## Member Services Directory

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>LIFE INSURANCE AND AD&amp;D</th>
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<tbody>
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<td>Aetna</td>
<td>Prudential Life Insurance</td>
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<td>Blue Cross/Blue Shield</td>
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<td>CIGNA</td>
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<tr>
<td>United Healthcare</td>
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<td>Kaiser Permanente</td>
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<td>Humana HMO (KY)</td>
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<td>ChoiceCare/Humana HMO (OH)</td>
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<td>Prescription Medco Health Solutions</td>
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<td>DENTAL</td>
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<td>Aetna</td>
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<td>VISION</td>
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<td>VSP</td>
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<tr>
<td>DISABILITY</td>
<td></td>
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<td>Kemper National Services</td>
<td></td>
</tr>
</tbody>
</table>

| SPENDING ACCOUNTS                            |                          |
| Aetna                                        |                          |

| DISABILITY                                   |                          |
| Kemper National Services                     |                          |

### Benefits Service Center

**Telephone Enrollment**

(Available 24 hours a day except 1 a.m. to 12 noon on Sundays)

**Service Center Representative**

(Press “*0#” at main menu; 8 a.m. to 8 p.m. CST, Monday through Friday)

---

1-800-UPS-1508

Single-call access to all your benefits.

**UPSer.com**

Find the link for all your benefits and more. Look for the Personalized Directory of Health and Wellness Benefits at the Benefits tab.
When Coverage Begins
Coverage from the UPS Health and Welfare Package begins for you and your eligible dependents after 60 days of employment provided you have gained seniority. See the Plan booklet section “UPS Health and Welfare Package for Retired Employees” for eligibility provisions under that Plan.

Summary of Dental Coverage

<table>
<thead>
<tr>
<th>Coverage</th>
<th>In-network and Out-of-area</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Covered at 100%</td>
<td>Covered at 80% R&amp;C</td>
</tr>
<tr>
<td>Basic Services</td>
<td>Covered at 100%</td>
<td>Covered at 80% R&amp;C</td>
</tr>
<tr>
<td>Major Services</td>
<td>Covered at 80%</td>
<td>Covered at 50% R&amp;C</td>
</tr>
<tr>
<td>Annual maximum benefit</td>
<td>None</td>
<td>$2,500</td>
</tr>
<tr>
<td>(orthodontia not included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child orthodontia</td>
<td>Covered at 50%</td>
<td>Covered at 50% R&amp;C</td>
</tr>
<tr>
<td>Lifetime maximum orthodontia benefit</td>
<td></td>
<td>$1,500 in- and out-of-network combined</td>
</tr>
<tr>
<td>Lifetime maximum TMJ coverage</td>
<td></td>
<td>$1,500 in- and out-of-network combined</td>
</tr>
</tbody>
</table>
This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2013, unless otherwise noted below. You should keep this with your UPS Health and Welfare Package Summary Plan Description for future reference. The terms of the Plan are not changing and remain in full force and effect, except as specifically described in this Summary.

**Spending Accounts**
As part of the continued implementation of the Patient Protection and Affordable Care Act (PPACA), also known as “health care reform,” beginning January 1, 2013, the maximum employee contribution amount that you may elect to make during the Plan year to contribute to the Health Care Spending Account is $2,500.

If you elect to participate in a Health Care Spending Account, then lose eligibility (for example, you terminate employment) and later become eligible again for this Plan or any other UPS-administered plan during the same year, the maximum employee contribution amount that you will be able to elect for the remainder of the year will be reduced by the total contributions you had already made during the same year. For example, if you elected $2,500 for the year beginning January 1, 2013 and you terminate employment on March 31, 2013 after having contributed only $208, the $2,500 maximum employee contribution you can elect for 2013 will be reduced by the $208 that you already contributed, to $2,292 for the remainder of 2013.

**Mental Health Parity**
Effective January 1, 2013, out-of-network and out-of-area behavioral health claims are no longer subject to a deductible. All eligible behavioral health claims are paid at the applicable coinsurance percentage, subject to any other Plan limitations, without regard to whether you have satisfied the medical deductible. Any coinsurance amounts that you are otherwise required to pay are applied to the applicable out-of-pocket maximum.

**Behavioral Health Benefits**
*The following language is a clarification of current Plan administration of out-of-network facility claims for behavioral health benefits. All other provisions of your behavioral health benefits remain unchanged.*

If you choose to seek treatment outside the ValueOptions network, the facility or treatment center must meet the following criteria to be eligible for coverage under the Plan.
- Possess all valid and applicable state licenses
- Possess the minimum level of professional liability coverage required by law
- Meet acceptable criteria for malpractice claims history for the past five years
- Possess a Drug Enforcement Administration (DEA) certification, if applicable
- Maintain accreditation from one of the following accrediting bodies:
  - National Committee for Quality Assurance (NCQA)
  - The Joint Commission (TJC)
  - The Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Council on Accreditation (COA)
  - American Osteopathic Association (AOA)
  - Healthcare Facilities Accreditation Program (HFAP)
  - Accreditation for Ambulatory Health Care (AAAHC)
  - Det Norske Veritas (DNV)
  - Community Health Accreditation Program (CHAP)

Facilities such as therapeutic boarding schools and wilderness treatment programs often do not meet the criteria listed above and cannot be covered.

For program specific criteria, contact ValueOptions at 1-800-336-9117 to obtain detailed coverage information.

**Grandfather Plan Status**
The medical plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, 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 your Plan may not include certain consumer protections of
PPACA that apply to other plans; for example, the requirement to provide preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA; for example, the elimination of lifetime limits on essential health benefits (as defined by PPACA).

Questions regarding which protections apply and which do not apply to cause a plan to change from grandfathered health plan status can be directed to the Plan administrator at 1-800-UPS-1508. 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.

Women’s Health Rights
The Women’s Health and Cancer Rights Act requires that we notify you annually that your Plan provides coverage for the following after a covered mastectomy:

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

Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.
Summary of Material Modifications
UPS Health and Welfare Package for Retired Employees
September 2012

This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2013, unless otherwise noted below. You should keep this with your UPS Health and Welfare Package for Retired Employees Summary Plan Description for future reference. The terms of the Plan are not changing and remain in full force and effect, except as specifically described in this Summary.

### Mental Health Parity
Effective January 1, 2013, out-of-network and out-of-area behavioral health claims are no longer subject to a deductible. All eligible behavioral health claims are paid at the applicable coinsurance percentage, subject to any other Plan limitations, without regard to whether you have satisfied the medical deductible. Any coinsurance amounts that you are otherwise required to pay are applied to the applicable out-of-pocket maximum.

### Behavioral Health Benefits
The following language is a clarification of current Plan administration of out-of-network facility claims for behavioral health benefits. All other provisions of your behavioral health benefits remain unchanged.

If you choose to seek treatment outside the ValueOptions network, the facility or treatment center must meet the following criteria to be eligible for coverage under the Plan.

- Possess all valid and applicable state licenses
- Possess the minimum level of professional liability coverage required by law
- Meet acceptable criteria for malpractice claims history for the past five years
- Possess a Drug Enforcement Administration (DEA) certification, if applicable

- Maintain accreditation from one of the following accrediting bodies:
  - National Committee for Quality Assurance (NCQA)
  - The Joint Commission (TJC)
  - The Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Council on Accreditation (COA)
  - American Osteopathic Association (AOA)
  - Healthcare Facilities Accreditation Program (HFAP)
  - Accreditation for Ambulatory Health Care (AAAHC)
  - Det Norske Veritas (DNV)
  - Community Health Accreditation Program (CHAP)

Facilities such as therapeutic boarding schools and wilderness treatment programs often do not meet the criteria listed above and cannot be covered.

For program specific criteria, contact ValueOptions at 1-800-336-9117 to obtain detailed coverage information.
**Summary of Material Modifications**

**UPS Health and Welfare Package**

**UPS Health and Welfare Package for Retired Employees**

**September 2010**

This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2011, unless otherwise noted. Items noted with an asterisk (*) do not apply to retirees or their covered dependents. You should keep this with your UPS Health and Welfare Package and UPS Health and Welfare Package for Retired Employees Summary Plan Description for future reference.

### Health Care Reform*

In March, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), also known as “health care reform.” Effective January 1, 2011, PPACA requires the following changes to your UPS-administered health care plan. If the PPACA provisions requiring these Plan changes are ever repealed, the changes made solely as a result of PPACA will be terminated and the provisions of the Plan modified by PPACA will be reinstated effective the date the law is repealed.

#### Grandfather Plan Status

UPS believes this Plan is a “grandfathered health plan” as defined under PPACA. A grandfathered health plan is permitted to preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections included in PPACA which apply to other plans that are not grandfathered plans. For example, the requirement to provide preventive health services without any cost sharing does not apply to a grandfathered health plan such as your Plan. However, grandfathered health plans are not exempt from all consumer protections included in PPACA. For example, PPACA’s prohibition against lifetime limits on “essential benefits” does apply to grandfathered health plans.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator identified in the Summary Plan Description (SPD). 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 Web site has a table summarizing protections under PPACA, and which do and do not apply to grandfathered health plans.

#### Dependent Children Under Age 26

You may now cover a “Child” through the end of the month in which the child turns age 26. A “Child” is defined as your natural child, your adopted child, a child placed with you for adoption, or a child for whom you are the legal guardian (as determined in accordance with applicable law).

If you have a “Child” who previously lost coverage under your Plan, was denied coverage, or was otherwise not eligible for coverage under your Plan because he or she did not satisfy your Plan’s prior definition of dependent child (for example, your child turned age 19 but was not a full-time student), you will have 30 days, beginning the first day of the annual enrollment period, to enroll yourself (if eligible but not enrolled) and/or your child in the Plan. If you enroll your child during the 30-day enrollment period, coverage for your child will be effective on January 1, 2011 (provided that the individual is a child on January 1, 2011). Notwithstanding anything to the contrary, an otherwise eligible child is not eligible for coverage under this Plan if the child is eligible for coverage another employer-sponsored plan (other than the parent’s employer-sponsored plan—keep in mind that the child could be eligible for the parent’s employer-sponsored plan as both a dependent and an employee).

A covered child who becomes incapacitated while covered under the Plan and before he or she turns age 26 is eligible to continue coverage after turning age 26 as long as you are eligible and as long as the following conditions are satisfied: (i) the incapacity exists, (ii) the child is unmarried, (iii) the child is primarily dependent on you for support and maintenance, and (iv) appropriate certification of disability is provided. You must apply to continue coverage for an incapacitated dependent prior to age 26.

The child must have a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the claims administrator. To apply for continuation of coverage for an incapacitated dependent, contact your claims administrator. Certification of the incapacitation by the claims administrator must occur prior to coverage being continued under the Plan. Certification must also occur before coverage is lost under the Plan. In addition, periodic medical documentation of
the continuing incapacity is required as determined by the claims administrator.

In addition, the following benefits previously provided only to children under age 19 are revised as follows:

- Charges for hearing exams and one hearing aid per ear every three years for children up to age 26 (must be prescribed by an otolaryngologist).
- Benefits are allowed for teeth straightening for your dependent children under 26 years of age. Services provided by the end of the month in which your child turns 26 are covered, as long as treatment began before the child’s 26th birthday.

**Elimination of Lifetime Maximum Benefits**

Lifetime dollar limits on aggregate benefits will be eliminated from your Plan effective January 1, 2011. If you are an otherwise eligible employee whose coverage previously ended upon reaching your lifetime maximum benefit under the Plan, you will have 30 days, beginning the first day of the annual enrollment period, to re-enroll in the Plan. If you choose to enroll, your coverage is effective January 1, 2011 (as long as you continue to meet the Plan’s eligibility requirements). You may also enroll any dependents whose coverage ended upon reaching their lifetime maximum.

**Elimination of Lifetime and Annual Dollar Limits for “Essential Benefits”**

Effective January 1, 2011, lifetime and annual dollar limits on essential benefits will be administered in accordance with PPACA. This means the dollar maximums on the following “essential benefits” will be eliminated:

- Lifetime limit on orthodontia
- Annual dollar limit on infertility drugs (only for participants in the applicable Aetna HMO)

**Elimination of Pre-existing Conditions on Benefits for Children Under Age 19**

Pre-existing condition limits will be eliminated from your Plan effective January 1, 2011, for children under age 19. The following are considered by PPACA to be the only pre-existing conditions under the Plan. All language in the SPD will otherwise continue to be administered based on the terms and intent of the Plan, with only the pre-existing condition exclusions removed in the following provisions for children under age 19:

- Cosmetic/plastic surgery needed to correct a malformation as a direct result of disease, surgery performed to treat a disease, or an accidental injury that occurred prior to coverage under the Plan is not covered.
- Dentures and bridgework for replacement of teeth extracted before the patient was covered by a UPS dental option are not covered.
- Orthodontia treatment already in progress prior to becoming covered under the Plan is not covered.
- Replacement of congenitally missing teeth is not covered.

**HCSA Reimbursement of Over-the-Counter Drugs**

Any expenses incurred on or after January 1, 2011 for over-the-counter (OTC) medicines or drugs (with the exception of insulin) will be eligible for reimbursement from a Flexible Spending Account such as your health care savings account (HCSA) only if the medications are prescribed by a physician. The terms “medicines or drugs” and “prescribed” will be defined in accordance with applicable IRS regulations.

**Mental Health Parity**

Effective January 1, 2011, the administration of your behavioral health coverage will be amended per the federal regulations set forth in the Mental Health Parity and Addiction Equity Act.

**Deductibles and Out-Of-Pocket Maximums**

All behavioral health charges for out-of-network treatment will now apply to your out-of-network medical deductible.

All in-network behavioral health charges will now apply to your in-network, out-of-pocket maximum.

All out-of-network behavioral health charges will now apply to your out-of-network, out-of-pocket maximum.

**Precertification Requirements**

All inpatient behavioral health treatment (including but not limited to partial hospitalization, intensive outpatient treatment and residential treatment) must be precertified with ValueOptions. If you use a ValueOptions network provider or facility, they will begin the precertification process for you. If you have the Traditional medical option and use an out-of-network provider or facility, you are responsible for starting the precertification process yourself. If you do not call ValueOptions to precertify an inpatient stay when it is required, you will pay a $250 fee for failure to precertify. The $250 fee will not apply toward your out-of-pocket maximum. All inpatient treatment must be determined to be medically necessary by ValueOptions.

ValueOptions must always precertify the following services, regardless of whether an in- or out-of-network provider or facility is used. If you fail to have these services approved in advance, no benefits are payable.

- Psychological testing
- Complex medication management
- Electroconvulsive therapy (ECT)
- Biofeedback
- Hypnotherapy
- Aversion therapy
There is no precertification requirement for in- or out-of-network outpatient treatment. However, all treatment must be determined, by ValueOptions, to be medically necessary.

