**Summary Plan Description**

**ALPA Retiree Health Plan for JetBlue Pilots**

**Effective: May 1, 2019**



**ALPA Retiree Health Plan for JetBlue Pilots**

**Section 1. Introduction**

**Overview**

This Summary Plan Description (“SPD”) is designed to provide you with a description of the ALPA Retiree Health Plan for JetBlue Pilots (the “Plan”), sponsored by Air Line Pilots Association, International (the “Association”).

The Plan is a “Health Reimbursement Arrangement” (“HRA”) that was established effective May 1, 2019 pursuant to a collective bargaining agreement between the Association and JetBlue Airways Corporation (the “Company”) effective August 1, 2018 (the “Agreement”). The Association has established the Plan, along with a corresponding VEBA Trust, to fund benefits under the Plan. The Plan is designed to provide notionally funded accounts for pilots to pay for qualified medical expenses permissible under the Internal Revenue Code and IRS rules, when they are no longer flying for the Company.

This SPD is intended to provide an overview of the Plan as of May 1, 2019 but does not attempt to cover all details. In all cases, your rights and benefits are governed by the terms and conditions of the formal Plan document and the Agreement, and in the event of a conflict between those documents and this SPD, those documents will govern.

**Administration**

The Association is the “Plan Administrator”. However, most administrative functions under the Plan are carried out by an Administrative Board, whose members are appointed by the Association. The Association and the Administrative Board contract with third-party vendors to: maintain the recordkeeping of HRA Account balances; receive and review claims for benefits under the Plan; make initial determinations as to whether a claim is properly payable under the terms of the Plan; pay claims determined to be properly payable; and perform such other administrative services as necessary or appropriate.

**If you have questions about the Plan, including your account balance or a claim, you can obtain information as follows:**

**Web:**  smartchoiceaccounts.com

**Phone:** 1-866-287-2483

**Fax:** 855-673-6719

**Mail:** Enterprise (09754)  
 PO Box 660114  
 Dallas, TX 75266-0114

**Section 2. Funding of VEBA Trust / Investments**

**Benefits Funded by the VEBA Trust**

Benefits are provided through a special trust called a “VEBA Trust”. The term “VEBA” refers to a voluntary employees’ beneficiary association, which is a trust permitted under Section 501(c)(9) of the Internal Revenue Code to pay certain types of health & welfare benefits.

A notional HRA Account is created for you that reflects all amounts contributed to the VEBA Trust on your behalf, as discussed below in Section 3, including allocations of any investment gains or losses and allocations of any forfeitures. Please note that your HRA Account is a notional account representing a recordkeeping of your share of the pooled assets of the VEBA Trust rather than specific identifiable assets of the VEBA Trust. All benefits payable under the Plan will be paid or provided for solely from the assets held in the VEBA Trust, and the Company will have no liability or responsibility other than to make contributions. Benefits payable to you or your Beneficiaries under the Plan are strictly limited by your HRA Account balance on the date payment is processed. Neither the Company nor ALPA nor any other individual or entity other than the VEBA Trust are liable for the payment of benefits under the Plan.

**Investments**

The Administrative Board has sole discretionary authority and responsibility for directing the investment of VEBA Trust assets. You do not direct the investment of your HRA Account. Information about gains and losses can be found by logging in to the Plan website. Investment gains in the Trust are not taxed as long as they meet certain requirements. The Administrative Board will manage the investments in a manner intended to satisfy these requirements.

**Section 3. Contributions and Allocations**

**Amount of Contributions/Allocations**

While you are a pilot on the system seniority list, the Company will make the following contributions on your behalf:

* *Company Hourly Contributions* – Effective May 1, 2019, the Company will contribute $1.00 to an interest-bearing escrow account on your behalf for each hour for which you are entitled to be paid (whether for work/training or sick/vacation) as a Company Hourly Contribution. The funds in the escrow account will be transferred to the VEBA Trust once the IRS has finished processing the VEBA’s tax-exempt status, and all Company Hourly Contributions will thereafter be made directly to the VEBA Trust. Company Hourly Contributions are made on a bi-monthly basis.
* *Company Excess Contributions* – Effective August 1, 2018, if a Company contribution cannot be made to the JetBlue Airways Retirement Plan on your behalf due to limits on total annual contributions under Internal Revenue Code Section 415(c), the excess will be contributed to an interest-bearing escrow account on your behalf as Company Excess Contributions. The funds in the escrow account will be transferred to the VEBA Trust once the IRS has finished processing the VEBA’s tax-exempt status, and all Company Excess Contributions will thereafter be made directly to the VEBA Trust.
* *Investment Gain / Loss Allocations* – Investment gains and losses in the Trust portfolio will be allocated on a pro-rata basis and detailed as Investment Gains/Losses on your HRA Account statement.
* *Forfeiture Allocations* – Forfeitures will be allocated on a per capita basis and will be detailed as Forfeitures on your HRA Account statement.

