals. See page "Hawaii Medical Service Association (HMSA)" on page 17 for contact information.

As a participant in HMSA, you and your covered dependents can elect Dental coverage through MetLife and Vision coverage through Davis Vision. See page 17 for a benefit summary of the HMSA Medical option.

Opt Out of FedEx Express Medical Coverage

You can elect to opt out of FedEx Express Medical coverage if you have other individual medical coverage or group medical coverage through a family member or other employment. If you choose to opt out of FedEx Express Medical coverage, you will not have Medical (including mental health/substance abuse and prescription drug) coverage through FedEx Express for yourself or any covered dependents.

Typically, the advantage of opting out is the elimination of duplicate coverage and the requirement to coordinate coverage between two medical plans. By opting out of FedEx Express Medical coverage, your other medical plan will be your primary coverage.

You can elect to opt out of FedEx Express Medical coverage on FedEx Benefits Online. You will be required to complete an online affidavit stating you have other medical coverage.

If you choose to opt out, you may re-enroll in FedEx Express Medical coverage **only** if you lose your other medical coverage or during the next Annual Benefits Enrollment period. If you lose your other medical coverage, you must access FedEx Benefits Online to elect Medical coverage within 31 days following the date of loss of the other coverage.

Important: If you elected to opt out of Medical coverage for calendar year 2014 and make no election for 2015, you will automatically opt out of Medical coverage for 2015.

When You Need Care Right Away…Emergency and Urgent Care

Base Plan and Buy Up Plan — 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 do not receive medical care right away. You are covered 24 hours a day, 7 days a week for emergency services anywhere in the world.

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

Base Plan and Buy Up Plan — Urgent Care

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

YOUR BENEFITS	HOW TO RECEIVE THEM
Urgent Care Centers	Urgent Care Centers are physician offices that provide walk-in care and extended hours. Office hours and days of operation vary and it is recommended that you call your physician in advance to determine if urgent care is available, the location where extended care is available and the hours of operation.

When Traveling or Temporarily Residing Outside Your Home State

If you are traveling outside your home state, you and your enrolled dependents can access care from participating health care providers.

YOUR BENEFITS	HOW TO RECEIVE THEM
Protection — when traveling or temporarily living outside your home state The BlueCard PPO network enables members traveling outside their home state to access a broader network of doctors and hospitals at discounted rates. The PPO provides continued benefits for you and your enrolled dependents (even out-of-state students) when traveling or temporarily residing outside your home state.	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. You can also find BlueCard PPO providers at *www.anthem.com/ca*. Click on the Provider Finder and follow the instructions. When prompted, enter the Prefix Identification Number "FXF." • If you receive services from a provider in the national BlueCard PPO network, the provider will file the claim for you. • 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. Please save all relevant statements and attach to the claim form for reimbursement.

continued...

Access to HTH Provider Network — When Traveling Outside the U.S. — Call 1.888.243.2358

YOUR BENEFITS	HOW TO RECEIVE THEM
Inpatient emergency/urgent care — when traveling outside the U.S. You may access HTH Worldwide participating hospitals for inpatient services to receive in-network benefits. Inpatient out-of-network care that is medically necessary and deemed urgent or emergent will be covered at the in-network benefit level, when billed as such. If care is deemed not urgent or emergent, services will be covered subject to Anthem's PPO out-of-network benefits.	Be prepared for the unexpected; call the International Provider Access number printed on the back of your ID card before leaving the U.S. An International Coordinator will provide you with a list of HTH Worldwide participating hospitals in several international cities. For inpatient care at a participating 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*.
Outpatient emergency/urgent care — when traveling outside the U.S. Outpatient out-of-network care that is medically necessary and deemed emergent or urgent will be covered at the in-network benefit level, when billed as such. If care is deemed not urgent or emergent, services will be covered subject to Anthem's PPO out-of-network benefits. Always carry your ID card when traveling outside the U.S. You are covered 24 hours a day, 7 days a week, regardless of your location.	If you need emergency medical care, go to the nearest hospital. Call the International Provider Access number on the back of your ID card if you are admitted to the hospital. 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 *www.anthem.com/ca*.

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 do not receive medical care right away. You are covered 24 hours a day, 7 days a week for emergency services anywhere in the world.

Urgent care services are those 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.

Quick Care Options

NEW for 2015! Anthem's Quick Care Options program is designed to educate you on the most effective use of emergency rooms and urgent care centers. When you can't see your doctor or if your doctor's office is closed, there may be viable emergency room alternatives such as retail health clinics, walk-in doctor's offices and urgent care centers. Visit *www.anthem.com/ca* or call the number on your medical ID card for more information and to find out if other sites of care are available in your area. Not all types of care and facilities are available in all areas.

MEDICAL PLAN OPTIONS — BENEFITS AT A GLANCE

The charts on the following pages give a brief description of some of the main features and coverages for each FedEx Express Pilot Medical Plan option.

Benefit changes for 2015 have been highlighted in **bold**.	**Base Plan** *Open Access PPO — Administered by Anthem*		**Buy Up Plan** *Open Access PPO — Administered by Anthem*	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM BENEFIT	N/A			
ANNUAL DEDUCTIBLE	$250 individual $750 family	$250 individual $750 family	N/A	$250 individual $750 family
OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)	$2,000 individual $6,000 family Inpatient Hospital/Outpatient Surgery Facility copayments and all coinsurance, excluding prescription drug, apply to out-of-pocket maximum.	$3,250 individual $9,750 family Inpatient Hospital/Outpatient Surgery Facility copayments and all coinsurance, excluding prescription drug, apply to out-of-pocket maximum.	N/A	$3,250 individual $9,750 family Inpatient Hospital/Outpatient Surgery Facility copayments and all coinsurance, excluding prescription drug, apply to out-of-pocket maximum.
PREVENTIVE CARE (BASED ON VENDOR STANDARD GUIDELINES)	100% coverage $20 copayment applies if PCP bills for an office visit	70% coverage after deductible	100% coverage $20 copayment applies if PCP bills for an office visit	70% coverage after deductible
OFFICE VISITS	$20 copayment per PCP/$40 copayment per specialist visit. No PCP referral required. OB/GYN is considered a PCP	70% coverage after deductible	$20 copayment per PCP/$40 copayment per specialist visit. No PCP referral required. OB/GYN is considered a PCP	70% coverage after deductible
INPATIENT HOSPITAL SERVICES (SEMIPRIVATE ROOM)	$150 copayment, then 90% coverage after deductible Member responsible for preauthorization	$150 copayment, then 70% coverage after deductible Member responsible for preauthorization	$150 copayment, then 100% coverage Member responsible for preauthorization	$150 copayment, then 70% coverage after deductible Member responsible for preauthorization
OUTPATIENT LAB, RADIOLOGY, DIAGNOSTIC AND PRE-ADMISSION TESTING*	90% coverage after deductible If services performed in physician's office, may be subject to office visit payment	70% coverage after deductible	100% coverage If services performed in physician's office, may be subject to office visit payment	70% coverage after deductible
MATERNITY	$20 copayment per visit	70% coverage after deductible	$20 copayment at first visit; then 100% coverage	70% coverage after deductible
EMERGENCY SERVICES	$75 copayment (waived if admitted), then 90% coverage after deductible if an emergency If not a true emergency, services are covered at the out-of-network level (70% coverage after deductible) Ambulance: 90% coverage after deductible	$75 copayment (waived if admitted), then 90% coverage after deductible if an emergency If not a true emergency, services are covered at the out-of-network level (70% coverage after deductible) Ambulance: Covered at the in-network level if an emergency. If not a true emergency, 70% coverage after deductible.	$75 copayment (waived if admitted), then 100% coverage if an emergency If not a true emergency, services are covered at the out-of-network level (70% coverage after deductible) Ambulance: 100% coverage	$75 copayment (waived if admitted), then 100% coverage if an emergency If not a true emergency, services are covered at the out-of-network level (70% coverage after deductible) Ambulance: Covered at the in-network level if an emergency. If not a true emergency, 70% coverage after deductible.