To ensure you receive the maximum benefits under the Plan, you should always contact ValueOptions at 1-800-336-9117 prior to seeking any mental health or substance abuse treatment.

Mental health parity legislation does not affect the Solutions – Your EAP and Work/Life Benefit program, also administered by ValueOptions. You are eligible to receive six free in-person visits (per issue, per year) with a licensed, in-network Employee Assistance Program provider, as well as referrals for legal, financial and work/life resources. Refer to your SPD or contact ValueOptions at 1-800-336-9117 for program details.

Hyatt Legal Plan
The Hyatt Legal Plan will offer the following new services:

- **Adoption and Legitimization (Contested and Uncontested).** This service covers all legal services and court work in a state or federal court for an adoption by the legal plan member and spouse. Legitimization of a child by the legal plan member and spouse, including reformation of a birth certificate, is also covered. This includes international adoptions.

- **Security Deposit Assistance.** This service covers counseling the participant as a tenant in recovering a security deposit from the participant's residential landlord for the participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the participant for the small claims trial. This service does not include the legal plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

### Women’s Health Rights
The Women’s Health and Cancer Rights Act requires that we notify you annually that your Plan provides coverage for the following after a covered mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of all stages of a mastectomy, including lymph edemas.

Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.

### Privacy Notice
Federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require health plans and health plan providers to protect the privacy of certain health information, while allowing the flow of information needed to provide high-quality health care. UPS has provided employees covered under a UPS-administered health care plan with a privacy notice describing the permissible uses and disclosures of health plan information.

To obtain a copy of that notice, you can:

- Visit [www.upshealthyconnections-informedchoices.com](http://www.upshealthyconnections-informedchoices.com) and click the Privacy link at the bottom of each page of the site;
- Log on to [www.UPSers.com](http://www.UPSers.com) and find your health care benefits information under the My Life and Career tab; or
- Call the UPS Benefits Service Center toll-free at 1-800-UPS-1508.
This notice is intended to fulfill UPS’s legal obligation to notify employees of material changes to the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. This notice formally amends the coverage available under the Plans.

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Summary of Material Modifications
UPS Health and Welfare Package
UPS Health and Welfare Package for Retired Employees
December 2009

This SMM excludes any employee covered by the National Master LTD Plan.

This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2010. You should keep this with your UPS Health and Welfare Package and UPS Health and Welfare Package for Retired Employees Summary Plan Description for future reference.

Long-Term Disability
Effective January 1, 2010, MetLife® will become the new long-term disability (LTD) claims administrator. The long-term disability benefits under the Plan are not changing; however, MetLife will be assuming the fiduciary responsibility.

LTD Claims On or Before December 18, 2009
If you are receiving long-term disability benefits on December 18, 2009, MetLife will assume, effective January 1, 2010, all financial and fiduciary responsibility with respect to your long-term disability benefits. UPS will no longer pay those benefits or have any responsibility to pay those benefits. If your claim is later reduced or denied by MetLife and you wish to appeal, you must appeal to MetLife, who will be the claims fiduciary with respect to such insured claims.

MetLife should contact you about your claim, but if you have any questions or issues, you can contact MetLife directly at 1-877-638-4877.

LTD Claims Incurred in 2009 and Reported On or After December 19, 2009
If you had a new or recurring disability in 2009 and reported the claim on or after December 19, 2009, MetLife will be your new claims administrator effective January 1, 2010. Until January 1, 2010, you should call Aetna Disability and Absence Management (ADAM) at 1-866-825-0186 to report any claims or if you have questions about your benefits. Effective January 1, 2010, you should contact MetLife directly at 1-877-638-4877 or online at www.metlife.com/mybenefits to file your claim. UPS will continue to fund these benefits; however, MetLife will be the claims fiduciary. If your benefits are reduced or denied by MetLife, and you wish to appeal, you must appeal to MetLife.

LTD Appeals Rights and Procedures
If your LTD claim is denied in whole or in part, you may appeal this decision. If you choose to appeal, you must do so by sending a written request for appeal directly to MetLife at:

MetLife Disability
P.O. Box 14592
Lexington, KY 40511-4592

The appeal process will continue to be a two-level process, but will be handled by MetLife instead of UPS. The first level of appeal must be filed within 180 days from the receipt of the denial. If the first-level appeal is denied, you have a right to a second-level appeal. The second-level appeal must be filed within 60 days of receipt of the first-level denial. Please include in your appeal letter the reason(s) you believe the claim was improperly denied and submit any additional comments, documents, records or other information (including medical documentation, test results, x-rays, etc.) relating to your claim that you deem appropriate. You have the right, upon request, to receive a copy of the documents, records, or other information MetLife has that are relevant to your claim. These documents may include any provided by medical or vocational expert(s) whose advice was obtained in connection with your claim.

LTD Claims Incurred On or After January 1, 2010
MetLife will insure all long-term disability benefits to the extent that you incur a disability (or are treated as having a new disability) on or after January 1, 2010, pursuant to an insurance policy issued to UPS. In this case, the insurance carrier, MetLife, is the applicable claims fiduciary and assumes all financial responsibility with respect to claims for benefits provided under the insurance contract. This means that UPS no longer has any discretionary authority
This notice is intended to fulfill UPS’s legal obligation to notify employees of material changes to the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. This notice formally amends the coverage available under the Plans.

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Summary of Material Modifications
UPS Health and Welfare Package
UPS Health and Welfare Package for Retired Employees
September 2009

This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2010, unless otherwise noted. Items noted with an asterisk (*) do not apply to retirees or COBRA participants or their covered dependents. You should keep this with your UPS Health and Welfare Package and UPS Health and Welfare Package for Retired Employees Summary Plan Description for future reference.

Medical vendor consolidation
Effective January 1, 2010, the medical claims administrators under the Plan are changing to a state-by-state designation, regardless of whether you elect the primary care physician (PCP) network, the preferred provider network (PPN), or participate in the Traditional medical option. This change impacts current Plan participants and newly eligible participants.

Your medical claims administrator, either Aetna® or BlueCross® BlueShield®, will be determined by your home ZIP Code. Refer to your 2010 annual enrollment information for the medical claims administrator who will administer benefits for your state. You will receive new medical ID cards prior to January 1, 2010.

All employees who live in the network area will now have the choice of participating in either the PCP or PPN option. If you participate in the PCP network, you will no longer be required to obtain a referral to see a specialist, although you should select a PCP as described in the Plan.

If you have a covered dependent who is a non-resident or is enrolled as a result of a Qualified Medical Child Support Order (QMCSO), he or she will be covered by the same medical carrier that provides your coverage, regardless of the state in which your dependent resides.

To learn more about your medical claims administrator, visit the Aetna or BlueCross BlueShield Web site or call their member services number. For Aetna, visit www.aetna.com and choose the Aetna Choice® POS II (Open Access) Plan or call 1-800-237-0575. For BlueCross BlueShield, visit www.bcbsil.com/ups and choose the PPO network, or call 1-800-516-1270.

Network Carrier Changes
The following HMO and/or EPO options will have network carrier changes effective January 1, 2010:

- BlueCross BlueShield EPO in Ohio will be replaced with an Aetna EPO
- CIGNA HMO in New Mexico will be replaced with a BlueCross BlueShield EPO
- Kaiser Permanente® HMO options will no longer be offered in Colorado and Oregon. Please review your annual enrollment options carefully to determine what options are available to you.

Behavioral Health Coverage
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act requires that financial requirements (for example, co-pays, deductibles and out-of-pocket limits) and treatment limits (for example, days of coverage, office visits and frequency of treatment) applicable to eligible mental health and substance abuse benefits offered under the plan be no less restrictive than the predominant financial requirements and treatment limitations imposed on substantially all of the related medical benefits covered under the Plan. All benefit requirements for medical necessity and pre-certification remain in place, as well as all previous exclusions. To ensure you receive the maximum benefits under the Plan, you should always contact ValueOptions at 1-800-336-9117 prior to seeking any mental health or substance abuse treatment.

In addition, active employees should periodically check the online Summary Plan Description (SPD) for any specific changes made pursuant to the new law.

ValueOptions must always pre-certify the following services, regardless of whether an in- or out-of-network provider or facility is used:

- All inpatient treatment (including but not limited to partial hospitalization, intensive outpatient treatment and residential treatment)
- The first 10 visits of outpatient treatment (including but not limited to individual therapy, medication management, group therapy and family therapy) per provider per lifetime do not require preauthorization. All outpatient treatment after the initial 10 visits will require preauthorization. This does not include psychiatric testing or complex medication management.
- All substance abuse treatment
- Psychological testing
- Complex medication management
• Electroconvulsive therapy (ECT)
• Biofeedback
• Hypnotherapy
• Aversion therapy

If you fail to have these services approved in advance, no benefits are payable.

The Parity legislation does not affect the Solutions – Your EAP and Work/Life Benefit program, also administered by ValueOptions. You are eligible to receive six free in-person visits (per issue, per year) with a licensed, in-network Employee Assistance Program provider, as well as referrals for legal, financial and work/life resources. Refer to your SPD or contact ValueOptions at 1-800-336-9117 for program details.

The Maintenance of Benefits provisions of the Plan apply to mental health and substance abuse benefits for participants covered by two group health plans. This means that benefits paid under the UPS medical option you select, when added to the benefits paid by another group plan for the same services, will not exceed the amounts that would have been paid under your UPS medical option. ValueOptions will require verification of other coverage once per year, prior to any claims being paid. Please refer to your SPD for more information.

In compliance with the Parity legislation, eligible mental health and substance abuse benefits will be covered at the same level as any other covered medical expense. The following table lists the new benefit levels for behavioral health coverage.

<table>
<thead>
<tr>
<th>Mental Health &amp; Substance Abuse</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Opt 1</td>
<td>Opt 2</td>
</tr>
<tr>
<td>Inpatient</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospital &amp; Facility Admission Fee</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after $10 copay</td>
<td>100% after $10 copay</td>
</tr>
</tbody>
</table>

All out-of-network treatment are subject to reasonable and customary limits

**Supplemental AD&D Coverage Rate Changes**

Supplemental AD&D coverage rates are increasing effective January 1, 2010. Refer to your rate sheet from Prudential Insurance Company of America for more information. Supplemental AD&D is an after-tax benefit paid for on an after-tax basis.

**Eligibility: Social Security Number Required**

Due to recent regulation changes, you must provide a Social Security number (SSN) to the UPS Benefits Service Center for each dependent you wish to enroll in the Plan to satisfy federal reporting requirements. This condition allows UPS to comply with a Medicare law requiring health plan administrators to electronically report data for covered plan participants to the Centers for Medicare and Medicaid Services (CMS).

Spouses, same-sex domestic partners and/or civil union partners are not eligible to begin coverage until an SSN has been provided as part of enrollment. Coverage for dependent children will begin upon enrollment. However, if a child’s SSN is not received by the due date indicated on the enrollment form, coverage for the child will be terminated retroactive to the date coverage began. You may be required to reimburse the Plan for any expenses for which benefits were paid on behalf of an otherwise ineligible dependent. See the Right of Recovery section of the SPD for more information on the Plan’s right to reimbursement.

**Eligibility: Michelle’s Law**

Eligibility for coverage for your children (and eligible stepchildren) ends on December 31 of the calendar year in which your child reaches the dependent eligibility age limit as determined by the Plan. If your child graduates from or leaves school before the age limit is reached, coverage continues through December 31 of the year in which he or she graduates or leaves; or until the child becomes covered through another plan, whichever is earlier.

However, if it is medically necessary for your covered child to take a “school leave,” meaning the child stops being a full-time student solely as a result of serious illness or injury, your child may continue to be covered under the Plan on the same terms and conditions as before the school leave.

This coverage continues until either 12 months following the year in which the school leave began; or the date coverage would otherwise end under the Plan (for example, the child reaches the dependent eligibility age limit or you terminate your employment), whichever is earlier. In order for coverage to continue, you must provide the UPS Benefits Service Center a written certification from the child’s physician that the child suffers from a serious illness or injury and that the school leave is medically necessary. Unless prohibited by federal COBRA rules, the school leave is considered a Qualifying Event for purposes of COBRA and this continuation of coverage will be applied toward the COBRA continuation coverage period.

**Eligibility: Children’s Health Insurance Program Reauthorization Act – CHIPRA**

If your child covered under the Plan experiences a loss of eligibility for a Medicaid or a state Children’s Health Insurance Program and you are covered, you may change options for your medical and/or dental coverage.
In addition, if your child covered under the Plan receives a determination by Medicaid or a state Children’s Health Insurance Program that the child is eligible for qualifying health plan premium assistance, you may change your family status and/or medical option. If you opted out of coverage, you may start coverage.

You must call the UPS Benefits Service Center (1-800-UPS-1508) within 60 days of the date of the event to request a change in coverage. You are not allowed to change coverage after the 60-day period, until the next annual enrollment period.

**Eligibility: Quit for Life**
As a clarification of current Plan administration, the Quit For Life® Tobacco Cessation Program is available to all active employees who otherwise satisfy the eligibility requirements for the UPS Health and Welfare Package, including such employees on an approved leave of absence, and their dependents who are 18 years and above and who otherwise satisfy the eligibility requirements for the Plan.

All retired employees who are enrolled in medical coverage under the UPS Health and Welfare Package for Retired Employees and who are under 65 are also available for this program, as well as their dependents who are 18 years old or older and are covered under the medical plan.

**Vendor Contact Information**
The following are updated addresses for the Plan’s administrative services providers:

**Long-Term Care**
MetLife – LTC Group
P.O. Box 927
Westport, CT 06881-0937

**Personal Line Insurance (Home & Auto)**
Metropolitan Property and Casualty Insurance Company
c/o MetLife Voluntary Benefits Group Sales
10 South LaSalle Street, Suite 350
Chicago, IL 60603

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**Women’s Health Rights**
The Women’s Health and Cancer Rights Act requires that we notify you annually that the Plan provides coverage for the following after a covered mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of all stages of a mastectomy, including lymph edemas.

Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.

**Privacy notice**
Federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require health plans and health plan providers to protect the privacy of certain health information, while allowing the flow of information needed to provide high-quality health care. UPS has provided employees covered under a UPS-administered health care plan with a privacy notice describing the permissible uses and disclosures of health plan information.