Investment Gain / Loss Allocations and Forfeiture Allocations will continue as long as you have an HRA Account, even after you are no longer on the seniority list.

You are not permitted to opt out of the Company contributions described above.

**Employee Contributions**

Due to IRS requirements, voluntary employee contributions to your HRA Account are not allowed.

**Section 4. How You Can Use Your HRA Account**

**When Benefits Begin**

The Plan permits HRA Accounts to pay “Eligible Medical Expenses” incurred on or after the date you become permanently disabled (as determined by the Administrative Board in its sole discretion) or terminate employment with the Company, whether through retirement or otherwise. However, please see Sections 5 and 6 below regarding what happens to your HRA Account if you die.

Even though the Plan is effective May 1, 2019, no claims can be made until January 1, 2020. You can make claims for medical expenses incurred between May 1, 2019 and December 31, 2019 during the “run-out period” from January 1, 2020 to March 31, 2020, which is discussed further below.

**Eligible Medical Expenses**

“Eligible Medical Expenses” are those expenses incurred by you, your Spouse, or your Dependents that constitute qualified medical expenses under Section 213(d) of the Internal Revenue Code. This   
generally includes things like medical bills, prescription drugs, health insurance premiums, and long-term care insurance premiums (subject to age-based limits). Various types of expenses, such as elective cosmetic surgery, do not qualify. Distributions from your HRA Account to reimburse you for Eligible Medical Expenses are not taxable. More information about Eligible Medical Expenses is available on the Plan website and at <https://www.irs.gov/pub/irs-pdf/p502.pdf>.

**Spouse**

Your “Spouse” is an individual who is recognized as your lawful husband or wife under federal law. This does not include an individual from whom you are legally separated, unless required by law.

**Dependent**

Your “Dependent” is any “dependent” under Section 152 of the Internal Revenue Code. In the case of a Dependent child, the child will cease being a Dependent under the Plan as of the later of (1) the last day of the calendar year in which the child reaches age 26 or (2) in the case of a disabled child who is 26 or older, the date the child ceases to be disabled.

Please note that you may obtain reimbursement for Eligible Medical Expenses of anyone who qualifies as your Dependent. However, you may not designate Dependents who are not your children as Beneficiaries.

**Plan Website and Mobile App**

You can view your account balance, submit and view claims, and validate Eligible Medical Expenses on the Plan website at smartchoiceaccounts.com, or by using the Smart-Choice Accounts Mobile App. Your available balance is updated daily as claims are processed or as additional funds (investment earnings for example) are added.

**How to Submit Claims for Reimbursement**

The website and mobile app offer you the convenience of submitting your claims electronically. You may also submit your claims using a traditional paper claim form. To request a paper claim form please contact the Smart-Choice Accounts customer service center at 1-866-287-2483.

Claims for reimbursement of Eligible Medical Expenses may be submitted at any time during the year in which they were incurred, or during a “run-out period” from January 1 through March 31 of the following year. Claims submitted after the run-out period are not eligible for reimbursement. Any claims incurred in 2019 cannot be submitted in 2019 and must be submitted between January 1, 2020 and March 31, 2020.

**When Benefits Stop**

* *Zero Balance:* Once all final contributions have been deposited into your HRA Account and your HRA Account balance is exhausted, you are not eligible for further benefits.
* *Forfeited Balance:* Benefit eligibility ends once your HRA Account balance has been forfeited in accordance with Section 7 below.
* *Reemployment:* If you are rehired or return to work following a permanent disability, you will immediately cease to be eligible for benefits as of the date of your return. However, you will still be able to receive reimbursements for Eligible Medical Expenses that you or your Spouse or Dependents incurred prior to your return during the period you were eligible for benefits under the Plan, as long as you submit all required documentation to the Administrative Board no later than 90 days following your return to work and otherwise comply with any applicable Plan rules. Once you return to work, you will not become eligible to use your HRA Account to reimburse Eligible Medical Expenses until you again satisfy one of the initial eligibility requirements above.
* *Death:* If you die, your HRA Account can be used by your Beneficiaries as described below.