For preauthorization, call 1.800.274.7767. Failure to obtain any recommended preauthorization of specific services will result in denial of benefits determined not medically necessary.

**Preauthorization by the member is recommended for certain diagnostic procedures. Check online at* www.anthem.com/ca/provider/f1/s0/t0/pw_a092321.pdf *before you schedule the surgery/procedure to see if preauthorization is required.*

	Base Plan *Open Access PPO — Administered by Anthem*		Buy Up Plan *Open Access PPO — Administered by Anthem*	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
URGENT CARE FACILITY	$35 copayment, then 90% coverage after deductible	$35 copayment, then 70% coverage after deductible	$35 copayment, then 100% coverage	$35 copayment, then 70% coverage after deductible
OUTPATIENT SURGERY*	$50 copayment, then 90% coverage after deductible Member responsible for preauthorization	$50 copayment, then 70% coverage after deductible Member responsible for preauthorization	$50 copayment, then 100% coverage Member responsible for preauthorization	$50 copayment, then 70% coverage after deductible Member responsible for preauthorization
CHIROPRACTIC CARE	90% coverage after deductible $1,750 annual maximum (in-network and out-of-network combined)	70% coverage after deductible $1,750 annual maximum (in-network and out-of-network combined)	$20 copayment each visit $1,750 annual maximum (in-network and out-of-network combined)	70% coverage after deductible $1,750 annual maximum (in-network and out-of-network combined)
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY	Inpatient: 90% coverage after deductible Outpatient: $20 copayment Limits apply	70% coverage after deductible Limits apply	Inpatient: 100% coverage Outpatient: $20 copayment Limits apply	70% coverage after deductible Limits apply
SKILLED NURSING FACILITY	90% coverage after deductible Member responsible for preauthorization	70% coverage after deductible Member responsible for preauthorization	100% coverage Member responsible for preauthorization	70% coverage after deductible Member responsible for preauthorization
INPATIENT REHABILITATION	90% coverage after deductible Member responsible for preauthorization	70% coverage after deductible Member responsible for preauthorization	100% coverage Member responsible for preauthorization	70% coverage after deductible Member responsible for preauthorization
HOME HEALTH CARE	90% coverage after deductible Member responsible for preauthorization	70% coverage after deductible Member responsible for preauthorization	100% coverage Member responsible for preauthorization	70% coverage after deductible Member responsible for preauthorization
HOSPICE	90% coverage after deductible Inpatient requires preauthorization; member responsible for preauthorization	70% coverage after deductible Inpatient requires preauthorization; member responsible for preauthorization	100% coverage Inpatient requires preauthorization; member responsible for preauthorization	70% coverage after deductible Inpatient requires preauthorization; member responsible for preauthorization
DURABLE MEDICAL EQUIPMENT (DME)/ EXTERNAL PROSTHETIC DEVICES	90% coverage after deductible	70% coverage after deductible	100% coverage	70% coverage after deductible
PRESCRIPTION DRUGS (RETAIL) FOR 1-MONTH SUPPLY	• Generic: $10 copayment • Preferred Brand: **$49 copayment** • Non-Preferred Brand: **$72 copayment** 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.	50% of cost of prescription In no case can the 50% coinsurance be less than what would have been paid in-network.	• Generic: $7.50 copayment • Preferred Brand: $35 copayment • Non-Preferred Brand: $55 copayment 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.	50% of cost of prescription In no case can the 50% coinsurance be less than what would have been paid in-network.

For preauthorization, call 1.800.274.7767. Failure to obtain any recommended preauthorization of specific services will result in denial of benefits determined not medically necessary.

**Preauthorization by the member is recommended for certain diagnostic procedures. Check online at www.anthem.com/ca/provider/f1/s0/t0/pw_a092321.pdf before you schedule the surgery/procedure to see if preauthorization is required.*

	Base Plan *Open Access PPO — Administered by Anthem*		Buy Up Plan *Open Access PPO — Administered by Anthem*	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS (MAIL ORDER) FOR 3-MONTH SUPPLY	• Generic: $10 copayment • Preferred Brand: **$74 copayment** • Non-Preferred Brand: **$122 copayment**	Not covered	• Generic: $7.50 copayment • Preferred Brand: $65 copayment • Non-Preferred Brand: $115 copayment	Not covered
EMPLOYEE ASSISTANCE PROGRAM (EAP)	100% coverage for short-term counseling sessions up to 8 visits All EAP services must be preauthorized through Anthem at 1.866.621.0130.	Not covered	100% coverage for short-term counseling sessions up to 8 visits All EAP services must be preauthorized through Anthem at 1.866.621.0130.	Not covered
MENTAL HEALTH/ SUBSTANCE ABUSE	Outpatient Visit: $20 copayment All other services: 90% coverage, no deductible or facility copayment Member responsible for inpatient preauthorization*	70% coverage for all services, no deductible or facility copayment Member responsible for inpatient preauthorization*	Outpatient Visit: $20 copayment All other services: 100% coverage, no deductible or facility copayment Member responsible for inpatient preauthorization*	70% coverage for all services, no deductible or facility copayment Member responsible for inpatient preauthorization*

**For preauthorization, call 1.800.274.7767. Failure to obtain any recommended preauthorization of specific services will result in denial of benefits determined not medically necessary.*

International Plan — Administered by GeoBlue

(Available to Internationally-based Pilots only)