To obtain a copy of that notice, you can:

- visit [www.upshealthyconnections-informedchoices.com](http://www.upshealthyconnections-informedchoices.com) and click the Privacy link at the bottom of each page of the site;
- log on to [www.UPSers.com](http://www.UPSers.com) and find your health care benefits information under the My Life and Career tab; or
- call the UPS Benefits Service Center toll-free at 1-800-UPS-1508.
This notice is intended to fulfill UPS’s legal obligation to notify employees of material changes to the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. This notice formally amends the coverage available under the Plans.
Summary of Material Modifications
UPS Health and Welfare Package
UPS Health and Welfare Package for Retired Employees
September 2008

This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2009, unless otherwise noted. You should keep this with your UPS Health and Welfare Package and UPS Health and Welfare Package for Retired Employees Summary Plan Description for future reference.

Routine Physical Evaluations
The Plan guidelines have changed to allow one physical evaluation each year at age 50 and older.

Same Sex Partner Eligibility
As a clarification of current Plan administration, in order for your same-sex partner and his or her eligible dependents to be eligible for coverage under the UPS Health and Welfare Package or UPS Health and Welfare Package for Retired Employees, you and your same-sex partner must either: follow the same-sex domestic partner enrollment process as described in the Same-Sex Domestic Partner brochure, enter into a civil union, or be married. You must also provide the standard dependent verification documentation as required by the Plan.
Summary of Material Modifications
UPS Health & Welfare Package
UPS Health & Welfare Package for Retired Employees
April 2008

This notice details Plan improvements, changes, clarifications, and required notifications effective April 1, 2008, unless otherwise noted. You should keep this with your UPS Health and Welfare Package and UPS Health and Welfare Package for Retired Employees Summary Plan Description for future reference. Items noted with an asterisk (*) do not apply to retirees and COBRA participants or their covered dependents.

Same-Sex Domestic Partner Benefits
Effective April 1, 2008, UPS will now offer same-sex domestic partner benefits under the Plan. This opportunity allows an employee to elect coverage for his or her same-sex domestic partner and/or his or her dependent children under the Plan. Eligible same-sex domestic partners and/or their dependent children will be eligible for medical, dental, vision and other types of coverage available under the Plan. Eligibility details can be found in the Same-Sex Domestic Partner brochure and the Summary Plan Description. You can ask questions about coverage or request a copy of the Same-Sex Domestic Partner brochure by calling the Benefits Service Center at 1-800-UPS-1508.

Life Insurance Benefits*
Effective April 1, 2008, UPS, through the insurance contract with Prudential, will now provide eligible covered same-sex domestic partners and/or their dependent children with basic and supplemental life insurance. An eligible same-sex domestic partner and/or his or her dependent children will be eligible to elect the same amounts of insurance and be subject to evidence of insurability requirements imposed on all other covered dependents under the Plan.

Women’s Health and Cancer Rights Act
The Women’s Health and Cancer Rights Act requires that we notify you annually that the Plan provides coverage for the following after a covered mastectomy:
− Reconstruction of the breast on which the mastectomy was performed
− Surgery and reconstruction of the other breast to produce a symmetrical appearance
− Prostheses, and
− Treatment of physical complications of all stages of a mastectomy, including lymph edemas.

Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.
Summary of Material Modifications
UPS Health and Welfare Package
UPS Health and Welfare Package for Retired Employees
October 2007

Each year we announce material changes to the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. This notice details Plan improvements and required notifications effective January 1, 2008 unless otherwise noted. Items noted with an asterisk (*) do not apply to retired employees and COBRA participants.

Group Legal Plan*
The Signature LegalCare legal assistance plan will be replaced by the Hyatt Legal Plan, available from MetLife®. If you are currently participating in Signature LegalCare and want to have coverage in the new legal plan for 2008, you do not need to enroll in the Hyatt Legal Plan during annual enrollment—your coverage for legal assistance benefits in 2008 will be through the Hyatt Legal Plan. If you’re currently using a legal professional under the current plan, you should check to see if he or she is a participating provider through the new Hyatt Legal Plan for services provided in 2008. If you do not currently have legal assistance coverage through the Plan, and are not in an area that has a separate, negotiated group legal plan, you may begin receiving legal benefits in the Hyatt Legal Plan for 2008. To enroll, call the Benefits Service Center during annual enrollment at 1-800-UPS-1508.

Personal Lines Insurance*
Auto and home insurance from MetLife Auto & Home®, made available to UPSers August 1, 2007, will continue to provide UPSers with an additional choice in personal lines insurance in 2008. The MetLife Auto & Home program is available in all 50 states; and discounts such as safe driving, anti-lock brakes and others may be available in your state. Whether or not you are currently enrolled in auto and/or home insurance from Liberty Mutual, you may choose to purchase one or more policies from either Liberty Mutual or the new MetLife Auto & Home option—whichever best meets the needs of you and your family.

Spending Accounts*
To comply with Internal Revenue Service regulations, there are two changes to the administration of the Flexible Spending Accounts.

1. Effective July 1, 2007, all receipts submitted to the Health Care Spending Account for reimbursement of copayments or coinsurance must clearly state that the expense is a copayment or coinsurance. Any receipt that does not clearly identify the expense as a copayment or coinsurance for a qualified medical expense will be returned to the participant with a request for the additional information needed to process the claim.

2. Under the Child/Elder Care Spending Account, you will no longer be reimbursed for any portion of overnight camp, even if the daytime portion is broken out from the total camp fee on your receipt. To receive reimbursement for the daytime expense of any overnight camp, your receipt must include only the expenses for the daytime portion. Otherwise, your claim will be denied with no opportunity to resubmit it listing only the daytime portion.

Solutions
Effective January 1, 2007, Plan administration of outpatient treatment and the use of out-of-network providers is modified as follows.

Out-of-Network Providers
You no longer have to seek a core specific certification provider if you seek care outside the ValueOptions network; however, the provider must hold the highest level of license or certification that the state in which they are practicing offers. Because licensing requirements vary from state to state, it is best to
call ValueOptions before you start treatment to verify that you are seeing an appropriate provider.

**Network Carrier Changes**
The BlueCross BlueShield New England HMO will be replaced with the UnitedHealthcare Choice EPO in the following states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Please review your annual enrollment options carefully to determine what options are available to you. If you are currently a participant in the BlueCross BlueShield New England HMO, you should have already received a letter by mail about the changes that may affect you, as well as detailed information about the new EPO.

**Long-Term Disability***
*Although this language was included in the SMM effective August 1, 2004, it was not reflected in the most current printing of the Summary Plan Description:*

If you are an employee covered by another LTD benefit plan that UPS administers or makes contributions for, you are not eligible for long-term disability benefits under the UPS Health and Welfare Package.

**Civil Unions**
Effective July 30, 2007, UPS is pleased to offer eligible employees the opportunity to cover their same-sex civil union partners and eligible dependent children of their same-sex civil union partners. Currently New Jersey, Vermont and Connecticut provide the opportunity for same-sex couples to legally and formally recognize their commitment to one another in a civil union ceremony.

If you participate in the Health and Welfare Package or the Health and Welfare Package for Retired Employees, you may be eligible to elect certain benefits—such as medical, dental and vision coverage—for your same-sex civil union partner and his or her eligible dependent children. However, there are many legal and tax implications you should consider.

Additionally, certain insured products—such as life insurance—may not provide coverage to civil union partners and/or dependent children of same-sex civil union partners. Consequently, if you are covered through one of these insured products, no civil union partner coverage may be available. You should contact the insurance carrier directly with any questions about eligibility.

Civil union partners are not considered spouses under the Internal Revenue Code. Accordingly, they may not receive tax-free benefits from employer benefit plans. Any benefits received by a civil union partner and/or his or her children must be taxed.

As a result, the full cost of medical, dental and vision coverage for your civil union partner and his or her eligible dependent children will be added to your income and subject to federal, state and local taxes, as well as applicable employment and payroll taxes. These additions—known as imputed income—are based on the price of the coverage you select. (After-tax benefits are not affected by imputed income.) If the civil union partner and/or his or her children are the employee’s tax dependents under the Internal Revenue Code, benefits are not taxable.

If you have deductions for your coverage, your civil union partner and/or his or her eligible dependent children will also cause deductions just as it would for any employee. However, the full value (the price tag) of civil union partner benefits will be taxed and shown as imputed income in your gross wages on your paycheck and your year-end W-2 statement. A separate line-item, DOMPARTBEN, will appear on your pay stub.*

To find out further details about these benefits, you can contact the Benefits Service Center at 1-800-UPS-1508 to request a copy of the UPS Health and Welfare Package Civil Union brochure.

Please note: This opportunity does not remove the eligibility requirement in the UPS Health and Welfare Package for Retired Employees that your eligible dependents must be eligible at the time of your retirement.

*Retirees may also be eligible for civil union partner and child coverage, depending on your Plan’s standard dependent eligibility rules found in your Summary Plan Description. Although retirees do not have payroll deductions, you may still have imputed income as a result of your civil union partnership and retiree Plan costs, if any. Retirees who have a civil union partner and/or civil union dependent children will be sent a W-2 statement at the end of the year with the value (the price tag) of your civil union partner benefits.
Life Events*
Although this language was included in the SMM effective January 1, 2006, it was not reflected in the most current printing of the Summary Plan Description and did not indicate that it does not apply to retirees.

If you experience any of the following events, you may change medical, dental, and vision options (if multiple options are offered) in addition to other changes you are permitted to make as set forth in the life events chart:

- Marriage
- Birth, placement for adoption, child gains eligibility
- You or your spouse lose other group health coverage

Life Insurance and AD&D*
With the implementation of a new contract with Prudential Life Insurance, supplemental life insurance and accidental death and dismemberment (AD&D) rates have changed. The new rates for 2008 are listed in the table on the following page. Rates shown are your cost per year for each $1,000 of supplemental coverage.

<table>
<thead>
<tr>
<th>Age</th>
<th>Employee Supplemental Life</th>
<th>Spouse Supplemental Life</th>
<th>Child Supplemental Life</th>
<th>Employee Supplemental AD&amp;D</th>
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<td>Non-Smoker</td>
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<td>229.84</td>
<td>197.70</td>
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</table>

*Child Supplemental Life rates are for $2,500 or $7,500 of supplemental coverage, respectively. All rates shown are your cost per year for each $1,000 of coverage.
Summary of Material Modifications
UPS Health and Welfare Package
UPS Health and Welfare Package for Retired Employees
February 2007

This notice details Plan improvements, changes, clarifications, and required notifications effective February 1, 2007. You should keep this with your UPS Health and Welfare Package and UPS Health and Welfare Package for Retired Employees Summary Plan Description for future reference.

Quit For Life™ Tobacco Cessation Program
Effective February 1, 2007, UPS is offering a new tobacco cessation program benefit as a component of the UPS Health and Welfare Package and UPS Health and Welfare Package for Retired Employees to help participants quit tobacco use. All tobacco types are included (cigarettes, cigars, and smokeless tobacco).

What the Program Includes
• Up to five outbound counseling and intervention calls to you.
• In-depth assessment to evaluate readiness to quit tobacco use.
• Assistance and support with over-the-counter Nicotine Replacement Therapy (NRT) in the form of patch or gum only. If you decide that NRT is right for you, this program provides direct mail order of NRT. There is no cost to the participant for the NRT. This program provides assistance and support with NRT throughout the program cycle.
• Assistance and support regarding prescription medications such as bupropion and Chantix.
  Note: Prescription medication is not covered under this program. If you are a participant in the Medical Plan, you should check your Medical Plan’s Summary Plan Description (SPD) for prescription drug coverage information. Assistance and support provided by Free & Clear®, the program’s administrator, should not be a substitute for your doctor’s advice.
• Quit Guide sent to your home following program registration.
• Unlimited and easy access to quit coaches through a toll-free number for twelve months from the time of enrollment.
• Access to Web Coach™, an interactive Web site that helps you stay on track between calls.

Eligibility
.Quit For Life is available to all active and retired employees under age 65 who are covered under the Medical Plan that is a component of the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. Quit For Life is also available to all dependents of such active and retired employees who are age 18 years and older covered under the Medical Plan.

Enrolling/Registering In Quit For Life
Contact a quit coach at 1-866-QUIT-4-LIFE (1-866-784-8454) or online at www.freeclear.com/ups. TTY is available at 1-877-777-6534.

The Quit For Life program provides two lifetime quit attempt cycles per individual. For example: If, at the time of your fifth outbound intervention call you have not been successful in your attempt to quit, you will be offered an opportunity during the call to re-enroll in the Quit For Life program. If you choose not to re-enroll at that time, you will be called again six months after your initial enrollment date and invited to re-enroll. This allows the Quit Coaches to build on your success and keep the positive momentum going; remembering that behavior change is a process, and each time you attempt to quit you are getting closer toward the ultimate goal of being tobacco free.

You and/or your dependent must provide your employee ID number to prove eligibility when contacting Quit For Life.
Plan Administration
Quit For Life is administered by:
Free & Clear, Inc.
999 Third Avenue, Suite 2100
Seattle, WA 98104

Short-Term Disability
The claims administrator for short-term disability coverage, Aetna, has changed its name to Aetna Disability and Absence Management (ADAM). You can file a claim online through a link at UPSers.com under the My Life and Career tab or directly at www.wkabsystem.com; or by calling 1-800-UPS-1508.

You will need to register as a new user the first time you access the site. From the www.wkabsystem.com home page:
• Click New User Registration.
• Enter UPS as the Company Identifier.
• To create your account, enter your Employee ID as the User ID, and choose a password you’d like to use.

Women’s Health and Cancer Rights Act Notice
The Women’s Health and Cancer Rights Act requires that we notify you annually that the Plan provides coverage for the following after a covered mastectomy:
• Reconstruction of the breast on which the mastectomy was performed.
• Surgery and reconstruction of the other breast to produce a symmetrical appearance.
• Prostheses.
• Treatment of physical complications of all stages of a mastectomy, including lymph edemas.

Coverage is subject to the same deductible, coinsurance provisions and other limitations and exclusions applicable under the Plan.
Summary of Material Modifications
UPS Health and Welfare Package
UPS Health and Welfare Package for Retired Employees
October 2006

Each year we announce material changes to the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. This notice details Plan improvements and required notifications effective January 1, 2007. Items noted with an asterisk (*) do not apply to retired employees.

Medical
Preventive care
The Plan now will provide preventive care coverage for Gardasil, a new vaccine intended to help prevent cervical cancer. Current eligibility for receipt of the vaccine is defined as girls and women between ages 9-26. The vaccine is a series of three parts given over a 180-day period. Coverage of the Gardasil vaccine will be the same as other preventive care vaccinations under the Plan.

Additionally, coverage for Well-Child Care has increased from six visits up to age one year, to seven visits.

Network administration change
The Blue Cross Blue Shield (BCBS) Point of Service (POS) plans in Indiana, Kentucky, Ohio, South Carolina and Wisconsin will have claims administration processed in a different location. The Member Services phone number also will change.
- The new Indiana, Kentucky, Ohio, and Wisconsin BCBS Member Services phone number is 1-800-514-4541.
- The new South Carolina BCBS Member Services phone number is 1-800-821-3023.