**Section 5. How Your Surviving Spouse Can Use Your HRA Account**

**Automatic Primary Beneficiary**

Your surviving Spouse is automatically your primary Beneficiary, and you cannot name any other individual as your primary Beneficiary. If you die while on the seniority list, or while eligible for benefits under the Plan, any remaining balance in your HRA Account will be available to your surviving Spouse. If you do not have a surviving Spouse, your HRA Account will be divided into separate sub-accounts for your non-spouse Beneficiaries (*See Section 6 below*).

**Surviving Spouse’s Use of Your HRA Account**

Upon your death, your surviving Spouse should contact the Claims Administrator for information on accessing your HRA Account. Your surviving Spouse can use your HRA Account for reimbursement of Eligible Medical Expenses incurred by you (before you died), your surviving Spouse, and any of your surviving Dependents (even if they are not your designated Beneficiaries). Your surviving Spouse cannot use your HRA Account for reimbursement of expenses incurred by other individuals (e.g., a new spouse or other dependents of your Spouse who were not your Dependents at the time of your death).

**When Surviving Spouse Benefits Stop**

If your Spouse dies, he or she is no longer eligible for benefits under the Plan. (*See Section 7 below*).

**Section 6. How Your Other Beneficiaries Can Use Your HRA Account**

**Your Other Beneficiaries**

If your Spouse dies, or if you do not have a surviving Spouse, any remaining balance in your HRA Account will be divided into separate sub-accounts for your other Beneficiaries. These Beneficiaries will be each of your surviving Dependent children who were designated by you in accordance with the Plan’s Beneficiary designation process. If you have no designated Beneficiary on file on the date of your death, each of your surviving children who were Dependents immediately prior to your death will become a Beneficiary. There are no other default Beneficiaries under the Plan.

**Establishment of Beneficiary’s Sub-Account**

Each Beneficiary receives an equal share, unless you designate a different percentage in accordance with the Plan’s Beneficiary designation process. In the case of your Spouse’s death (or if you are unmarried, upon your death), the Beneficiary sub-accounts are established no sooner than 180 days after the date of death. This is to provide time for the submission and processing of any trailing claims to the original HRA Account.

**Beneficiary’s Use of PMHP Sub-Account**

Once established, each Beneficiary can use his or her HRA sub-account for reimbursement of Eligible Medical Expenses incurred solely by that Beneficiary. The Beneficiary cannot submit claims for expenses incurred by any other individual (e.g., the Beneficiary’s spouse, children, or other dependents).

**When Benefits for Your Beneficiaries Stop**

A Beneficiary remains eligible for benefits until the end of the year in which he or she turns age 26. However, if the Beneficiary (or someone acting on the Beneficiary’s behalf) submits proof of disability prior to turning age 26, the Beneficiary remains eligible as long as the disability continues. The Administrative Board has sole discretion to determine whether a Beneficiary is disabled.

When a Beneficiary turns age 26 (or, if later, ceases to be disabled), his or her account remains open for 90 days after the end of the year in order to allow the Beneficiary time to submit any trailing claims for expenses incurred prior to the end of the year in which he or she ceased to be eligible. The remaining balance in his or her HRA sub-account then will be re-allocated per capita among the HRA sub-accounts of your other surviving Beneficiaries. If there are no other surviving Beneficiaries, the Beneficiary’s HRA sub-account will automatically be forfeited and re-allocated as described in Section 7 below.

If a Beneficiary dies, the remaining balance in his or her HRA sub-account will be re-allocated per capita among the HRA sub-accounts of your other surviving Beneficiaries. If there are no other surviving Beneficiaries, the Beneficiary’s HRA sub-account will automatically be forfeited and re-allocated as described in Section 7 below.

**Section 7. Forfeitures**

Your HRAaccount will be forfeited on the later of:

* 90 days following the end of the calendar year of your death being reported, if you do not have a Spouse or Beneficiary;
* 90 days following the end of the calendar year in which the death of your last-surviving Spouse or Beneficiary occurred;
* 90 days following the end of the calendar year in which all of your surviving Beneficiaries (if any) no longer qualify as Beneficiaries under the Plan (e.g., in the case of a Dependent child, due to attainment of age 26 or cessation of disability);
* 90 days following the end of the calendar year in which your HRA Account balance is twenty dollars ($20) or less during the calendar year (or such other dollar amount and/or period of time determined by the Administrative Board; or
* the date the Plan Administrator, in its sole discretion, terminates your HRA Account for cause (for example, submission of a fraudulent claim relating to your HRA Account).