	OUTSIDE THE UNITED STATES	IN THE UNITED STATES	
		IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum Benefit	N/A		
Annual Deductible	N/A		
Out of Pocket Maximum *(Including Deductible)*	$1,650 Individual / $4,125 Family		
Preventive Care *(Based on Vendor Standard Guidelines)*	100% coverage	100% coverage	90% coverage
Office Visits	$10 copayment	$30 copayment	90% coverage
Inpatient Hospital Services *(Semiprivate Room)*	100% coverage	90% coverage	
Outpatient Lab, Radiology, Diagnostic and Pre-Admission Testing	100% coverage	90% coverage	
Maternity	$10 copayment	$30 copayment for pre-natal visits 90% coverage for Delivery	90% coverage
Emergency Services	$50 copayment (waived if admitted) then 100% coverage Ambulance coverage: 100%	$50 copayment (waived if admitted) then 90% coverage Ambulance coverage: 90%	
Urgent Care Facility	100% coverage	90% coverage	
Outpatient Surgery	100% coverage	90% coverage	
Chiropractic Care	100% coverage up to 20 visits annual maximum benefit (includes acupuncture)	90% coverage up to 20 visits annual maximum benefit (includes acupuncture)	
Physical, Speech and Occupational Therapy	Inpatient: 100% coverage Outpatient: Plan pays up to 12 visits annual maximum	Inpatient: 90% coverage Outpatient: Plan pays up to 12 visits annual maximum	
Skilled Nursing Facility	100% coverage up to 120-day limit annually	90% coverage up to 120-day limit annually	
Inpatient Rehabilitation	100% coverage	90% coverage	
Home Health Care	100% coverage up to 30 visits annual maximum	90% coverage up to 30 visits annual maximum	
Hospice	100% coverage up to 180 days lifetime maximum	100% coverage up to 180 days lifetime maximum	
Durable Medical Equipment (DME)/ External Prosthetic Devices	100% coverage	90% coverage	
Hearing Services	For a covered person who is a dependent child under age 26, 100% of covered expenses up to a maximum of $1,000 per Hearing Aid every three years		
Prescription Drugs *(Retail)* **for 1-Month Supply**	90% coverage You pay the cost of the drug if less than the copayment. 70% coverage for injectables	• Generic: $5 copayment • Brand: $15 copayment 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. 70% coverage for injectables	80% coverage In no case can the 80% coinsurance be less than what would have been paid in-network. 70% coverage for injectables
Prescription Drugs *(Mail Order)* **for 3-Month Supply**	• Generic: $10 copayment • Brand: $60 copayment • Non-Preferred Brand: $60 copayment • Injectables 70% coverage	• Generic: $10 copayment • Preferred Brand: $60 copayment • Non-Preferred Brand: $110 copayment • Injectables 70% coverage	No coverage
Employee Assistance Program (EAP) *Anthem EAP www.AnthemEAP.com* *1.866.621.0130 – Inside the U.S.* *44.20.8987.6230 – Outside the U.S.*	100% coverage for short-term counseling sessions up to 8 visits All services must be preauthorized.	100% coverage for short-term counseling sessions up to 8 visits All services must be preauthorized.	No coverage
Mental Health/Substance Abuse	Inpatient: 100% coverage Outpatient: $10 copayment	Inpatient: 90% coverage Outpatient: $30 copayment	Inpatient: 90% coverage Outpatient: 90% coverage

Benefit changes for 2015 have been highlighted in **bold**.

Hawaii Medical Service Association (HMSA)

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None	
Annual Out-of-Pocket Maximum	$2,500 per person / $7,500 per family — (medical plan coverage); **$3,600 individual / $4,200 family — (prescription plan coverage)**	
Lifetime Maximum	No lifetime maximum benefit	
Primary Care or Specialist Visit *(Office/Clinic Visits)*	$14 copayment	
Preventive Care	100% coverage for: • Routine physical exam, well-woman exam and well-baby care/well-child care through age 21 • Preventive screenings (Grade A&B recommendations of the U.S. Preventive Services Task Force) • Standard Immunizations	
Hospital Services		
– *Facility Fee (for example, Hospital Room)*	80% coverage	
– *Inpatient Diagnostic Tests, X-ray and Blood Work*	80% coverage	
– *Physician Visit*	$20 copayment per visit	
– *Surgeon Fee*	80% coverage	
Maternity		
– *Prenatal and Postnatal Care*	90% coverage	
– *Inpatient Services and Delivery*	90% coverage	
Outpatient Surgery		
– *Facility Fee*	80% coverage	
– *Physician Visit*	$14 copayment	
– *Surgeon Fee*	80% coverage	
Outpatient Lab and X-ray	80% coverage	
Outpatient Blood Work	100% coverage	
Imaging *(CT/PET Scans, MRIs)*	80% coverage	
Emergency Room Services		
– *Physician Visit*	$20 copayment per visit	
– *Emergency Room*	$100 copayment	
– *Ambulance (Air or Ground)*	80% coverage	
Urgent Care	$14 copayment	
Chiropractic Care	• Plan pays $10 per visit; Maximum of 12 visits per calendar year • X-ray films of the spine only: 50% coverage up to $ 50 per calendar year	
Mental Health/Substance Abuse		
– *Physician Visit*	Outpatient: $14 copayment per visit; Inpatient: 100% coverage	
– *Hospital and Facility Services*	Inpatient and Outpatient: 80% coverage	
Other Services		
– *Home Health Care*	80% coverage	
– *Rehabilitation Services*	80% coverage	
– *Skilled Nursing Care*	80% coverage	
– *Durable Medical Equipment*	80% coverage	
– *Hospice*	100% coverage	
Prescription Drugs — Retail *(Limit: 30-day supply)*	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY
– *Generic*	$7 copayment	$7 copayment plus 20% of remaining eligible charge
– *Preferred Brand (Formulary)*	$30 copayment	$30 copayment plus 20% of remaining eligible charge
– *Non-Preferred Brand (Non-Formulary)*	$75 copayment	$75 copayment plus 20% of remaining eligible charge
– *Specialty Drugs*	$100 copayment	Not covered
– *Insulin* • *Preferred Brand* • *Non-Preferred Brand*	 • $7 copayment • $30 copayment	 • $7 copayment plus 20% of remaining eligible charge • $30 copayment plus 20% of remaining eligible charge
– *Diabetic Supplies* • *Preferred Brand* • *Non-Preferred Brand*	 • $0 • $30 copayment	 • $0 • $30 copayment
– *U.S. Preventive Services Task Force A&B Recommended Drugs*	$0	20% coinsurance
Prescription Drugs – Mail Service *(Limit: 90-day supply)*	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY
– *Generic*	$11 copayment	Not Covered
– *Preferred Brand (Formulary)*	$65 copayment	Not Covered
– *Non-Preferred Brand (Non-Formulary)*	$200 copayment	Not Covered
– *Specialty Drugs*	Not Covered	Not Covered
– *Insulin* • *Preferred Brand* • *Non-Preferred Brand*	 • $11 copayment • $65 copayment	Not Covered
– *Diabetic Supplies* • *Preferred Brand* • *Non-Preferred Brand*	 • $0 • $65 copayment	Not Covered
– *U.S. Preventive Services Task Force A&B Recommended Drugs*	$0	Not Covered
	NOTE: When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you are responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you choose not to use the generic equivalent or if the particular generic equivalent was not available at the pharmacy.	
Online Care	You and your covered dependents may access HMSA's Online Care through *www.hmsa.com*. Your copayment is $10 for up to 10 minutes; $5 for an additional 5-minute extension. Each session is limited to a total of 15 minutes.	
Health Assessment	You and your covered dependents age 18 and older are entitled to Well-Being Connect, an online health portal that includes a well-being assessment that evaluates your health and lifestyle at no cost. The assessment helps you design a personal well-being plan that fosters healthy behavior.	
For Information Packet:	Call HMSA: **1.808.948.6111** Mainland: **1.800.776.4672** **Group Number 19337-1**	