Claims should be submitted by network to:

Indiana
P.O. Box 37010
Louisville, KY 40233-7010

Kentucky
P.O. Box 37690
Louisville, KY 40233-7690

Ohio
P.O. Box 37180
Louisville, KY 40233-7180

South Carolina
BlueChoice Healthplan
P.O. Box 6170
Columbia, SC 29260-6170

Wisconsin
P.O. Box 34210
Louisville, KY 40232-4210

If there is a change from information currently on your medical ID card, you will receive a new medical ID card with the new member service number and claims filing address prior to January 1, 2007. Please present this new card to your providers.

Spending Accounts*

Health Care Spending Account
For the Health Care Spending Account only, a “dependent” for whom you may claim eligible health care expenses is any individual who satisfies the requirements of Internal Revenue Code Section 105(b). Generally, this will be anyone you could claim as a dependent on your federal tax return unless:
- The individual has income in excess of the income threshold established for “qualifying relatives” (as defined by IRS Publication 502)
- You are a dependent of another person, or
- The individual is a child of yours who is married and files a joint tax return with his or her spouse.

In addition, a child of divorced or separated parents is considered a dependent of both parents for purposes of the HCSA, without regard to which parent claims the child on his or her tax return (if the child receives over half of his or her support from one or both parents and lives with one or both parents for more than half the year).

Child/Elder Care Spending Account (C/ESA)
Eligible dependents for the C/ESA only include the following (if they reside with you):
- A qualifying child of the employee who is age 12 or younger according to Internal Revenue Code Section 152(a)(1)
- Your spouse who is physically or mentally incapable of caring for her or himself and who resides with you for more than half the year
- A dependent of any age (including a parent) who is physically or mentally incapable of caring for her or himself and who resides with you for more than half the year

A dependent for purposes of the C/ESA is any individual whom you could claim as a dependent on your tax return (as defined by Internal Revenue Code Section 152) and anyone that you could otherwise claim as a dependent on your federal tax return unless:
- The individual has income in excess of the exemption amount set forth in Internal Revenue Code Section 151,
- You are a dependent of another person, or
- The individual is a child of yours who is married and files a joint tax return with his/her spouse.

In addition, a child of divorced or separated parents who resides with one or both parents for more than half of the year and receives over half of his or her support from one or both parents may only be the qualifying individual of the custodial parent without regard to which parent claims the child on his or her tax return.
Disability Into or After Retirement

The following language adds clarification to current Plan administration:

For disabled individuals entitled to Medicare as a result of a disability, the Plan will continue to provide coverage, supplemental to Medicare (i.e., Medicare is primary), until the normal coverage end date. In order to coordinate with Medicare, you and your family will receive the Traditional Program coverage.

Life Events\(^1\)

If you experience any of the following events, you may change medical, dental, and vision options (if multiple options are offered) in addition to other changes you are permitted to make as set forth in the life events chart:

– Marriage
– Birth, placement for adoption, child gains eligibility
– You or your spouse lose other group health coverage

\(^1\) Although this language was included in the SMM effective January 1, 2006, it was not reflected in the most current printing of the SPD.

Women’s Health and Cancer Rights Act

The Women’s Health and Cancer Rights Act requires that we notify you annually that the Plan provides coverage for the following after a covered mastectomy:

– Reconstruction of the breast on which the mastectomy was performed;
– Surgery and reconstruction of the other breast to produce a symmetrical appearance;
– Prostheses, and
– Treatment of physical complications of all stages of a mastectomy, including lymphedemas.

Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.

This notice is intended to fulfill UPS’s legal obligation to notify employees of significant changes to the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. This notice formally amends the coverage available under both Plans. Keep this notification with your Summary Plan Description for future reference.
Solutions – Your Employee Assistance Program and Work/Life Benefit

Effective June 1, 2006, UPS is offering you a new Employee Assistance Program (EAP) to help you balance your responsibilities at work and in your personal life.

The program, which is a component of the medical plan, offers free and confidential assistance with many of the work-life challenges you face each day. Solutions – Your Employee Assistance Program and Work/Life Benefit (Solutions), administered by ValueOptions, provides practical solutions, information, advice and support for a wide range of work-life issues including, but not limited to anxiety, depression, child or senior care, relationship or marital issues, alcohol or substance abuse, finding colleges, bereavement, financial or legal concerns, and parenting challenges.

Solutions can help you handle problems that affect your physical and mental well-being, as well as your relationships. Solutions offers confidential access 24 hours a day, 365 days a year to trained professionals who can discuss your question, problem, or concern. Depending on your situation, the Solutions counselor may do the following:

- Refer you to a licensed network EAP provider in your community for up to six in-person visits at no cost to you,
- Link you to available resources in your community;
- Offer you support over the telephone.

Additionally, if the counselor determines the situation requires it, you may be referred for additional assistance through the mental health or substance abuse coverage offered through your medical Plan. Any information about your call or treatment is confidential and may only be disclosed as permitted or required by law.

Solutions also provides access to a national network of independent attorneys who have experience in a variety of legal areas including bankruptcy, estate planning, taxes, family law, consumer and financial matters and traffic violations. For financial concerns, Solutions provides telephonic information and advisory services utilizing independent professionals with experience in financial matters, such as financial planners, certified public accountants and insurance specialists.

If legal representation is needed, Solutions will provide a referral to a local network attorney who will provide an initial one-half (1/2) hour face-to-face consultation at no charge and will provide additional legal services at a 25 percent reduction of their customary fees. You are responsible for all fees beyond the free initial consultation.

The attorneys and financial professionals will assist you with most situations, but some restrictions do apply. These restrictions include, but are not limited to:

- Employment issues – no advice will be offered on disputes between employee and employers;
- Corporate law – questions pertaining to corporate law, including those generated from employee or spousal-owned businesses, will not be answered;
- Second opinions – advice will not be given on how another attorney is handling a legal situation or rendering a subsequent opinion in case law;
- Third-party callers – participants cannot seek advice to help with someone else’s legal problems;
- Investments – financial professionals will not provide advice regarding specific investments vehicles such as stocks, bonds, or mutual funds. They can, however, provide advice on investment strategies.

UPS provides no warranties or representations regarding the quality of services provided by each individual attorney or financial professional.

Other Solutions services include educational materials that are provided to supplement referrals and include articles, checklists, booklets and pamphlets written by specialists and renowned experts and organizations. This additional information and support includes over 1,075,000 resources such as child and adult care providers, schools, colleges, and adoption services.
Eligibility
Solutions is available to all active employees and eligible dependents, employees on an approved leave of absence and all COBRA participants who elect to continue medical coverage. You do not have to enroll for this program, it is provided to you and your eligible dependents at no cost. Coverage begins when you and/or your dependents become eligible for health plan coverage. Please refer to the eligibility section in your Summary Plan Description booklet for details regarding eligible dependents and when coverage begins.

Contacting Solutions
You can contact Solutions by phone at 1-800-336-9117 or online at www.achievesolutions.net/UPS. You will need to provide sufficient information, as determined by the plan administrator, to prove eligibility when contacting Solutions.

Plan Administration
This section of your Summary Plan Description is amended to include this information.

Solutions – Your Employee Assistance Program and Work/Life Benefit is administered by:

ValueOptions
1199 S. Beltline Road, Suite 100
Coppell, TX 75019

Any appeals should be directed to ValueOptions.

Women’s Health and Cancer Rights Act Notice
The Women’s Health and Cancer Rights Act requires that we notify you annually that the Plan provides coverage for the following after a covered mastectomy:
− Reconstruction of the breast on which the mastectomy was performed;
− Surgery and reconstruction of the other breast to produce a symmetrical appearance;
− Prostheses, and
− Treatment of physical complications of all stages of a mastectomy, including lymph edemas.

Coverage is subject to the same deductible, coinsurance provisions and other limitations and exclusions applicable under the Plan.

Disability
Please note, your disability administrator has changed its name from Broadspire to Aetna.
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Overview of the Plan

Concern for the security and well-being of you and your family is the cornerstone of our benefits philosophy. We regard our benefits expenditures as an investment in your health and security. This book describes provisions of two plans: 1) the UPS Health and Welfare Package (for eligible employees) and 2) the UPS Health and Welfare Package for Retired Employees (for eligible retired employees — see page 84). Both Plans are designed to ensure that you receive value for the benefit dollars spent. Each Plan offers you a variety of benefit opportunities, allowing you to customize your benefits package to meet your own unique needs. Because your needs will change over time, you can select new benefits annually.

You have up to three medical options from which to choose:
- Option 1 — Primary Care Physician (PCP) Network
- Option 2 — Preferred Provider Network (PPN)
- HMO Option — Health Maintenance Organization

The Traditional Program is available if you live outside the boundaries of the medical options.

Comprehensive basic benefits include:
- medical, including prescription drug coverage and mental health/substance abuse*
- dental*
- vision*
- basic employee life and accidental death and dismemberment (AD&D) insurance
- basic spouse’s and children’s life insurance
- short-term disability
- adoption assistance

*Only medical, dental and vision coverage are provided under the UPS Health and Welfare Package for Retired Employees.

In addition you may elect and pay for the following supplemental coverages:
- supplemental employee life insurance
- supplemental employee AD&D
- supplemental spouse’s life insurance
- supplemental children’s life insurance
- group legal (in areas that do not have a separate legal benefit plan)
- personal lines insurance
- health care spending account (HCSA)
- child/elder care spending account (C/ECSA)
- long-term disability coverage (full-time employees only)

How the Plan Works

The key to the UPS Health and Welfare Package is choice, and that’s important because everyone has different lifestyles and different benefit needs. That’s why there are up to three medical plan options, dental and vision plan networks, and many other supplemental benefit options. Depending on your choices, your employment date and the benefit options you select — you may or may not have to make a contribution for coverage.

You can change your benefit choices each year during the annual enrollment period. The benefits you select at that time will be effective for the following calendar year.

The only time that you can change your benefits selections during the year is if you have a family status change, such as marriage, birth of a baby or adoption. See the Life Events section for more information on status changes.

This book describes provisions of two Plans: 1) The UPS Health and Welfare Package (for eligible employees) and 2) The UPS Health and Welfare Package for Retired Employees (for eligible retired employees).

Although much of the medical, dental and vision coverage provided by both Plans is similar, there are differences. See page 84, Retired Employee Health Care Coverage, for details.
Levels of Coverage
Medical and Legal
If you enroll for medical or legal, you’ll be asked to choose one of the following levels of coverage:
- you only
- you plus family (spouse and/or children)

You may enroll for legal coverage as long as you don’t currently participate in a negotiated group legal plan.

Life and AD&D
UPS automatically provides basic life insurance for you, your spouse and dependent children, and basic accidental death and dismemberment insurance (AD&D) for you. In addition, you may also choose:
- group supplemental life and/or AD&D for yourself
- supplemental life insurance for your spouse
- supplemental life insurance for your children

Paying for Supplemental Benefits
With the Health and Welfare Package, UPS doesn’t decide which, if any, supplemental benefits to purchase for you...you decide for yourself.

Depending on the choices you make and their associated cost, you may have a payroll deduction contribution. Each year you will receive information explaining your choices and your contribution amount, if any.

Taxes and Your Benefits
One of the advantages of the UPS Health and Welfare Package is that you can pay your portion, if any, for many benefits on a before-tax basis. You’re able to do this because the Plan falls under Section 125 of the Internal Revenue Code, which states that employees do not pay tax on the amount they pay for certain benefits. (The tax advantages for the child/elder care spending account are similar, but based on Section 129 of the Code.)

The following chart shows which benefits are paid for before-tax and after-tax:

<table>
<thead>
<tr>
<th>Before-Tax</th>
<th>After-Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent medical*</td>
<td>Employee supplemental life insurance</td>
</tr>
<tr>
<td>Spending accounts</td>
<td>Spouse’s supplemental life insurance</td>
</tr>
<tr>
<td>Supplemental AD&amp;D</td>
<td>Children’s supplemental life insurance</td>
</tr>
<tr>
<td></td>
<td>Legal</td>
</tr>
<tr>
<td></td>
<td>Long-term disability</td>
</tr>
<tr>
<td></td>
<td>Personal lines</td>
</tr>
</tbody>
</table>

*Dependent coverage may require a before-tax contribution, depending on your employment date and negotiated eligibility.
Eligibility

As a bargaining unit employee of UPS, you’re eligible to participate in the UPS Health and Welfare Package per the terms of your collectively bargained agreement. Please see your Insert for specific details of your group’s eligibility for coverage.

For eligibility provisions of the UPS Health and Welfare Package for Retired Employees, see page 84.

Eligible Dependents

It’s important that you know exactly what “dependent” means. The term has the same meaning for medical, dental, vision, life insurance and legal coverage, and different meanings for the Health Care Spending Account and the Child/Elder Care Spending Account.

Medical, Dental, Vision, Life Insurance and Legal Coverage

You may enroll your dependents for coverage if the dependent is:

- your legal spouse as defined by applicable state law*
- an unmarried child who is:
  - a natural child; an adopted child (or a child placed for adoption); a stepchild living with you at least half of the time; a stepchild who is a full-time student away from home, provided that the stepchild lived with you at least one half of the time in the year immediately prior to the year the stepchild became a full-time student away from home; or a child living with you for whom you are a court-appointed legal guardian or custodian, and
  - under age 19 and financially dependent on you, or up to age 25 if a full-time student and still financially dependent on you, or an incapacitated child (see next column).

*If your spouse is your legal spouse under the common law of the state in which you reside, you will be required to provide evidence of the state’s law on common law marriages and evidence that you meet such legal requirements.

The Plan Administrator may periodically request proof of dependent status. Failure to provide proof may result in termination of dependent coverage.

For the UPS Health and Welfare Package, “placed for adoption” means that you have become legally obligated to support the soon-to-be-adopted child as a result of beginning the adoption process.

A student is considered full-time if s/he meets the requirements of full-time status for the school s/he attends. You must certify your child’s student status each year during annual enrollment or s/he will lose coverage for the following year.

Your children’s (and eligible step-children’s) eligibility for coverage ends on December 31 of the calendar year in which they have their 19th birthday (or 25th birthday if full-time students). You must certify your child’s student status each year during annual enrollment or s/he will lose coverage for the following year. If your child graduates from or leaves school before the age limit is reached, coverage continues through December 31 of the year in which s/he graduates or leaves, or until s/he becomes covered through another plan, if earlier.

If your dependent loses eligibility for any other reason, for example marriage, coverage ends on the date of the event.

Incapacitated Children

A child who becomes incapacitated before age 19 (or before age 25, if a full-time student) is eligible to continue certain coverages as long as the incapacitation exists. This continuing coverage is available as long as the child becomes incapacitated while covered by the Plan, is unmarried and depends primarily on you for support and maintenance.