**Forfeiture Allocations**

Forfeitures are processed annually. The exact timing may vary from year to year based upon administrative discretion.

Reallocation of forfeitures is made per capita to the following HRA Accounts, as determined by the Administrative Board:

* HRA Accounts of any pilots who are still employed by the Company;
* HRA Accounts of any pilots who have become eligible for benefits due to permanent disability or termination of employment with the Company, provided the HRA Account has a balance;
* HRA Accounts of any surviving Spouses, provided the HRA Account has a balance; and
* HRA Account sub-accounts of any Beneficiaries, provided the sub-account has a balance.

**Section 8. Claims and Appeals Procedures**

The Administrative Board has sole discretionary authority to grant or deny benefits with respect to a claim under the Plan.

**Initial Claims Relating to Reimbursement of Eligible Medical Expenses**

The Claims Administrator is responsible for deciding initial claims under the Plan with respect to the reimbursement of Eligible Medical Expenses. Each claimant must file individual claims with the Claims Administrator no later than March 31 of the year following the calendar year in which the claim was incurred. If a claim is denied, the claimant may file a Level 1 appeal with the Claims Administrator by completing a Level 1 appeal form and sending it to Claims and Appeals Management, P.O. Box 7105  
Rantoul, IL 61866-7105 within 180 days of receiving a denied claim. The form to be used as a Level 1 appeal may be obtained by logging onto the Plan website.

**Disposition of Appeals of Eligible Medical Expense Claims**

The Claims Administrator will notify you of its determination with respect to a Level 1 appeal within 30 days of receipt of the appeal. If the Claims Administrator determines more time is needed due to matters beyond its control, the response may be extended for up to 15 days. The Claims Administrator will notify you before the end of the 30-day period if an extension is necessary. If the extension is necessary because you did not submit required information, the Claims Administrator will provide you with an additional 45-days to provide the information. In the case of insufficient information, the time period allowed for making the appeal decision is tolled from the date the notice is sent to you until the date you respond to the notice. The decision will be in writing and will include a specific reason for the decision and will reference the Plan provision which the determination is based. The letter will include a description of any additional material or information necessary to perfect the claim and will instruct you how to appeal the denial to the Administrative Board.

If the Claims Administrator denies your Level 1 appeal, you may file a written Level 2 appeal with the Administrative Board within one-year of receiving the adverse Level 1 appeal decision. The Administrative Board will notify you of its determination on the Level 2 appeal within 60 days of receipt of the appeal. If the Level 2 appeal is denied, the notice will be in writing and will include specific reference to the Plan document to support the decision. If the Administrative Board determines more time is necessary to make a determination, they may extend this 60-day period one time, for up to 15 days. If the extension is necessary because you did not submit required information, the Administrative Board will specify the additional required information necessary to make a decision and grant you an additional 45 days to provide the information. The time period for making a Level 2 appeal determination is tolled until the date you respond to the request for information.

**Initial Claims Other Than Claims for Medical Expense Reimbursement**

If you have a claim under the Plan that is *not* a claim for reimbursement of Eligible Medical Expenses, including a claim that involves the application, interpretation or administration of the Plan, the claim must be filed with the Administrative Board within 60 days of the date the claim arose.

**Disposition of Initial Claims Other Than Claims for Medical Expense Reimbursement Before the Administrative Board**

The Administrative Board will notify you of its determination of your initial claim not related to medical expense reimbursement within 90 days of receipt of the claim. If the Administrative Board determines more time is needed due to matters beyond its control, the response may be extended for up to an additional 90 days. The Administrative Board will notify you before the end of the initial 90-day period if an extension is necessary. If the extension is necessary because you did not submit required information, the Administrative Board will provide you with an additional 45-days to provide the information. In the case of insufficient information, the time period allowed for making the appeal decision is tolled from the date the notice is sent to you until the date you respond to the notice. The decision will be in writing, will include a specific reason for the decision and will reference the Plan provision which the determination is based. The letter will include a description of any additional material or information necessary to perfect the claim and will instruct you how to appeal the denial to the Administrative Board.