LOCAL HMO OPTIONS

Local HMOs (California and Hawaii only)

In addition to the FedEx Express Medical Plan options available to you, you may have the option to enroll in a local HMO. Local HMOs have their own guidelines and features, and are fully insured rather than being self-funded like the FedEx Express Medical Plan options. The FedEx contribution to the cost of the local HMOs is comparable to the cost the company pays for the FedEx Express Medical Plan options. Therefore, if you choose to enroll in an HMO with monthly premiums greater than the company's contribution to the FedEx Express Medical Plan options, you will pay the difference in cost. This amount is indicated in your Personalized Letter (new hires only). The monthly cost is also located on page 31 of this guide and can be viewed on FedEx Benefits Online in the EVALUATE and ENROLL sections.

How the HMOs Work

You must choose a Primary Care Physician (PCP) or health care facility from the HMO's 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 only a small copayment for most office-based physician services. For most other medical services you pay a percentage of the covered expense — your coinsurance — up to a specified dollar amount annually. Preventive services are covered at 100%. When you reach the HMO's annual out-of-pocket maximum, the Plan pays 100% of covered expenses for the rest of the calendar year.

If you go outside the HMO network for care, the services are not covered and you are responsible for all medical charges. Keep in mind, HMOs operate independently of FedEx — each has its own guidelines.

What's Covered

If you are considering enrolling in a local HMO, take some time to review the charts on the following pages. These charts contain an overview of the 2015 Plan design changes and benefits offered by each local HMO. If you need more specific information about what is or is not covered by a particular local HMO, just call the HMO at the number listed under "Additional Information" in the HMO's chart, and a detailed schedule of benefits and services will be provided, without charge, upon request. Give them the group number if it's requested. Keep in mind, if you enroll in a local HMO, you and your covered dependents can elect to have Dental coverage through MetLife and Vision coverage through Davis Vision.

The local HMO will also mail a complete packet to you as a prospective enrollee, including a list of their participating providers and enrollment material, without charge, upon request. Detailed provider lists will be furnished automatically, without charge, to participants. If you need an enrollment packet or detailed schedule of benefits and services, call early so you will get the HMO's information in time to meet the enrollment deadline. If you enroll in a local HMO, you should keep this *Health Enrollment Guide*, as well as the schedule of benefits provided by the HMO, which summarize the key features of the HMO option, because these features are not described in the *Pilot Benefit Book*.

Coverage varies from one local HMO to another. If you have a specific health care need, call the HMO directly for information about limitations and/or exclusions, and request that one of their detailed HMO packets be mailed to you. Call early so you will get the information in time to meet the enrollment deadline.

	Kaiser Permanente — California
IN THE HOSPITAL	
Room and Services	90% coverage for semiprivate room after deductible
Physician Visits	90% coverage after deductible
Laboratory Tests and X-rays	90% coverage after deductible
Surgery	90% coverage after deductible
Maternity Care	90% coverage after deductible
Emergency Care **• In HMO Service Area**	90% coverage after deductible
• Out of HMO Service Area	90% coverage after deductible; limited to emergency services required before member's condition permits transfer or travel to the nearest Kaiser facility
Ambulance	$150 per trip when determined to meet the criteria that define an emergency
Inpatient Mental Health	90% coverage after deductible
Inpatient Substance Abuse	90% coverage after deductible for detoxification; $100 per admit for residential treatment
IN THE DOCTOR'S OFFICE AND OUTPATIENT	
Office Visits	$25 copayment per visit; $15 copayment for chiropractic services per visit, maximum 20 visits per calendar year. 50% coinsurance after deductible for diagnosis and treatment of infertility; eligible treatments include fertility drugs administered during an office visit and artificial insemination.
Laboratory Tests and X-rays	$10 per encounter (except that MRI, CT and PET are $50 per procedure)
Surgery	90% coverage after deductible per visit/procedure
Maternity Care	100% coverage per prenatal visit and initial post-partum visit
Well-Baby/Well-Child Care	100% coverage (23 months or younger)
Preventive Care	100% physical exams, GYN exams. 100% coverage for routine immunizations, mammograms and allergy injections. $25 copayment for allergy testing, hearing test and vision exams.
Physical/Speech/Occupational Therapy (Outpatient)	$25 copayment per visit
Prescription Drugs*	**Retail** Generic — $10 for 30-day supply, $20 for 31–60-day supply, $30 for 61–100-day supply Brand Name — $20 for 30-day supply, $40 for 31–60-day supply, $60 for 61–100-day supply **Mail Order** Generic — $10 for 30-day supply, $20 for 31–60-day supply Brand Name — $20 for 30-day supply, $40 for 31–60-day supply
Durable Medical Equipment	80% coverage; includes diabetic supplies
Outpatient Mental Health	Individual: $25 copayment per visit; Group: $12 copayment per visit; no outpatient visit limit
Outpatient Substance Abuse	Individual: $25 copayment per visit; Group: $5 copayment per visit; no outpatient visit limit
Deductible	$250 individual / $500 family per calendar year
Out-of-Pocket Maximum	$3,000 individual / $6,000 family
Annual Copayment Maximum	N/A
ADDITIONAL INFORMATION	
For HMO Packet:	1.800.464.4000; *www.kp.org*
Group Number	16239 — Northern California 104563 — Southern California

Benefit changes for 2015 have been highlighted in **bold**.