The child must have a mental or physical incapacitation that renders the child unable to care for herself/himself, as determined by the network manager or claims
administrator. For this purpose, the incapacitation needs to be verified before coverage can be continued. In addition, periodic medical documentation of the continuing incapacitation is required as determined by the network manager or claims administrator.

Health Care Spending Account
For the Health Care Spending Account, you may claim eligible health care expenses for anyone you claim as a dependent on your federal income tax return (e.g., dependent children or elderly parents). These dependents do not have to be covered by the UPS Health and Welfare Package.

Child/Elder Care Spending Account
Eligible dependents for the Child/Elder Care Spending Account include the following if they reside with you:
- children age 12 or younger
- your spouse who is physically or mentally incapable of caring for himself or herself
- dependent of any age (including a parent) residing in your home for at least eight hours a day, who is physically or mentally incapable of self-care and dependent on you for at least 50 percent of his or her financial support.

When Spouses or Children Are UPSers
If you and your spouse or child both work for UPS and are both eligible for the UPS Health and Welfare Package, the following conditions apply:
- Each of you may select employee coverage under the medical, dental and vision options. Only one spouse may elect coverage for your eligible children.
- Each of you can be covered only once; you may not be covered as both an employee and a spouse or child of an employee. You may select coverage for your spouse or child as your dependent and your spouse or child may select no coverage. Your spouse or child should then be listed on your enrollment form as a dependent whom you want to cover.
- You and your spouse or child may each select employee life insurance as an employee.* Only one spouse may select life insurance coverage for your eligible children.

If you are eligible for the UPS Health and Welfare Package and your spouse or child is covered by another UPS-sponsored plan (e.g., Flexible Benefits Plan, UPS Health and Welfare Package for Retired Employees or a multi-employer health care plan to which UPS contributes):
- You may select any available family coverage option (you only or you plus family).
- You may enroll your spouse or child in the UPS Health and Welfare Package. (However, your spouse or child will continue coverage through the multi-employer plan and UPS will continue to contribute to that plan on your spouse’s or child’s behalf.)
- You may decide not to participate in the Plan. Your coverage would be provided by your spouse’s or child’s plan based on that plan’s eligibility provisions (parents are not covered by most health care plans). However, you may select participation in the other coverages in the Health and Welfare Package: life insurance*, AD&D, legal, spending accounts and personal lines insurance.

Refer to “Maintenance of Benefits,” page 76, for information about how the Plan pays benefits when you have coverage from two plans.

QMCSCO
Medical (including HCSA), dental and vision coverage will comply with the terms of a Qualified Medical Child Support Order (QMCSCO) to the extent that a QMCSCO does not require the Plan to provide coverage it does not otherwise provide. A medical child support order is a judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction or an administrative process established under state law which has the force and effect of law or a judgment from a state court directing a plan administrator to cover a child by a company’s group health plans.

*If your spouse or child is eligible for supplemental life insurance through the UPS Health and Welfare Package, the Flexible Benefits Plan or the UPS Crewmembers Benefit Package, you are not eligible to cover your spouse or child for supplemental life insurance through the UPS Health and Welfare Package. Your spouse or child must elect employee supplemental life insurance through her/his own employee plan.
Federal law requires that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child covered by the order will be notified of the implementation procedure to determine if the order is valid. If you have any questions or would like to receive a copy of the UPS written procedure for determining whether a QMCSO is valid, please contact your Human Resources department.

When Coverage Starts

All full-time and part-time regular seniority employees eligible for coverage from a UPS-administered or contributory plan and their eligible dependents are eligible for comprehensive basic and supplemental benefits from this Plan on their group’s initial effective date.

If you were not eligible for coverage on your group’s initial effective date:

- Comprehensive basic coverage for you and your dependents begins after the number of calendar days of employment specified in your Insert, providing you have gained seniority. Please refer to the applicable collective bargaining agreement for a definition of seniority.
- Optional supplemental benefit coverage begins on January 1 following the next annual enrollment after you become eligible for comprehensive basic benefits.

Coverage could be delayed for all benefits except medical, dental and vision in the following circumstances:

- If you’re ill or injured and absent from work on the date your coverage should start, coverage starts on the day you return to work. Your dependents’ coverage is also delayed until your coverage starts.
- If your dependent is ill or injured and confined at home, in a hospital or in another facility providing health care on the day coverage should start, his or her UPS Health and Welfare Package coverage begins 31 days after the end of the confinement, or with satisfactory evidence of his or her good health if earlier than 31 days.

For information about the special rules that govern the effective date of life insurance coverage, see the Life Insurance and AD&D section.

How Long Coverage Lasts

In general, your UPS Health and Welfare Package coverage continues as long as you meet the Plan’s eligibility requirements. Your dependents coverage will continue as long as you remain eligible for the Plan and your dependents meet the eligibility requirements. (Please see the Life Events section for more details.) However, UPS reserves the right to amend or terminate the Plan at any time.

For UPS Health and Welfare Package for Retired Employees enrollment information, see page 84.
Enrollment

There are three types of UPS Health and Welfare Package enrollments:

- Initial enrollment for all full- and part-time seniority employees eligible for coverage prior to their group’s initial effective date
- Initial enrollment for newly hired employees who become eligible for the first time and rehired eligible employees who were not previously eligible in the current Plan year
- Annual enrollment which happens every year during the fourth quarter

Initial Enrollment Between Annual Enrollment Periods

If you become eligible for benefits after annual enrollment has ended for the year, you’ll choose from the following list of available coverages for you or you and your family:

- Medical Option 1 — Primary Care Physician Network
- Medical Option 2 — Preferred Provider Network
- HMO Option — Health Maintenance Organization

Dental and vision are automatic features if you elect medical coverage. You will also receive the following coverage:

- employee basic life insurance
- employee basic AD&D
- spouse’s and children’s basic life insurance
- short-term disability
- adoption assistance

At the next annual enrollment, you may select new benefit choices.

Annual Enrollment

Each year you will have the option to keep your present coverage or change to any other available options. In addition to the options available if you enroll between annual enrollments, you may also choose:

- employee group supplemental life insurance
- spouse’s and children’s supplemental life insurance
- employee supplemental AD&D insurance
- health care or child/elder care spending accounts
- group legal coverage
- long-term disability (full-time employees only)

You are also eligible to participate in the personal lines insurance after your first annual enrollment.

If You Do Not Enroll

If you do not enroll for Plan coverage within your initial enrollment period (45 days from the date your enrollment kit is created), you’re automatically assigned the following Basic Coverage:

- Medical Option 2 — including dental and vision, for you or you and your family (based on your dependents on file on your enrollment deadline)
- employee basic life insurance
- employee basic AD&D
- spouse’s basic life insurance
- children’s basic life insurance
- short-term disability

At future annual enrollments, if you do not make new benefits selections you’ll receive the same coverage for you and your dependents that you had in the prior year, except in the following situations:

- If you wish to continue participation in the spending accounts — you must annually elect participation in the spending accounts.
- If your dependent child is a full-time student age 19 or older — you must certify full-time student status each year during annual enrollment to maintain their coverage. If you do not certify student status, coverage will end on December 31 of that Plan year.

If your child’s coverage ends as a result of your failure to certify her/his student status, coverage can be reinstated effective the date your child returns to school full-time (not retroactively to January 1). You must call the UPS Benefits Service Center within 60 days of the return-to-school date in order to add your dependent to your coverage.

Opting Into the Network

If you live outside the network area (out-of-area) but feel the network is convenient to you, you may elect to participate in the network. See page 16 for details.
Life Events

The Health and Welfare Package is regulated by the Internal Revenue Code, and changes during the year are restricted. However, the IRS realizes that certain events do occur during the year that create the need for you to change your benefit choices.

You're allowed to change certain benefit selections during the year depending on the type of change in your family status that occurs — as long as the change in selection is consistent with the change in status. As a general rule, you will only be allowed to make coverage changes if the event results in you, your spouse, or your dependents gaining or losing coverage eligibility under an employer-sponsored plan. For example, if you have a baby, you can change your level of medical coverage from employee plus spouse to employee plus spouse and children, but you may not decrease your life insurance.

60-Day Time Limit

You must call the UPS Benefits Service Center (1-800-UPS-1508) within 60 days of the date of the event to request a change in coverage. You're not allowed to change coverage after the 60-day period — until the next annual enrollment period.

Effective Date of Revised Coverage

Revised coverage is effective retroactive to the date of the event, with the following exceptions:

- life insurance*
  - For life insurance requiring evidence of insurability, the requested level of coverage is effective when approved by Prudential. Until then, the highest level of coverage (up to level requested) not requiring evidence of insurability is effective.
- spending accounts
  - If you change your contribution to the spending accounts, the effective date of that coverage change is the date you notify the Benefits Service Center.

*In certain circumstances, your or your dependents’ coverage could be delayed. Please see page 51 for further details.

Spending Account Contributions and Coverage Changes

If you change your contribution amount (HCSA or C/ECSA) because of a status change, for instance a marriage or birth of a child, the following occurs:

- If you increase your account balance, the amount of the increase is prorated throughout the remaining calendar year. For instance, if you increased your account from $1,200 to $1,500, then the additional $300 would be prorated over the remaining pay periods and added to your current per-pay-period contribution amount. The amount of the increase is available for expenses incurred after the effective date of the change.
- If you decrease your account balance, your new per-pay-period contribution is calculated by taking any contributions already deducted from your paycheck and subtracting those from your new annual amount, and dividing that difference by the remaining pay periods in the year.

For example, assume your original annual contribution was $1,200, and in May you decreased your annual contribution amount to $600. You would have paid for four months at $100 per month. Subtract the $400 you have already paid from your new annual contribution amount of $600. Then divide the remaining $200 by the number of remaining pay periods in the year. That would be your new per-pay-period contribution amount.

You may not decrease your account to an amount that is less than what you have already contributed. In the example above, for instance, you could not decrease your account to less than $400, because you have already contributed $400. (Some changes in status, however, allow you to stop your account altogether.)
### UPS Health and Welfare Package

**Allowable Coverage Changes Matrix**

(Only the changes that are listed are allowed.)

<table>
<thead>
<tr>
<th>Event</th>
<th>Medical</th>
<th>AD&amp;D</th>
<th>Employee Life*</th>
<th>Spouse’s Life*</th>
<th>Children’s Life*</th>
<th>Legal</th>
<th>LTD</th>
<th>Health Care</th>
<th>Child/Elder Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Start dependent coverage</td>
<td>No changes</td>
<td>Increase coverage</td>
<td>Add coverage</td>
<td>Add coverage</td>
<td>Start coverage; change family status</td>
<td>No changes</td>
<td>Start or increase contributions</td>
<td>Start, stop or change contributions</td>
</tr>
<tr>
<td>Divorce; Legal Separation; Annulment</td>
<td>Start or stop dependent coverage</td>
<td>No changes</td>
<td>Increase or decrease coverage</td>
<td>Drop coverage</td>
<td>No changes</td>
<td>Start or drop coverage; change family status</td>
<td>No changes</td>
<td>Stop or decrease contributions</td>
<td>Start, stop or change contributions</td>
</tr>
<tr>
<td>Birth; Adoption or Placement for Adoption; Child Gains Eligibility</td>
<td>Start dependent coverage</td>
<td>No changes</td>
<td>Increase coverage</td>
<td>Add coverage</td>
<td>Add or increase coverage</td>
<td>Start coverage; change family status</td>
<td>No changes</td>
<td>Start or increase contributions</td>
<td>Start or increase contributions</td>
</tr>
<tr>
<td>Death of Spouse</td>
<td>Start or stop dependent coverage</td>
<td>No changes</td>
<td>Increase or decrease coverage</td>
<td>Drop coverage</td>
<td>No changes</td>
<td>Start or drop coverage; change family status</td>
<td>No changes</td>
<td>Stop or decrease contributions</td>
<td>Start, stop or change contributions</td>
</tr>
<tr>
<td>Death of Child; Loss of Child’s Eligibility; Termination of Adoption Proceedings</td>
<td>Stop dependent coverage</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Drop coverage</td>
<td>No changes</td>
<td>No changes</td>
<td>Stop or decrease contributions</td>
<td>Stop or decrease contributions</td>
</tr>
<tr>
<td>Dependent Loses Eligibility for Spending Accounts</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Stop or decrease contributions</td>
<td>Stop or decrease contributions</td>
</tr>
<tr>
<td>Loss of Outside Medical Coverage Eligibility with Other Employment</td>
<td>Start dependent coverage</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
</tr>
<tr>
<td>Change in Spouse’s Employment or Coverage; Open Enrollment Period Differs from Employee’s</td>
<td>Start or stop dependent coverage</td>
<td>No changes</td>
<td>No changes</td>
<td>Add or increase coverage</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Start or increase contributions (Spouse gains Employment)</td>
<td>Start, stop or change contributions</td>
</tr>
</tbody>
</table>

*See the Life Insurance section for details about coverage maximums and evidence of insurability requirements.*
### UPS Health and Welfare Package

**Allowable Coverage Changes Matrix** *(continued)*

(Only the changes that are listed are allowed.)

<table>
<thead>
<tr>
<th>Event</th>
<th>Medical</th>
<th>AD&amp;D</th>
<th>Employee Life*</th>
<th>Spouse’s Life*</th>
<th>Children’s Life*</th>
<th>Legal</th>
<th>LTD</th>
<th>Health Care</th>
<th>Child/Elder Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in Child/Elder Care Provider or Cost</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Start, stop, or change contributions (limited to 4 changes/year)</td>
</tr>
<tr>
<td>Court-Ordered Coverage for Child**</td>
<td>As dictated by court order</td>
<td>As dictated by court order</td>
<td>As dictated by court order</td>
<td>As dictated by court order</td>
<td>As dictated by court order</td>
<td>No changes</td>
<td>As dictated by court order</td>
<td>As dictated by court order</td>
<td></td>
</tr>
<tr>
<td>Gain or Loss of Eligibility for Medicaid</td>
<td>If covered, change family status. If opted out, start coverage. If now have outside coverage, can opt out.</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Start, stop or change</td>
<td>Start or stop coverage</td>
<td>Start, stop or change contributions</td>
<td>No changes</td>
</tr>
</tbody>
</table>

*See the Life Insurance section for details about coverage maximums and evidence of insurability requirements.

**Must comply with QMCSO, see page 5.
What if…

If your employment status with UPS changes, that may affect UPS Health and Welfare Package coverage for you and your eligible dependents. For the following life events, here’s how your benefits are affected.

...You Fail to Maintain Eligibility?