If your claim that is not related to medical expense reimbursement is denied, you may appeal in writing to the Administrative Board in writing within one-year of the date of the denial. The Administrative Board will notify you of its determination on appeal within 60 days of receipt of the appeal. If the appeal is denied, the notice will be in writing (or electronic notice) to you and will include specific references to the Plan document to support the decision. If the Administrative Board determines more time is necessary to make a determination, they may take an additional 15 days to decide by notifying you of the necessary extension prior to the end of the initial 60-day period. If the extension is necessary because you didn’t submit required information, the Administrative Board will specify the additional required information necessary to make a decision and grant you an additional 45 days to provide the information.

**Notice of Decision**

If an appeal is denied, the notice will be in writing (or electronic notice) and will include:

* the reason(s) for the adverse decision;
* a reference to the plan provision(s) or guidelines, protocol or similar criteria on which the adverse decision is based;
* a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
* if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy shall be furnished (free of charge) upon request; and
* any other information required by federal law

The decision of the Administrative Board is final and binding on you and all other parties. The grievance procedures under the Agreement do not apply to any claims under this Plan.

**Improper or Incomplete Claim**

The Claims Administrator or the Administrative Board, as applicable, may notify you that your claim is improper or incomplete and may request additional information. The time from the date of the notice requesting further information until such information is received does not count toward the time period the Administrative Board is allowed to notify you of its decision. You have 45 days after receiving the notice to provide information or to complete the claim.

**Misstatement of Facts**

The submission of a claim is a certification that the information is true, correct and complete. Falsified claims are void and falsifying a claim in any manner will result in a denial of benefits. The Plan Administrator and the Plan retain the right to recover any payments made on the basis of a falsified claim. Recovery may be made from any person submitting a claim or receiving the payment.

**Overpayments**

The Plan Administrator and the Plan have the right to recover any overpayment from the person to whom such overpayment was made, or from any person benefiting from such overpayment. Any benefits payable to you or your Beneficiary may be reduced by the amount of any outstanding overpayment.

**Limitation on Bringing Legal Action**

You (or any other claimant) must exhaust your appeal rights under the Plan before bringing any legal action with respect to a claim for benefits under the Plan. In addition, any such action must be brought within three years from the date on which you submitted your claim or such claim was required to be submitted, whichever is earlier.

**Section 9. Plan Information**

**Plan Name**

ALPA Retiree Health Plan for JetBlue Pilots

**Plan Number**

537

**Plan Year**

The calendar year beginning on January 1st and ending on December 31st.

**Plan Sponsor**

Air Line Pilots Association, International

Steve Hodgson, Retirement & Insurance Department

535 Herndon Parkway

Herndon, VA 20170

**Employer Identification Number**

The Employer Identification Number assigned by the IRS to the Trust is 32-0584293

**Plan Administrator**

Air Line Pilots Associational, International

Steve Hodgson, Retirement & Insurance Department

535 Herndon Parkway

Herndon, VA 20170

**Claims Administrator**

Alight Solutions

Enterprise (09754)  
PO Box 660114  
Dallas, TX 75266-0114

**Agent for Service of Legal Process**

Air Line Pilots Associational, International

Daniel S. White, Retirement & Insurance Department

535 Herndon Parkway

Herndon, VA 20170

Legal process may also be served on the Plan Administrator.

**Appeals to the Board**

Administrative Board

Steve Hodgson, Retirement & Insurance Department

Air Line Pilots Associational, International

535 Herndon Parkway

Herndon, VA 20170

**Plan Document**

You may obtain a copy of the Plan document upon written request to the Plan Administrator. Electronic copies are free, but there may be a charge if you request a paper copy.

**No COBRA Continuation Coverage Rights**

The Plan is not subject to the continuation coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time (“COBRA”).

**Alienation/Assignment**

The interests of pilots and other persons entitled to benefits under the Plan are not subject to the claims of their creditors and may not be voluntarily or involuntarily anticipated, assigned, alienated or subject to attachment, garnishment, levy, execution or other legal or equitable process, except as may be required by applicable law. Specifically, the Plan is not subject to domestic relations orders (QDROs) or other court orders calling for division of all or a portion of any HRA Account under the Plan.

**Amendment and Termination of the Plan**

While the Plan is expected to continue indefinitely, the Association reserves the right to modify, reduce, amend or terminate all or any part of the Plan at any time and for any reason, subject to the terms of the Agreement.

**ERISA Statement of Rights**

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

* Examine, without charge, at the Plan Administrator’s office and at other specified locations, all Plan documents, including collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
* Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
* Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied (through the appeal procedure) or ignored, in whole or part, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan participation does not give you any rights to continuing employment with the Company.