Health Plan Hawaii

	IN-NETWORK ONLY	
Annual Deductible	None	
Annual Out-of-Pocket Maximum	$2,500 individual / $7,500 family — (medical plan coverage); **$3,600 individual / $4,200 family — (prescription plan coverage)**	
Lifetime Maximum	No lifetime maximum benefit	
Primary Care or Specialist Visit *(Office/Clinic Visits)*	$20 copayment	
Preventive Care	100% coverage for: • Routine physical exam, well-woman exam and well-baby care/well-child care through age 21 • Preventive screenings (Grade A&B recommendations of the U.S. Preventive Services Task Force) • Standard Immunizations	
Hospital Services		
– *Facility Fee (for example, Hospital Room)*	80% coverage	
– *Physician Visit*	$20 copayment per visit	
– *Surgeon Fee*	100% coverage	
Maternity		
– *Prenatal care and first post-partum exam*	100% coverage	
– *Delivery (Surgery)*	100% coverage	
– *Inpatient Services (Hospital Room and Board)*	80% coverage	
Outpatient Surgery		
– *Facility Fee*	100% coverage	
– *Physician Visit*	$20 copayment	
– *Surgeon Fee*	$20 copayment	
Lab, X-ray and Blood Work	80% coverage	
Imaging *(CT/PET Scans, MRIs)*	80% coverage	
Emergency Room Services		
– *Physician Visit*	100% coverage	
– *Emergency Room*	$75 copayment	
– *Ambulance (Air or Ground)*	80% coverage	
Urgent Care	$20 copayment	
Chiropractic Care	• Plan pays $10 per visit; Maximum of 12 visits per calendar year • X-ray films of the spine only: 50% coverage up to $ 50 per calendar year	
Mental Health/Substance Abuse		
– *Physician Visit*	Outpatient: $20 copayment per visit; Inpatient: 100% coverage	
– *Hospital and Facility Services*	Inpatient: 80% coverage; Outpatient: 100% coverage	
Other Services		
– *Home Health Care*	100% coverage	
– *Rehabilitation Services*	$20 copayment per visit	
– *Skilled Nursing Care*	80% coverage	
– *Durable Medical Equipment*	50% coverage	
– *Hospice*	100% coverage	
Prescription Drugs – Retail *(Limit: 30-day supply)*	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY
– *Generic*	$7 copayment	$7 copayment plus 20% of remaining eligible charge
– *Preferred Brand (Formulary)*	$30 copayment	$30 copayment plus 20% of remaining eligible charge
– *Non-Preferred Brand (Non-Formulary)*	$75 copayment	$75 copayment plus 20% of remaining eligible charge
– *Specialty Drugs*	$100 copayment	Not covered
– *Insulin* • *Preferred Brand* • *Non-Preferred Brand*	 • $7 copayment • $30 copayment	 • $7 copayment plus 20% of remaining eligible charge • $30 copayment plus 20% of remaining eligible charge
– *Diabetic Supplies* • *Preferred Brand* • *Non-Preferred Brand*	 • $0 • $30 copayment	 • $0 • $30 copayment
– *U.S. Preventive Services Task Force A&B Recommended Drugs*	$0	20% coinsurance
Prescription Drugs — Mail Service *(Limit: 90-day supply)*	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY
– *Generic*	$11 copayment	Not Covered
– *Preferred Brand (Formulary)*	$65 copayment	Not Covered
– *Non-Preferred Brand (Non-Formulary)*	$200 copayment	Not Covered
– *Specialty Drugs*	Not Covered	Not Covered
– *Insulin* • *Preferred Brand* • *Non-Preferred Brand*	 • $11 copayment • $65 copayment	Not Covered
– *Diabetic Supplies* • *Preferred Brand* • *Non-Preferred Brand*	 • $0 • $65 copayment	Not Covered
– *U.S. Preventive Services Task Force A&B Recommended Drugs*	$0	Not Covered
	NOTE: When a prescribed brand name drug has a generic equivalent that is listed on the Hawaii Drug Formulary of Equivalent Drug Products, you are responsible for the appropriate copayment plus the difference between the generic and brand name cost. This procedure will apply regardless of whether you choose not to use the generic equivalent or if the particular generic equivalent was not available at the pharmacy.	
Online Care	You and your covered dependents may access HMSA's Online Care through *www.hmsa.com*. Your copayment is $10 for up to 10 minutes; $5 for an additional 5-minute extension. Each session is limited to a total of 15 minutes.	
Health Assessment	You and your covered dependents age 18 and older are entitled to Well-Being Connect, an online health portal that includes a well-being assessment that evaluates your health and lifestyle at no cost. The assessment helps you design a personal well-being plan that fosters healthy behavior.	
For HMO Packet:	Call HMSA: **1.808.948.6372** Mainland: **1.800.776.4672** ***www.hmsa.com*** **Group Number: 19342-1**	

IMPORTANT INFORMATION TO CONSIDER

Medical Coverage for 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 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 the Provider Finder and follow the instructions. When prompted, enter the Prefix Identification Number "FXF." You can also link to the directory from the EDUCATE section 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 Have Treatment in Progress

If you are currently in a local HMO, and plan to enroll in the Medical Base Plan or Buy Up Plan and have treatment for an acute medical condition in progress when your new coverage becomes effective, you may be eligible for transitional benefits. If eligible, you can continue treatment temporarily with your current physician and receive in-network benefits, even if your doctor is not in Anthem's network. However, you always have the choice to use any provider.

If your provider is not in Anthem's network, you will receive out-of-network benefits.

Transitional benefits apply only to short-term, intensive care such as:

- Chemotherapy,
- Pregnancy, or
- Hospice care.

This does not apply to chronic care, which means long-term or recurring care. Anthem's Medical Review department evaluates each case individually to determine transitional benefits, if any. Call Anthem Customer Service at 1.866.406.0982 to find out if your situation qualifies for transitional benefits.

Guidelines vary among local HMOs. If you are being treated for an acute condition and would like to enroll in a local HMO, check with that HMO. Phone numbers are listed in this guide.

If You Have a Pre-Existing Condition

You can enroll in any Medical Plan option available in your location, even if you or an eligible dependent has a pre-existing condition. There are no limits or exclusions for pre-existing conditions.

DON'T FORGET...

IF THERE'S A WORD OR TERM YOU DON'T UNDERSTAND, TURN TO THE HANDY "HEALTH CARE DEFINITIONS" AT THE END OF THIS GUIDE.

A LOOK AT DENTAL COVERAGE

FedEx Express Pilot Base and Buy Up Dental Plans provide you and your family with valuable help in paying for preventive dental services and treatment for dental problems. MetLife is the claims-paying administrator for these benefits. Dental benefits are self-funded, meaning all claims are paid by FedEx out of its general assets and contributions made by pilots.

You must meet the applicable annual dental deductible before benefits for most dental services are paid. Preventive dental care checkups are covered each year and are not subject to the annual deductible. After you or your covered dependent has met the dental deductible, your selected plan pays a percentage of the cost of your covered dental expenses.

Charges for eligible services are allowed only when deemed necessary for treatment of dental disease or injuries. All eligible expenses for treatment of dental disease or injuries must be medically necessary. MetLife, the claims-paying administrator for Dental benefits, determines medical necessity. It is strongly recommended that you obtain a predetermination of benefits before incurring $200 or more in dental expenses.

Your dental benefits will coordinate with benefits you may be eligible for under another plan.

If you have questions, call MetLife Customer Service at 1.800.540.5233.

Active Pilot Dental Benefits	Base	Buy Up
Annual Deductible	$100 individual $300 family	$50 individual $100 family
Annual Maximum Benefit after Deductible	$2,750 individual	$2,750 individual
Lifetime Maximum	$30,000 individual	$30,000 individual
Class I (Preventive) Services: • Dental X-rays • Sealants (permanent molars only) • Preventive care	80% coverage after deductible	90% coverage after deductible
Class II Services: • Restorations (fillings), including amalgam, silicate, plastic and composite restoration • Endodontics • Oral Surgery • Extractions • Other services	80% coverage after deductible	80% coverage after deductible
Class III Services: • Crowns and/or replacement crowns (when medically necessary)	75% coverage after deductible	80% coverage after deductible
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.	50% coverage after deductible	50% coverage after deductible

MetLife PDP (Preferred Dentist Program)

The MetLife PDP is a network of over 110,000 dentists nationwide who have contracted with MetLife to provide dental care at specially negotiated rates. Though there is no penalty for using a dentist who is not in the network, there may be a reduced benefit if your dentist's fees are over customary and reasonable limits. You can locate a participating dentist by calling 1.800.474.PDP1 (1.800.474.7371) or on the internet at *www.metlife.com/mybenefits*.