After meeting the Plan’s initial eligibility provisions you must receive earnings at least one day during the current calendar month to maintain eligibility for that calendar month. This includes any time recorded during the month including earnings from work time, sick time or vacation time. Exceptions to this condition are approved leaves of absence or lay offs, which have specific benefit extension provisions (detailed later in this section).

If you fail to maintain eligibility, coverage will be terminated effective the last day of the month you received earnings. If you remain an active employee, coverage is reinstated the day you return to work.

For information about spending accounts if you fail to maintain eligibility, see “Spending Accounts and Leaves” on page 13.

If you terminate employment, you may convert your, your spouse’s and your children’s life insurance to individual policies. You cannot convert AD&D coverage to an individual policy. See page 55, “If You Leave UPS or Retire…” for more details about continuing life insurance coverage.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents can continue health coverage from the UPS Health and Welfare Package for a period of time after your termination date. (Please see the COBRA section for more information.) Also, you may convert your and your dependents’ life insurance to individual policies. You cannot convert AD&D coverage to an individual policy. See page 55, “If You Leave UPS or Retire…” for more details about continuing life insurance coverage.

...You Retire

If you take early or normal retirement based on the provisions of your pension plan, you and your eligible dependents may become eligible for retired employee medical, dental and vision coverage from the UPS Health and Welfare Package for Retired Employees.

If you retire:
- at any age with 30 or more years of credited service, or
- at age 50 or older with 25 or more years of credited service, or
- at age 55 or older with 20 or more years of credited service

And
- at least 10 years of the credited service were earned while a UPS employee

And
- you begin receiving a benefit based on the early or normal pension provisions of your pension plan,

Then
- you and your eligible dependents will become eligible for medical, dental and vision coverage from the UPS Health and Welfare Package for Retired Employees.

A year of credited service is defined as:
- any year worked as a full-time or part-time UPS employee
- any year earned and credited by your pension plan prior to becoming a UPS employee
- any year you are receiving long-term disability payments from the Plan...
You can participate in the UPS Health and Welfare Package for Retired Employees or you can elect COBRA coverage from the Health and Welfare Package. You can elect COBRA coverage and then participate in the UPS Health and Welfare Package for Retired Employees when COBRA coverage ends. However, you cannot elect coverage from the UPS Health and Welfare Package for Retired Employees and then switch to COBRA coverage from the UPS Health and Welfare Package.

See page 55, “If You Leave UPS or Retire…” for more details about continuing life insurance coverage.

...You Die
If you die while you’re covered by the UPS Health and Welfare Package as an active employee, your eligible dependents’ health care coverage will continue for up to six months following the date of your death. Your dependents will continue to contribute their share of the cost of coverage, if any. When this continued coverage ends, your dependents may extend health coverage in accordance with COBRA provisions for up to an additional 30 months, for a total of 36 months of coverage. (Please see the COBRA section for more information.)

Your surviving spouse and children may convert their basic life insurance to individual policies. See page 55, “If You Leave UPS or Retire…” for more details about continuing life insurance coverage.

...You Are Laid Off
If you are laid off (and recorded as such in the UPS eligibility system), your UPS Health and Welfare Package coverage will be continued until the last day of the month following the month in which your layoff begins, provided you pay your share of any applicable cost. In addition, you can then continue your medical, dental, vision and health care spending account coverage through COBRA. (Please see the COBRA section for more information.)

If you terminate employment, you may convert your, your spouse’s and your children’s life insurance to individual policies.

...You Take an Approved Leave of Absence
FMLA
If you’re on an approved leave of absence as provided by the Family and Medical Leave Act of 1993 or company policy, your and your dependents’ full medical, dental, vision, life insurance and AD&D coverage can be continued during your leave. You’ll need to continue to pay your share of the cost of the coverage, if any. If your leave is approved for extension beyond that provided by FMLA or company policy, your coverage from the UPS Health and Welfare Package will continue provided you pay the full cost of coverage (see “Personal Leave”). You’ll need to notify the company in writing that you want to extend your leave and make the necessary payments directly to the UPS Benefits Service Center.

Personal Leave
You may also continue coverage if you are on another type of approved leave of absence, such as personal leave. You are responsible for the full cost of coverage during a personal leave. Medical (including the Health Care Spending Account), dental and vision coverage are continued through COBRA.

Although not required by COBRA, supplemental coverage (such as long-term disability, legal and supplemental life and AD&D insurance) may also be elected and continued during your leave. If you choose not to continue your supplemental life insurance, when you return to work you must provide evidence of insurability in order to begin coverage again.

You must call the Benefits Service Center at 1-800-UPS-1508 to continue HCSA coverage during a leave of absence.
You may choose to continue COBRA coverage in accordance with the COBRA provisions described on page 88. You may elect to continue any or all of your supplemental coverage.

Regardless of whether you elect to continue your coverage, UPS-provided basic life and AD&D insurance and short-term disability are continued until the earlier of 12 months or the date you terminate employment.

If you elect coverage, and then fail to make timely and full payments, your coverage will be terminated according to the following guidelines:
- Any amounts received by the COBRA administrator will be applied first to your COBRA coverage.
- If the amount is insufficient to pay for your COBRA coverage, all COBRA and supplemental coverage will be terminated.
- If the amount is sufficient to pay for your COBRA coverage, but insufficient to pay for your supplemental coverage, your supplemental coverage will be terminated.
- If your supplemental life insurance coverage is dropped for non-payment, you must provide evidence of insurability to begin coverage again upon return to work.

**Military Leave**

Except for military leaves of less than 31 days (or otherwise required by federal law), benefits cease and therefore deductions also cease. Refer to page 88 for details about continuing coverage under COBRA.

### Spending Accounts and Leaves

- **C/ECSA**
  Your C/ECSA contributions will stop during your leave until you return to work. Upon return to work, your per-pay-period contribution amount will automatically be reinstated. Only eligible expenses incurred prior to your date of leave and after your return to work will be eligible for reimbursement.

- **HCSA**
  During a leave, contributions to your HCSA may be continued on an after-tax basis, or stopped.
  - If you choose to continue your contributions on an after-tax basis during your leave, any eligible expenses incurred during your leave will be eligible for reimbursement. You must call the Benefits Service Center at 1-800-UPS-1508 to continue HCSA coverage during a leave of absence.
  - If you stop your contributions during your leave, only expenses incurred prior to your leave or upon your return to work will be eligible. Expenses incurred during your leave will not be eligible for reimbursement. Upon return to work, your per-pay-period contribution amount will automatically be reinstated, (for more details about FMLA leaves, see the following page). Your annual contribution amount will be reduced by the amount not contributed during your leave.

For instance, if your annual contribution amount is $1,200, and you are on leave for three months and do not continue your contributions on an after-tax basis during your leave, your revised annual contribution amount will be reduced to $900 (reduced by $300 — the amount you didn’t pay while on leave).

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### ...You Have Jury Duty

If you have jury duty, your UPS Health and Welfare Package participation continues. You will make contributions for supplemental coverage as if you were an active employee.
Upon returning from FMLA leave, your per-pay-period contribution amount will automatically be reinstated and your annual contribution amount will be reduced by the amount not contributed during your leave.

Alternatively, if you call the Benefits Service Center within 30 days of your return to work, you may choose to have your pre-leave annual contribution amount continued and “catch up” the contributions you missed while on leave. These catch-up contributions will be prorated over the remaining pay periods in the year. Even if you catch up your contributions, expenses incurred during your leave are not eligible for reimbursement.

...You Become Disabled
You and your dependents still have medical protection if you become disabled. If you are on short-term disability, your UPS Health and Welfare Package participation continues. You make contributions for supplemental coverage as if you were an active employee.

Health Coverage
If you’re unable to work due to an on-the-job injury or an off-the-job injury or illness, you and your covered dependents will continue to have medical coverage for up to the 12-month period following the date your disability began. You continue to be responsible for your share of the costs. When your 12-month extension ends, you and your dependents may elect COBRA continuation for an additional 18 months, for a total of 30 months of coverage. (Please see the COBRA section for more information about continued coverage.)

If you are a participant in the long-term disability plan, you and your eligible family members will continue to receive comprehensive basic coverage from the Plan for as long as you remain an eligible LTD participant (up to five years). You continue to be responsible for your share of the cost of coverage (less the cost of LTD coverage).

If you or a dependent become eligible for Medicare benefits as a result of a disability, there are rules that determine whether the UPS Health and Welfare Package pays benefits first, or whether Medicare is primary. See page 77.

Life Insurance and AD&D
Your basic group life coverage (for you and your dependents) and basic AD&D coverage continue for up to 12 months following the date your disability begins. You may also continue to pay for and receive supplemental coverage during that time. After 12 months, your supplemental life insurance is portable and can be continued on a direct-billed basis. You may also choose to convert your and your dependents’ basic group life policy to an individual policy without providing evidence of insurability. See page 55, “If You Leave UPS or Retire…” for more details about continuing life insurance coverage.
Medical

Choice is a central part of the medical care provided through the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. You have up to three options within each Plan, giving you the flexibility to find the one that best meets your needs and suits your lifestyle.

Medical Option 1 is a Primary Care Physician Network. With this option, you select a Primary Care Physician (PCP) who coordinates your medical care. The costs to you are less when your services are provided or coordinated by your PCP.

Medical Option 2 is a Preferred Provider Network. Your costs are less when you choose your care from a network of primary and specialty care physicians, but you don’t have to select a Primary Care Physician.

The HMO Option is a Health Maintenance Organization. All medical care is coordinated through the network in this option.

See “A Guide to Network-Based Health Care” later in this section for more information about each type of network.

These networks offer many advantages to you:

- Participating doctors and hospitals go through a stringent credentialing process and background check by the network manager before they’re allowed to participate in the network.
- The network doctors and hospitals have agreed to treat network participants for set fees that are usually lower than you would be billed without these arrangements.
- With a Primary Care Physician Network, your PCP takes on the role of your health care advocate, giving you personalized care — almost like the family doctor years ago.
- In a Primary Care Physician Network and the HMO, the focus is on improving your health and preventing disease. As a result, more preventive and wellness services are covered. This approach to your health care considers your total health, or the whole picture.

The chart below summarizes your options based on the networks in your home ZIP Code:

<table>
<thead>
<tr>
<th>If you have…</th>
<th>Your choices are…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Primary Care Physician or Preferred Provider Networks</td>
<td>— Medical Option 1, Primary Care Physician Network, and/or — Medical Option 2, Preferred Provider Network, and/or — HMO Option (if available)</td>
</tr>
<tr>
<td>Inadequate access to both Option 1 and Option 2</td>
<td>— Traditional Program or, — Opt in to Options 1, 2 or HMO</td>
</tr>
</tbody>
</table>

About Medical Coverage

The medical section details coverage from both Plans: the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. However, the lifetime maximum is different in each Plan. See page 85 for details of the UPS Health and Welfare Package for Retired Employees lifetime maximum.
To some extent, your choices will depend on your home ZIP Code. In some areas, Primary Care Physician or Preferred Provider Networks may not have an adequate number of physicians to meet our access standards. If you live in one of these areas outside the network, but you feel you have adequate access to the doctors in the network or consider them close or convenient enough, you still may choose the network by “opting in.” If you live in a ZIP Code that falls outside the network and you do not “opt in” to the network, you’re considered “out of area” and will receive your coverage from the Traditional Program. Health Maintenance Organization service areas are, in some cases, regulated by state law.

You may opt in to the network at any time during the year by calling the UPS Benefits Service Center at 1-800-UPS-1508. However, you will be required to remain in the network for the rest of the Plan year. You will automatically remain in the network from year to year unless you call at annual enrollment to change back to your out-of-area coverage.

In describing the medical benefits provided by the Plans, this section first explains:
- how the network-based options work
- how the Traditional Program works
- your expenses
- expenses covered by the Plan
- prescription drug benefits
- Solutions — for mental health and substance abuse treatment

A Guide to Network-Based Health Care

What Is Network-Based Health Care?

Network-based health care is a system where certain aspects of medical care are managed — for quality and value. Care is provided by physicians who participate in a network. In Primary Care Physician or Preferred Provider Networks, each time you need health care services, you can choose whether to go to a network provider or go to a provider outside the network; in other words, you choose the coverage you want at the point of service.

The current network managers for Options 1 and 2 are Aetna, Blue Cross Blue Shield, CIGNA or United Healthcare, depending on where you live. UPS intends that all the network managers will consistently administer the Option 1 and 2 medical benefits provided through the Plans. For additional information, contact your network manager. The network manager’s name and toll-free telephone number appear on your medical ID card.

Although UPS has long relationships with these managers, over time the composition of a network or the network managers in your area may change.

Three Types of Medical Networks

UPS has established three types of medical networks based on the medical resources available in your community. You and eligible family members will enjoy the highest benefit level when you receive care provided by the network offered in your area. This is known as receiving “in-network” care. In Options 1 and 2, you always have the flexibility to use any health care provider you wish to use — even out-of-network providers. However, you will receive the lower level of benefits if you go “out-of-network.” HMO benefits are limited to care received by network providers.

You have several choices regarding your medical network including the type of network (Primary Care Physician, Preferred Provider or HMO) and your choice of a primary care doctor if you choose a Primary Care Physician Network or in some cases an HMO.

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*Network* means a selected group of doctors, hospitals and other health care providers who have agreed to provide their services at negotiated rates.

*Network manager* means the company that establishes and maintains the network for the network-based health care options. The network manager is also responsible for processing claims for in- and out-of-network treatment.
Primary Care Physician Network
If you choose to participate in a Primary Care Physician Network, you and each of your family members will choose a Primary Care Physician, or PCP, who becomes the one doctor who knows your medical history and provides or coordinates your care. You receive in-network benefits when you seek care first through your PCP. Your PCP will refer you to specialists, if necessary, and will coordinate any hospital or medical services you require.

Preferred Provider Network
If you choose to participate in a Preferred Provider Network, you and your family can also enjoy the benefits of network-based care. You and your family may seek care from any physician or hospital. By seeking care from a network provider, you receive higher, in-network benefits, and you are not responsible for completing or filing claim forms. You may seek care from an out-of-network provider and still receive benefits. However, you will generally pay more than if you had used an in-network provider and you will also have to file a claim.

Participants in the Preferred Provider Network are not required to select a Primary Care Physician, but it is a good idea to see the same physician on a regular basis.

Health Maintenance Organization (HMO)
If you choose to participate in an HMO, you and your family can also enjoy the benefits of coordinated care. You and your family receive all of your medical care from HMO providers and facilities (except in emergency situations). In some HMOs, you select a Primary Care Physician to coordinate most of your care.

Although not for everyone, HMO participants appreciate features like easy access, coordinated care and the emphasis on quality care they offer.