A LOOK AT VISION COVERAGE

FedEx Express Pilot Vision coverage provides benefits for pilots and covered dependents for vision examinations and eyewear. In addition, pilots and dependents can receive discounts provided under the Advantage Eye Care Program. Davis Vision is the claims-paying administrator for this benefit, which 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 out of its general assets and contributions made by pilots.

Davis Vision contracts with licensed optometrists nationwide 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, the amount you pay may be less than if you use out-of-network providers and there are no claim forms to complete.

To locate an in-network provider in your area, call Davis Vision at 1.888.603.3339 or visit *www.davisvision.com*. If you receive services from an out-of-network provider, you can file a claim for reimbursement at the levels shown in the chart below. Claims must be submitted within one year of the date the charge was incurred.

Vision Benefits	In-Network Provider	Out-of-Network Provider
One routine eye examination, including dilation when indicated by your provider, once every 12 months	100% coverage	Up to $50 reimbursed
One pair of frames once every 24 months	100% coverage up to $115 retail value after a $15 copayment*	Up to $120 reimbursed
One pair of standard glass, plastic or safety lenses once every 12 months **NOTE:** You cannot receive benefits for contact lenses and spectacle lenses during the same 12-month period.	100% coverage after a $15 copayment*	• Single vision: Up to $35 reimbursed • Bifocal: Up to $50 reimbursed • Trifocal: Up to $65 reimbursed • Lenticular: Up to $90 reimbursed
Lens options for spectacle lenses: • Oversized • PGX (sun-sensitive glass) • Progressive addition multifocal • Blended bifocal • Polycarbonate • Solid, gradient or sun-tinted plastic • UV and scratch-resistant coatings • Quadrifocal (safety glasses only) • Full spectrum • Faceted • Ski-type coating • Low-power aspheric • Intermediate 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.	100% coverage after a $15 copayment	Not covered
One pair of contact lenses once every 12 months **NOTE:** You cannot receive benefits for contact lenses and spectacle lenses during the same 12-month period.	Choose from a special collection of standard soft daily wear, planned replacement and disposable lenses or 100% coverage up to $110 for non-plan lenses which includes lenses, care kit for proper cleaning and sterilization, and related expenses (for example, fitting fee). You must pay costs in excess of $110. First-time wearers must pay $10 fee toward the cost of professional fitting. 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.	Up to $135 reimbursed for exam, fitting, follow-up and materials; up to $55 reimbursed for materials only.

NOTE: Davis Vision will repair or replace any damaged or destroyed frame or spectacle lens (totally provided by Davis) for a period of one year from the delivery date, regardless of the cause of such damage. You must return the damaged or destroyed frame and/or lens to Davis Vision in order to take advantage of this warranty.

**If frames and lenses are purchased during the same visit, only one $15 copayment applies.*

Advantage Eye Care Program

FedEx has made arrangements for all pilots and eligible dependents to have access to the Advantage Eye Care Program to purchase vision care services and eyewear at specially negotiated prices. These services must be received from an in-network provider.

All pilots and eligible dependents are eligible for the Advantage Eye Care Program even if not enrolled for Vision coverage. However, you must have your eligible dependents listed on FedEx Benefits Online.

Call Davis Vision at 1.888.603.3339 for authorization prior to making an appointment. You must select the type of services you expect to need and make advance payment to Davis Vision.

Feature	Your Cost*
Eye examination	**$50–$78 based on the area of the country**
Single vision lenses and frames	**$121.70**
Bifocal lenses and frames	**$134.76**
Trifocal lenses and frames	**$147.82**
Single vision lenses only	**$ 64.18**
Bifocal lenses only	**$ 77.24**
Trifocal lenses only	**$ 90.30**
Frames only	**$ 71.88**
Contact lenses (new wearers)	**$142.60**

** In addition to your cost above, you will pay a $15 materials fee at the provider's office.*

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.

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

WHAT'S NOT COVERED — LIMITS AND EXCLUSIONS

There are limits and exclusions that apply to your health 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 Base Plan and Buy Up Plan, administered by Anthem.

KEY: •• *In-Network and Out-of-Network* • *In-Network Only* • *Out-of-Network Only*

Limits for Base Plan and Buy Up Plan

•• **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.

•• **Ambulance service** is limited for travel to and from the nearest appropriate facility.

•• **Anesthetics** and their administration are limited based on Anthem's guidelines.

• **Assistant surgeon** charges are limited out-of-network to a percentage of the allowable Usual & Customary (U&C) limits or negotiated fees and are based on Anthem's guidelines.

•• **Augmentative communication devices** are limited based on Anthem's guidelines.

•• **Biofeedback** is limited based on Anthem's guidelines.

• **Birthing center charges** shall be considered one charge for mother and child where Anthem has contracted per diem charges with an in-network provider; birthing center charges shall be considered separate charges 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 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.

•• **Consumable (disposable) medical supplies are limited to** ostomy supplies and urinary catheters.

• **Co-surgeons** are limited out-of-network to a percentage of the allowable U&C limit or negotiated fees.

•• **Electronic heart pacemaker** is limited based on Anthem's guidelines.

•• **Enteral and/or nutritional formula** is limited based on Anthem's guidelines.

•• **Extracorporeal Shock Wave Lithotripsy charges** are limited based on Anthem's guidelines.

•• **Genetic testing** is limited based on Anthem's guidelines.

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

• **Home births or home deliveries** are only excluded in-network.

•• **Home health aide services** must be rendered or supervised by a registered nurse, registered physical therapist, registered occupational therapist or medical social worker.

•• **Home health care services and supplies** are limited based on Anthem's guidelines.

•• **Home uterine monitoring** is limited based on Anthem's guidelines.

•• **Hospice services and supplies** are limited based on Anthem's guidelines.

•• **Infertility drugs** are covered when used in conjunction with testing and treatment of the underlying medical condition.

• **Inpatient hospital room and board** is limited up to the semiprivate room rate. If the hospital only has private rooms, benefits are covered at the private room rate unless Anthem has a negotiated rate.

•• **Lesion removal** is limited based on Anthem's guidelines.

• **Mammograms** are covered based on physician's orders.

•• **Mastectomy due to cancer** is limited to the following services and supplies:
1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prosthesis; and
4. Treatment of physical complications at all stages of mastectomy including treatment for lymphedema.

•• **Medical supplies** are limited based on Anthem's guidelines.

•• **Multiple surgical procedures.** When multiple surgical procedures are performed during a single operative session, payment is based on Anthem's guidelines.

•• **Organ transplant program** charges are limited based on Anthem's guidelines.

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

•• **Other nutritional formula** is limited to nutritional formula requiring a prescription based on Anthem's guidelines.

•• **Outpatient physical therapy, speech therapy and occupational therapy** are limited based on Anthem's guidelines.

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

• **Participating midwife** must provide services under the direct supervision of an in-network physician at an authorized in-network facility.

•• **Podiatric treatment** is limited based on Anthem's guidelines, and in addition: Covered expenses for weak, strained, unstable, flat or unbalanced feet, metatarsalgia and bunions are limited to:
(a) Surgical procedures or nail root removal
(b) Lab and X-rays
(c) Medical supplies
(d) Corrective shoes used in lieu of or as part of a brace
Corns, calluses and toenail trimming are not covered expenses unless they are necessary for treating metabolic or peripheral-vascular disease.

•• **Post-mastectomy bras** are limited based on Anthem's guidelines.

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

- **Prescription drugs** prescribed by a practitioner and dispensed by a licensed pharmacist in connection with a hospital confinement, or issued, administered or delivered by a practitioner or home health agency, are limited based on Anthem's guidelines.
- **Preventive care** is limited based on Anthem's guidelines.
- **Prolotherapy** is limited based on Anthem's guidelines.
- **Prosthetic device** or appliance used to replace or restore a functional body part, excluding TMJ, is limited based on Anthem's guidelines.
- **RAST testing** is limited based on Anthem's guidelines.
- **Reduction mammoplasty** is limited based on Anthem's guidelines.
- **Removal of birthmarks** is limited based on Anthem's guidelines.
- **Rental of durable medical equipment** is limited to the purchase price as determined by Anthem's guidelines.
- **Routine Pap smears** are limited based on Anthem's guidelines.
- **Skilled Nursing Facility.** Services provided by a Skilled Nursing Facility are limited based on Anthem's guidelines. Room and board, including regular daily services and supplies furnished by the Skilled Nursing Facility, are limited based on the guidelines. The admission must be preauthorized as determined by the guidelines. Failure to obtain such preauthorization will result in denial of benefits determined not medically necessary. Other services and supplies rendered during an approved confinement to a Skilled Nursing Facility are reviewed for medical necessity based on Anthem's guidelines.
- **Surgical dressings** are limited based on Anthem's guidelines.
- **Therapy needed for developmental delay** is limited based on Anthem's guidelines.
- **Transplant travel and lodging expenses** are limited based on Anthem's guidelines (only available when using a Network Transplant facility).
- **Treatment, including surgical, for morbid obesity** is limited based on Anthem's guidelines.
- **Tuberculin testing** is limited based on Anthem's guidelines.
- **X-ray and laboratory examinations** are limited based on Anthem's guidelines. Failure to obtain preauthorization for certain diagnostic procedures based on Anthem's guidelines shall result in denial of benefits determined not medically necessary.
- **X-ray, radium or other radioactive substances.** Treatment by X-ray, radium or other radioactive substances are limited based on Anthem's guidelines.

Exclusions for Base Plan and Buy Up Plan

- **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, supply or cosmetic or reconstructive procedure which is performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness 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. 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 are for a confinement for bed-rest only, without medical necessity, except as specifically provided under the Hospice Care benefit.
- **Dance therapy/movement therapy.**
- **Dental exclusions** listed in the *Pilot Benefit Book* are also exclusions based on Anthem's guidelines.
- **Dental implants** are not covered as medical expenses unless connected with treatment or extraction that results from accidental injury.
- **Dental plates, bridges, crowns, caps** or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in Anthem's guidelines. Cosmetic dental surgery or other dental services for beautification are not covered.
- **Educational services.** Testing or services that are educational or developmental, for vocational training or performed to treat learning disabilities.
- **Effective coverage.** Services received before your effective date or after your coverage ends.
- **Environmental change.** Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy.
- **Excess amounts.** Any amounts in excess of covered expense.
- **Exercise equipment.** Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness.
- **Expenses in excess of negotiated fees** or Customary & Reasonable FAIR Health Rates or National Care Network (NCN) limits.
- **Expenses incurred after the termination date of coverage.**
- **Expenses for travel and lodging** related to medical or dental treatment, except for organ transplants in-network and only available when using a Network Transplant facility.
- **Experimental or investigative procedure or medication.** But, if you are denied benefits because it is determined that the requested treatment is experimental or investigative, you may request an independent medical review.
- **Eye refractions or any other examinations** to determine the need for, or proper adjustment of, eyeglasses or for the purchase of eyeglasses under the medical coverage.

- **Food or dietary supplements.**
- **Growth hormones.** These are not covered as a medical expense.
- **Incidental procedures** or those that are not medically indicated at the time provided.
- **Infertility services** including artificial insemination, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or similar procedures, and associated direct medical procedures and pharmacy expenses.
- **Lifestyle programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by Anthem.
- **Local, state or federal agency services.** Any services actually given to you by a local, state or federal government agency, except when payment under this Plan is expressly required by federal or state law. The Plan will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- **Maintenance treatment** unless covered based on Anthem's guidelines.
- **Medical research.** Medical treatment primarily for research.
- **Mental health and substance abuse** services 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.
- **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.
- **No proof of charges.** Medical expenses for which you furnish no proof of charges.
- **Not medically necessary.** Services or supplies that are not medically necessary.
- **Optometric services**, eye exercises including orthoptics.
- **Orthopedic shoes** (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications except as specifically stated in Anthem's guidelines.
- **Other charges** excluded by Anthem's PPO.
- **Outpatient prescription drugs** or medications and insulin and diabetic supplies, except as covered under the Prescription Drug Benefit and deemed medically necessary. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.
- **Prescription and non-prescription diabetic supplies**, except as specifically stated in the "Prescription Drug Benefit" section of this booklet.
- **Prescription drugs not administered in a doctor's office** or facility. See the "Prescription Drug Benefit" section beginning on page 8.
- **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.

  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.
- **Travel and lodging expenses** related to organ transplants.
- **Vitamins** (except prenatal vitamins requiring a prescription and medically necessary for the treatment of an illness based on Anthem's guidelines), **minerals, homeopathic drugs and therapies, and over-the-counter medications.**
- **Volunteer services.** Professional services received from a volunteer or a person who lives in your home, or who is related to you by blood or marriage (Spouse of the covered patient, or 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.
- **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.

HOW TO GET MORE INFORMATION

Don't wait until the last minute! Call early if you need additional materials as your enrollment will not be extended. See your Personalized Letter (new hires only) for your enrollment deadline.