Advantages of Network-Based Health Care
Network-based health care has many advantages for UPSers. Following are some reasons UPSers usually prefer network-based care:

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Primary Care Physician Network</th>
<th>Preferred Provider Network</th>
<th>Health Maintenance Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each participating member of your family has his or her own personal Primary Care Physician.</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Health care providers participating in the network have been carefully evaluated and monitored by the network manager for the services they provide.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Preventive care and coordinated patient care are both emphasized.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>You do not have to complete or submit any claim forms.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Network provider charges are always within reasonable and customary (R&amp;C) limits.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>In-network providers handle all referrals to specialists (PCP Network and HMO only) and all hospital admission precertifications.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>You pay no annual deductible in-network.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>You have unlimited lifetime benefit maximum.</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>You are responsible only for modest office-visit and emergency-care copayments or coinsurance.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
| If you decide to seek out-of-network medical care, which you are always free to do, you will have to:  
  — Submit a claim form                                             | ✓                              | ✓                         | No coverage out of network     |
  — Pay a higher annual deductible                                     | ✓                              | ✓                         |                                 |
  — Pay for services at the time you receive them from the provider     | ✓                              | ✓                         |                                 |
  — Receive a lower level of benefit                                     | ✓                              | ✓                         |                                 |

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The Traditional Program

If you live outside both the Primary Care Physician and the Preferred Provider Network areas (usually UPSers who live in rural areas or outlying communities), you will be covered by the Traditional Program. The Traditional Program allows you to receive reimbursement for eligible expenses provided by the physician of your choice. You will also receive the following preventive care benefit features:
- well-child care
- immunizations
- routine mammograms
- routine gynecological examinations
- routine physical examinations

If you live close to a network area, you may join the network and receive in-network benefits. See page 16 for more details, or contact the UPS Benefits Service Center at 1-800-UPS-1508.

Choosing your Health Care Provider

If you Participate in the Primary Care Physician Network

If you choose this option, you and each covered family member select a PCP who provides the general care you need and refers you to specialists when needed.

Your PCP can be a family or general practitioner, an internist or a pediatrician. Each covered family member can choose a different PCP. For example, you and your spouse may want to select internists for yourselves and a pediatrician for your children.

There are two ways to find out which doctors are in the network:
- network Web site (log onto UPSers.com for a link)
- Member Services (call 1-800-UPS-1508, choose health care, provider directories )

If you want more information before selecting a PCP, call Member Services. A staff member can tell you which medical school the doctor attended, the year he or she graduated, his or her hospital of residency, whether weekend or evening hours are available, and at which hospitals the doctor has admitting privileges.

You may change your PCP at any time by calling the toll-free Member Services number printed on your ID card. Member Services will send you a new medical ID card, if necessary. Certain network managers may have a waiting period for changing your PCP. Call Member Services for details.

If your PCP leaves the network, you'll be notified and asked to select another PCP. Just call Member Services with the name of your new PCP prior to your first visit to your new PCP. You should also have your medical records transferred to your new PCP.

You must use your PCP to receive in-network benefits. If you go to a network doctor or hospital without your PCP's referral, your expenses will be paid on an out-of-network basis. There are five exceptions:
- Women do not need a referral from the PCP to visit a network obstetrician or gynecologist for Ob/Gyn-related care.
- Students away at school may receive non-preventive care without a referral from their PCP (see “Special Situations” on page 20).
- Solutions can be contacted directly by you or your covered dependents.
- Emergency care as described in “In an Emergency” on page 24.
- Selected network specialists in certain locations. Contact Member Services for details.

Claims administrator means the company that administers the Traditional Program and is responsible for processing claims for that option.
If You Need a Specialist in the Primary Care Physician Network

When your PCP refers you to a network specialist, you receive in-network benefits for covered services. Because you may choose at any time to seek care outside the network, your PCP’s referral to a network specialist notifies the network manager that your visit to the specialist has been authorized, and to pay your eligible claims in-network. Without the referral, your claims will be paid out-of-network, even if the specialist or hospital is a network provider.

Usually, you will receive authorization for a prescribed number of visits to a specialist within a specific time for a specific course of treatment. Make sure you and your specialist know how many visits have been authorized. Your PCP is responsible for coordinating the care you receive from a network specialist.

Referral to an Out-of-Network Provider

In the rare instance that you need to see a specialist who is not in the network, your PCP can request the network manager’s approval of the referral. If the request is approved, in-network benefits will be paid. Except for emergencies, and urgent care when traveling away from your network area, the network manager must approve the use of out-of-network providers and facilities in advance, or out-of-network benefits will apply.

Women Can Self-Refer to Network Ob/Gyn

Women do not need a PCP referral to visit a network obstetrician or gynecologist for Ob/Gyn-related care. However, Ob/Gyn providers may not be selected as primary care physicians.

If you go to a non-network Ob/Gyn for your routine check-up, only the laboratory fees are covered. The office visit itself is not covered.

If You Participate in the Preferred Provider Network

If you choose this option, you and each covered family member can obtain your health care from in-network providers (preferred providers) and receive the higher in-network level of benefits.

It is important to remember that you may use out-of-network providers if you wish. However, you will then receive benefits at the lower out-of-network level. In the rare instance that you need to see a specialist who is not in the network, your treatment will be covered on an out-of-network basis unless you have prior approval from the network.

If you Participate in the Health Maintenance Organization

If you choose this option, you and each covered family member may be required to select a PCP who will provide the general care you need and refer you to specialists when needed. Your PCP can be a general or family practitioner, an internist or a pediatrician.

If You Participate in the Traditional Program

If health care for you and your family is provided by the Traditional Program, you may receive your health care from any qualified health care provider. You pay for health care services as they are rendered and later submit a claim for reimbursement after you have met your annual deductible.

Even if you live outside the Primary Care Physician and Preferred Provider Network areas, you may still want to use in-network health care providers — if they are convenient to where you work, for example, or if you want to take advantage of in-network benefits. To take advantage of in-network benefits, call the UPS Benefits Service Center for further information about joining a network.
Special Situations

Primary Care Physician Network

- If you’re traveling and need urgent medical care when you’re away from home, call your PCP to discuss treatment. If your doctor recommends that you be treated where you are, your expenses will be paid at the in-network level. If you can’t contact your PCP, get the care your treating physician recommends. If you call your PCP within 48 hours, you’ll receive in-network benefits for the treatment (if otherwise covered by the Plan). However, because treatment was provided out-of-network, you’ll have to file a claim form.
- If your eligible dependent child attends school away from home, select a PCP for your child in your home network. The PCP will coordinate all care when your child is at home.

When your child is at school, non-preventive care is covered in-network without a referral from the PCP, provided it is otherwise covered by the Plan. It is still a good idea to keep your child’s PCP informed of any care received while away at school, so the PCP has a complete medical history on your child. Preventive care is only covered if provided by your child’s PCP.
- If you have eligible dependent children or an eligible spouse who permanently lives outside your network area (non-resident dependents), their covered expenses will be paid as in-network benefits. To designate your dependent children or eligible spouse as non-resident dependents, call the Benefits Service Center at 1-800-UPS-1508.

Preferred Provider Network

- If you’re traveling and need emergency or urgent medical care when you’re away from home, get the care your treating physician recommends. Your benefit will be paid at the in-network level (if otherwise covered by the Plan).
- If your eligible dependent child attends school away from home and needs non-preventive care away from your network, in-network benefits will apply.
- If you have eligible dependent children or an eligible spouse who lives permanently outside your network area (non-resident dependents), their covered expenses will be paid as in-network benefits. To designate your dependent children or eligible spouse as non-resident dependents, call the Benefits Service Center at 1-800-UPS-1508.

Health Maintenance Organization

Because only care received through the HMO is covered, special rules apply when you must seek care outside the HMO, for instance when you have an emergency or are travelling. For more information refer to the specific HMO literature or call Member Services.
- If you have an eligible dependent child attending school away from home you may wish to consider another medical option since all non-urgent care must be received from within the HMO network.
- If you have eligible dependent children or an eligible spouse who do not live in your network area, coverage is usually only available when they come to the network area for their care.
- Referrals to specialists outside the HMO are generally not given.

If you have any questions about these situations or others not described here, please contact Member Services.
Member Services

A Toll-Free Information Service

Member Services is your link to network care. You can call a Member Services representative to:
- ask questions about a network physician’s credentials
- ask questions about claims
- ask questions about your benefits
- change your PCP
- get a new ID card
- obtain information about a network provider or service
- precertify

Your medical ID card has a toll-free number for Member Services.

Precertification

Precertification is a process that takes a closer look at:
- A hospital stay recommended by your doctor
- A convalescent facility stay
- Home health care services
- Hospice services

The idea behind precertification is to make sure the confinement or services are medically necessary and appropriate for your care. Precertification starts with a call to Member Services. Here are the guidelines to remember:
- If you participate in the Primary Care Physician Network and in most Preferred Provider Networks and your care is provided or coordinated by your PCP or an in-network physician, he or she will start the precertification process. You don’t need to do anything.
- If you participate in the Primary Care Physician or Preferred Provider Network and use an out-of-network physician, or if you participate in the Traditional Program, you are responsible for starting the precertification process yourself.
- If you participate in an HMO, all precertification is completed for you by the HMO physicians. You don’t need to do anything.

If You Don’t Call to Precertify

In medical options 1, 2, and the Traditional Program, if you don’t call Member Services to precertify a hospital stay when it is required, you will pay a $250 fee for failure to precertify. The $250 fee will not apply toward your out-of-pocket maximum.

When to Precertify

If you are responsible for calling Member Services to precertify, you must call:
- 14 days before a scheduled hospital or convalescent facility admission
- Within 48 hours after an emergency admission, (your doctor, a family member or a friend may make the call for you). If the call can’t be made within 48 hours, it must be made as soon as possible. If your hospital confinement begins on a Friday or Saturday, the call must be made within 72 hours of admission.

What Happens When You Call to Precertify

When you call to precertify, a nurse consultant will ask for some information, including:
- your name and the patient’s name (if the patient is a dependent)
- the condition that is being treated
- your doctor’s name, address and phone number
- the hospital’s name, address and phone number
- the scheduled date of admission

If necessary, the nurse consultant will contact your doctor for more information. As part of the precertification process, the nurse consultant and your doctor will discuss your condition, the proposed treatment and any alternatives that could help you avoid a hospital stay.
You and your physician will be notified by mail of the certification decision. This notification will show the number of days certified. If your physician recommends that you be confined for a longer period of time than was certified, you, your physician or the hospital must call Member Services to certify the extra days. This must be done no later than the last day previously certified.

Remember — if you participate in the Primary Care Physician Network and your care is provided or coordinated by your PCP, he or she will initiate precertification of the extra days for you. If you participate in a Preferred Provider Network, check with your network for precertification requirements. Most in-network providers will initiate precertification for you.

**What Medical Expenses You Have to Pay**

The medical option you select pays a significant portion of the medical expenses you and your family may incur each year. You'll generally also pay a portion of the costs incurred. Here is a description of the types of charges for which you'll be responsible. For information about the amount of these charges, please refer to the charts on pages 40-41. For information about your HMO coverage, please refer to your local HMO materials.

**Deductible**

The deductible is the amount you must pay before certain benefits begin each year if you participate in:

- a network-based option and you receive out-of-network treatment, or
- the Traditional Program

The individual deductible must be paid each year before certain benefits are paid. (See page 40 for details). In addition to an individual deductible, each option has a family deductible amount that is twice the individual deductible. This means that if two or more family members have combined covered expenses that equal the family deductible amount, any further expenses incurred by any family member that year will be eligible for payment from the option you select. This is true even if no one person in the family has met the individual deductible.

Expenses credited toward the deductible are also credited toward the out-of-pocket maximum that applies each year.

The following chart shows several examples of how a family deductible might be met.

<table>
<thead>
<tr>
<th>Enrolled Family Members</th>
<th>Example #1</th>
<th>Example #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>$50</td>
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<td>Your Spouse</td>
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<td>Son</td>
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<td>Daughter</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$100</strong></td>
<td><strong>$100</strong></td>
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**If You Don’t Call to Precertify**

In medical options 1, 2, and the Traditional Program, if you don’t call Member Services to precertify a hospital stay when it is required, you will pay a $250 fee for failure to precertify. The $250 fee will not apply toward your out-of-pocket maximum. You may also be subject to the full cost of any charges for services not precertified.
Copayment
For some network-based services such as doctor’s office visits, you pay a low flat fee, called a copayment, for each in-network office visit. Then the Plan covers the remaining expense at 100 percent. A copayment also applies to network care for mental health or substance abuse through Solutions, to prescription drugs purchased through your prescription benefits and to certain emergency room services. See pages 40-41.

Coinsurance
Once you’ve met the deductible (if required), the Plan pays part of the remaining expense and you pay the rest. For example, if the Plan covers an expense at 80 percent, you pay the other 20 percent, which is called your coinsurance.

Coinsurance only applies if you select the Preferred Provider Network, the Traditional Program or the out-of-network benefit in the Primary Care Physician Network.

Hospital Admission Fee
In-network and Traditional Program hospital coverage is generally provided without a deductible. However, a $250 Hospital Admission Fee applies each time you’re admitted as a hospital inpatient if the admission is:
  - not coordinated by your PCP in a Primary Care Physician Network, or
  - at an out-of-network hospital without prior approval from the network manager in the Preferred Provider Network.

If you are readmitted to a hospital for the same or a related condition within 30 days after your stay as an inpatient ends, you will not have to pay another hospital admission fee.

Out-of-Pocket Maximum
Each option limits your total out-of-pocket expenses. The out-of-pocket maximum is the most you are required to pay toward health care expenses in a calendar year. Once your out-of-pocket expenses reach the maximum, the Plan pays 100 percent of most covered charges for the rest of the calendar year.

In calculating your out-of-pocket expenses, the dollar amounts included are the deductible, coinsurance amount, copays, and the hospital admission fee.

Dollar amounts not included in determining the out-of-pocket maximum are prescription drug expenses, mental health/substance abuse treatment expenses, the additional hospital admission fee (for failure to pre-certify), any amounts over reasonable and customary and expenses that are not covered by the Plan.

In Options 1 and 2, there are two out-of-pocket maximums — one for in-network care and one for out-of-network care. Only in-network expenses are applied to the in-network out-of-pocket maximum, and only out-of-network expenses are applied to the out-of-network out-of-pocket maximum.

If you are confined in the hospital from one calendar year to the next, your hospital charges for that stay will count toward the out-of-pocket maximum for the year that you are admitted, not the year you are discharged. This means that you do not have to start a new out-of-pocket maximum during your hospital stay. Physician and other charges related to the hospital stay begin a new out-of-pocket calculation on January 1.
Lifetime Benefit Maximum

Up to $1 million in lifetime medical benefits can be paid for each person participating in the UPS Health and Welfare Package. The maximum is a combined amount that is the total of benefits paid even if you switch from one option to another from year to year. The lifetime maximum includes your medical benefits and benefits you receive from Solutions for mental health/substance abuse care. However, benefits received under the prescription program do not count toward the lifetime benefit maximum.