IF YOU NEED…	CONTACT…
Anthem's Provider Directory A list of providers participating in the Anthem network in your area.	**Anthem 1.866.406.0982** Go to *www.anthem.com/ca*, click on the Provider Finder and follow the instructions. When prompted, enter the Prefix Identification Number "FXF." OR link from the EDUCATE section on FedEx Benefits Online.
Prescription Drug Formulary A list of the Preferred Brand drugs.	**Anthem's Pharmacy Service, supported by Express Scripts, Inc. (retail and mail order)** **1.800.700.2541** or ***www.anthem.com/ca***
Local HMO Enrollment Packet Enrollment packet for the local HMOs available in your area.	**The local HMO directly** Phone numbers are listed in the Benefit Summaries on pages 19 and 20.
Davis Vision Providers	**1.888.603.3339** or ***www.davisvision.com***
MetLife PDP Providers	**1.800.474.7371** or ***www.metlife.com/mybenefits***

IF YOU NEED INFORMATION…	CALL…
Anthem Customer Service	**1.866.406.0982**
FedEx Express Pilot Benefits Administration	**1.866.795.6353** **1.901.434.6353 in the Memphis area**
Anthem EAP	**1.866.406.0982 – Inside the U.S.** **44.20.8987.6230 – Outside the U.S.**
Davis Vision Customer Service	**1.888.603.3339**
MetLife Dental Customer Service	**1.800.540.5233**
GeoBlue Customer Service	**1.610.254.5304 – Outside the U.S. (direct/collect)** **1.855.282.3517 – Inside the U.S. (toll free)**

FedEx Express Pilot Benefits Administration

U.S. Mail FedEx Express
Pilot Benefits Administration
Building B, 3rd Floor
3620 Hacks Cross Road
Memphis, TN 38125-8800

COMAIL MEM/TN/38194
FedEx Express PBA – 7103

FAX FedEx Express PBA
1.901.434.9287

EMAIL *PBA@fedex.com*

FEDEX BENEFITS **ONLINE** @ fedex.ehr.com

HEALTH CARE DEFINITIONS

A–C

Change in Family Status
Allows you to add or drop dependent coverage within 31 days following 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 "Medical Plan Options — Benefits at a Glance" in this guide for more information.

Copayment
The flat fee you pay for certain services in Base Plan, Buy Up Plan, International Plan 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 & Child(ren)
- Pilot & Spouse
- Pilot & Family

Please note that Benefit communications may sometimes refer to you as "employee" rather than "pilot." For example, the FedEx Benefits Enrollment website refers to health coverage tiers as "Employee Only," "Employee & Spouse," and so on.

Customary & Reasonable (C&R)
The amount considered a typical charge made for a service, based on similar ranges of services of comparable complexity, by dentists in the same or similar geographic region as determined by MetLife, the claims-paying administrator's guidelines. If you enroll in the Base Dental or Buy Up Dental Plan and go outside the network, you'll be responsible for charges that exceed the C&R limit. Dental charges that exceed the C&R limit are not considered covered expenses.

D–G

Deductible (Annual)
The amount you pay for covered services each year before the Plan begins to pay benefits.

You must satisfy an annual deductible in the Medical Base Plan (in- and out-of-network) and Buy Up Plan (out-of-network only). See "Medical Plan Options — Benefits at a Glance" in this guide for more information.

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.

FAIR Health or National Care Network (NCN)
The Base and Buy Up Medical Plan options out-of-network reimbursement for non-participating providers 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.

If you enroll in the Base or Buy Up Medical Plan and go outside the network, you'll be responsible for charges that exceed the FAIR Health or NCN rates. Charges that exceed the FAIR Health or NCN rates are not considered covered expenses and do not apply to the maximum out-of-pocket.

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. See "How to Get More Information."

GeoBlue
Anthem's worldwide partner that can provide access, available 24 hours per day, 7 days per week, for urgent and emergent care all over the world to domestic pilots traveling outside the U.S. who are enrolled in the Medical Base Plan and Buy Up Plan. GeoBlue also administers the International Plan for internationally-based pilots.

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.

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

Medically Necessary
Criteria for determining medical necessity includes care that is:

- Commonly and customarily recognized by the most relevant medical specialist (such as cardiology, orthopedic) 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

Medical Plan Options
The plans available to you to provide medical benefits. Your Medical Plan options are based on your home ZIP code and include one or more of the following:

- Base Plan
- Buy Up Plan
- International Plan (for internationally-based pilots only)
- HMSA
- A Local HMO

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 provider network.

Out-of-Pocket Maximum
The most you will have to pay toward covered expenses in a calendar year. Once you meet the out-of-pocket maximum, the plan begins to pay 100% of covered expenses for the rest of the calendar year — unless any annual maximums apply. Charges that exceed Customary & Reasonable (C&R) or FAIR Health Rates or National Care Network (NCN) limits, as applicable, are not considered covered expenses and do not apply to the out-of-pocket maximum. See "Medical Plan Options — Benefits at a Glance" in this guide for information on each Medical Plan option's out-of-pocket maximums.

Preauthorization
A review for medical appropriateness before a medical service is rendered. Preauthorization is your responsibility. See "Medical Plan Options — Benefits at a Glance" in this guide for more information.

PPO (Preferred Provider Organization)
A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. You may seek care from out-of-network providers, but generally pay a higher deductible and coinsurance.

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-person exams, well-baby care and immunizations.

Primary Care Physician (PCP)
A doctor who coordinates the overall health care of patients. You can choose a PCP from a provider network directory that usually includes doctors in family practice, internal medicine and pediatrics.

Proprietary Drugs
Proprietary drugs include brand-name medications, single-source medications that do not currently have a generic equivalent, and medications that may come under a trademarked name.

Provider
A PCP, specialist, hospital, lab, pharmacy, or other health professional or facility that provides health care services or supplies.

R–T

Self-Funded Medical Plan Options
The Medical Base Plan and Buy Up Plan 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 not self-funded.

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.

MONTHLY COST — MEDICAL, DENTAL, VISION

2015 BENEFIT OPTIONS	Coverage Tiers: PILOT ONLY	PILOT & CHILD(REN)	PILOT & SPOUSE	PILOT & FAMILY
A MEDICAL				
Base Plan	$23.19	$ 98.92	$120.56	$154.57
Buy Up Plan	$66.47	$156.12	$185.48	$255.04
HMSA PPO	$23.19	$ 98.92	$120.56	$154.57
International Plan	$41.73	$129.83	$157.65	$214.84
LOCAL HMOs				
Health Plan Hawaii	$57.83	$167.50	$206.49	$331.72
Kaiser Permanente — California	$68.82	$199.72	$246.29	$396.20
B DENTAL*				
Dental Base Plan	**$ 4.64**	**$ 18.54**	**$ 20.10**	**$ 21.65**
Dental Buy Up Plan	**$ 7.74**	**$ 23.19**	**$ 24.74**	**$ 29.38**
C VISION*				
	$ 3.11	**$ 6.18**	**$ 6.18**	**$ 9.29**

A box ☐ in the table indicates a cost used in the example calculation below.

* If you wish to elect Dental and/or Vision coverage in addition to your Medical coverage, add the appropriate Medical coverage tier cost to the tier cost for the Dental and/or Vision coverage you wish to elect.

Example: You wish to elect the following for 2015:

A	FedEx Buy Up Plan with Pilot & Family coverage	$255.04
B	Dental Base Plan with Pilot & Child(ren) coverage	$ 18.54
C	Vision with Pilot & Spouse coverage	$ 6.18
	Total Monthly Cost	**$279.76**

NOTES

2015

PILOT HEALTH ENROLLMENT GUIDE