Each January, up to $1,000 in individual benefits paid during the preceding year will automatically be restored.

Lifetime maximums are unlimited if you select the HMO option. The Health and Welfare Package for Retired Employees has a separate lifetime maximum (see page 85).

Preventive Care

Since it’s often less painful and less expensive to keep people healthy than it is to treat them when they’re ill, the medical options cover preventive services. In determining how frequently or at what ages certain preventive care services are covered, the medical options generally follow the guidelines of the U.S. Preventive Services Task Force (for physical evaluations), the American Cancer Society (for mammograms) or the American Academy of Pediatrics (for well-baby care). For information about these guidelines and the benefits payable, contact the claims administrator if you participate in the Traditional Program. Use the toll-free 800 number which appears on your medical ID card. Your PCP or Member Services can provide this information if you participate in Option 1 or 2.

For more information on covered preventive care services, see page 40.

In an Emergency

Regardless of your option, in case of an emergency, seek medical care as quickly as possible. Then, within 48 hours after receiving treatment, contact your PCP (if you are participating in the Primary Care Physician Network or Health Maintenance Organization) or Member Services (if you are participating in the Preferred Provider Network) so that your care can be properly coordinated.

Emergency rooms should only be used for true emergencies. An emergency is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or the unborn child in the case of a pregnant woman) in serious jeopardy. Examples of emergencies include heart attack, loss of consciousness, excessive bleeding, severe or multiple injuries or serious burns.

Once you are discharged from the emergency room or admitted to the hospital from the emergency room, emergency coverage ends and benefits are covered as non-emergency treatment.

If you receive medically necessary care for a non-emergency at an emergency facility, you pay the first $100 of expenses, then the Plan pays 100 percent of the remaining covered expenses.

However, if you participate in a Primary Care Physician Network and your PCP sends you to the emergency room for non-emergency care, the Plan pays 100 percent of the related covered expenses after you pay a $25 copayment.
Ambulance Coverage (Ground or Air)

Emergency use of an ambulance is covered as an emergency benefit in all options. Non-emergency use of an ambulance is covered at the coinsurance level for each option, if it's medically necessary. HMO coverage may differ — see your local HMO coverage sheet.

Covered Expenses

Your medical benefits under Options 1, 2 and the Traditional Program cover the following types of medical services and supplies, but the amount you pay for each covered expense will vary with the option you select. Regardless of the option you select, the care must be:

- medically necessary, as determined by the network manager or claims administrator
- neither investigational nor experimental, as determined by the network manager or claims administrator
- within the reasonable and customary limit, as determined by the network manager or claims administrator, and
- not excluded by the Plan

Keep in mind that if you select the HMO option, coverage could be different. Refer to your HMO kit for details about your coverage, or call your HMO Member Services.

Medically Necessary Services and Supplies

Except as specifically noted under the Preventive Care section, only medically necessary services are covered by the UPS Health and Welfare Package. A service or supply is medically necessary if the network manager or claims administrator determines that it is required for the diagnosis, care or treatment of a disease, injury, or pregnancy in accordance with generally accepted medical practice.

To be medically necessary, the service or supply must be:

- Care or treatment that is as likely to produce a significant positive outcome as (and no more likely to produce a negative outcome than) any alternative service or supply, with respect both to the disease or injury involved and to the person’s overall health condition, or
- A diagnostic procedure, indicated by the health status of the person, that is as likely to result in information that could affect the course of treatment as (and no more likely to produce a negative outcome than) any alternative service or supply, with respect both to the disease or injury involved and the person’s overall health condition, and
- As to diagnosis, care, and treatment, no more costly (taking into account all health care expenses incurred in connection with the service or supply) than any alternative service or supply that meets the above tests.
Investigational or Experimental
This means that the medical use of a service or supply is still under study and the service or supply is not yet formally recognized throughout the medical profession in the U.S. as safe and effective for diagnosis or treatment. If a service or supply is furnished in connection with a service or supply that is investigational or experimental, as determined by the network manager or claims administrator, it is not covered.

Reasonable and Customary Charges
All eligible medical expenses received out-of-network or in the Traditional Program are subject to reasonable and customary (R&C) limits. A reasonable and customary charge is the lower of either the provider’s usual charge or the prevailing fee for a medical service or supply in your geographic area, as determined by the network manager or claims administrator. If you are charged more than the R&C limit, you must pay any amounts considered above the R&C limit. These charges do not count toward your out-of-pocket maximum. All benefits provided in-network in Options 1 or 2 are considered reasonable and customary.

Hospital Services
Inpatient
Options 1, 2 and the Traditional Program cover hospital charges for semiprivate room and board and related services and supplies. Other covered hospital services include:
- the use of operating, recovery and treatment rooms and their equipment
- the use of intensive care and cardiac care units
- dressings, splints and plaster casts
- inpatient laboratory and X-ray examinations
- physical therapy
- electrocardiograms
- oxygen and anesthesia and their administration
- the cost and administration of blood and blood plasma
- intravenous injections and solutions
- X-ray and radium therapy
- prescribed drugs

Outpatient
Options 1, 2 and the Traditional Program cover the following outpatient hospital services provided on an outpatient basis or by a licensed free-standing emergency care center, surgical center or birthing center:
- preadmission testing within seven days of a scheduled admission for non-emergency surgery
- chemotherapy infusion
- kidney dialysis performed either in the hospital or in your home
- hospital charges connected with outpatient surgery
- hospital emergency room care of an accidental injury or for emergency treatment of a life-threatening sudden and serious illness

Surgical Services
Covered surgical services include pre-operative and post-operative care within the 14-day period after surgery. These include:
- surgeon’s services
- anesthesiologist’s services
- assistant surgeon’s services, when medically necessary or when required by the hospital’s established policy

Keep in mind that if you select the HMO option, coverage could be different. Refer to your HMO kit for details about your coverage, or call your HMO Member Services.
Professional Services
Options 1, 2 and the Traditional Program cover the following professional services:
- doctor’s and osteopath’s services
- second surgical opinions
- chiropractor’s services
- podiatrist’s services
- services by a registered graduate nurse, licensed practical nurse or licensed vocational nurse
- examinations and other services for the treatment of an illness or injury, including radiation therapy and chemotherapy
- medical consultations when requested by the physician in charge of the patient
- diagnostic examinations, X-rays and laboratory tests, including their reading and interpretation
- charges for hearing exams and an initial hearing aid per ear per lifetime age 19 or older or one hearing aid per ear every three years for children up to age 19 (must be prescribed by an otolaryngologist)
- ambulance service to the nearest appropriate facility to treat a patient’s medical condition
- hemodialysis

Maternity and Obstetrical Services
Maternity and obstetrical services are covered like any other condition requiring medical treatment.

If you use a network obstetrician in either the Primary Care Physician Network or the Preferred Provider Network, or you participate in the Traditional Program, your first visit to the obstetrician is paid as any other office visit. After your initial visit to your obstetrician, the balance of the cost for maternity care for that pregnancy will be paid in full with no further office visit copayments applying.

If you choose to go out-of-network for maternity care, your coverage is reduced to 80 percent (after your deductible) for all maternity care, plus a $250 hospital admission fee.

Covered services include:
- normal delivery or delivery by cesarean section
- prenatal and postnatal care
- initial sonogram per pregnancy (additional sonograms are only covered if medically necessary)
- amniocentesis if medically necessary
- treatment by an obstetrician for complications during pregnancy and delivery
- services in connection with a miscarriage or abortion (including a voluntary abortion)
- surgery related to an extrauterine or ectopic pregnancy
- Lamaze or other child-birth preparation classes (upon completion of the class)
- services of a registered midwife; in order for delivery services to be covered, delivery must be performed in a hospital, licensed free-standing emergency care center or birthing center

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage for Reconstructive Surgery Following Mastectomies
The following services are covered by all options. Benefits are paid like any other covered services under the option you select:
- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient
Transplants
Transplants are covered as any other medical procedure in Options 1, 2 and the Traditional Program.

Network managers and claims administrators develop nationwide transplant networks to coordinate available resources for transplant procedures. National transplant networks are created using a rigorous credentialing methodology. Facilities participating in the transplant networks have been evaluated for their surgical and medical capabilities as well as their clinical outcomes (how well they perform).

While you are not required to, you are encouraged to consider using a facility in your network manager’s or claims administrator’s national transplant network. If you do, transportation costs as outlined below will be covered.

Reasonable and necessary (as determined by the network manager or claims administrator) transportation, lodging and meal expenses incurred by the recipient and a companion who travels the same day(s) as the recipient to and from the transplant center for pre-transplant evaluation, transplant surgery and necessary post-transplant services performed at the transplant center will be covered. If the recipient is a minor, transportation, lodging and meal expenses for two companions who travel with the minor will be covered. There is a daily maximum of $200 and an overall lifetime maximum of $15,000 for all transportation, lodging and meal expenses incurred for covered services per transplant.

No benefits are payable for services rendered by a member of the recipient’s, companion’s or donor’s immediate family. No benefits are payable for the purchase or shipment of home furnishings or personal belongings.

Medical Supplies
Options 1, 2 and the Traditional Program cover the following medical supplies:
- rental or purchase of durable medical equipment required for therapeutic use and prescribed by a physician. Durable medical and surgical equipment is equipment that is made to withstand prolonged use, made for and mainly used in the treatment of a disease or injury, suited for use in the home, not normally of use to persons who do not have a disease or injury, not for use in altering air quality or temperature and not for exercise or training. In determining the maximum amount that will be paid for durable medical equipment, the network manager or claims administrator will consider the appropriateness of the equipment based on your medical needs and suitable alternatives. To determine whether rental or purchase is appropriate, call Member Services at the number on your medical ID card.
- the purchase of artificial limbs or other prosthetic appliances
- medical supplies and dressings prescribed by a physician, for example, splints, trusses, braces, catheters, oxygen and equipment for its administration, blood and blood products, electronic pacemakers and colostomy bags and colostomy-related supplies, and
- PKU supplements

Call your network manager or claims administrator to determine if a certain medical supply is covered.

Total Parenteral Nutrition and Enteral Nutrition
Total parenteral nutrition (TPN) is required for patients with certain medical conditions that impair gastrointestinal function to a degree incompatible with life or with optimal recovery from interventional procedures, such as major surgery or cancer chemotherapy. These patients cannot be maintained through oral feeding and must rely on parenteral nutritional therapy for prolonged periods of time.

Enteral nutrition (EN) is considered necessary for a patient with a functioning gastrointestinal tract who, because of dysfunction of surrounding structures that are necessary to permit food to reach the gastrointestinal tract, cannot maintain weight or strength commensurate with his or her general condition. Examples of these conditions are head and neck cancer with reconstructive surgery, and central nervous system disease leading to interference with the neuromuscular mechanisms of ingestion.
TPN and EN covered expenses are:
- cost of nutrients/solutions, except baby food and other regular grocery items, including those that can be blended and used in enteral feeding systems
- cost of the infusion pump and Heparin lock
- supplies and equipment necessary for proper functioning and effective use of a TPN or EN system
- home visits by a physician or nurse in conjunction with TPN or EN

In order to qualify for this coverage, the patient must:
- require at least 75 percent of their total sustenance from EN or TPN
- have a long-term need for EN or TPN
- have a condition involving the GI tract which prevents adequate oral intake

Coverage under this provision excludes:
- EN for patients with a normally functioning GI tract whose need for enteral nutrition is due to a lack of appetite or cognitive problems
- standard infant formulas and formula and food products modified to be low protein for people with inherited diseases of amino acid and organic acid metabolism (except PKU)
- baby food and other regular grocery items, including those that can be blended and used in enteral feeding systems

Allergy Treatment
In-network allergy testing and treatment (including injections) is covered in full after the appropriate copayment or coinsurance based on your option. Injections received without an office-visit charge are covered at 80 percent, and you must submit a claim for reimbursement after your receive the injection.

Tests and injections are both covered at 80 percent after the deductible when care is received out-of-network and for participants in the Traditional Program.

Infertility Treatment
All options cover the diagnosis of the cause of infertility and/or medical treatment to correct that cause (Viagra and Levitra are not covered). Both men and women are covered for infertility treatment. However, all procedures and services, including lab and X-ray, intended to induce pregnancy (rather than to treat an underlying medical cause) are not covered. See the Prescription Drug Benefits section for details on how infertility medications are covered.

The following procedures are not covered by Options 1, 2 or the Traditional Program because they do not correct the underlying medical causes of infertility:
- artificial insemination
- in vitro fertilization with embryo transfer
- intrafallopian transfer
- sperm banking/semen specimen storage
- artificially assisted fertilization
- infertility counseling for, or related to, artificially assisted fertilizations
- services for and costs of a surrogate mother

Because of the variety of treatment approaches to infertility, you or your doctor may want to contact the network manager or claims administrator before treatment begins to determine if a particular treatment will be covered.

Chiropractic Treatment
All medically necessary services performed or directed by a licensed chiropractor are covered, with the appropriate copayment or coinsurance, up to a maximum of $40 per visit (including diagnostic testing). If a chiropractic network is not available in your area, in-network benefits are allowed for care from a chiropractor of your choice. There is an annual $1,000 maximum per individual for chiropractic care.

Special Types of Therapy
Options 1, 2 and the Traditional Program cover short-term rehabilitation therapy and speech therapy. Here are the procedures for each type of coverage.

If you participate in Option 1 or 2, rehabilitation and speech therapy benefits are covered in-network after your copayment or coinsurance for each visit. There is no limit for medically necessary visits. If you choose out-of-network care, or are in the Traditional Program,
you are limited to 60 visits (combined rehabilitation and speech therapy) per Plan year. Any in-network visits will be counted toward your out-of-network limit.

In any case, you must show improvement within 60 calendar days from the beginning of treatment for coverage to continue.

**Short-Term Rehabilitation Therapy**

Charges made by a physician or a licensed or certified physical or occupational therapist for furnishing short-term rehabilitation services for the treatment of acute conditions are covered.

Short-term rehabilitation therapy is physical therapy or occupational therapy for the improvement of a body function that has been lost or impaired due to injury or illness.

Charges are not covered for:

- services and supplies received while you or your dependent is confined in a hospital or other facility for medical care (these may be covered by other Plan provisions)
- services not performed by or under the direct supervision of a physician
- any services unless they are provided in line with a specific treatment plan that:
  - details the treatment to be given and the frequency and duration of the treatment, and
  - provides for ongoing reviews and is renewed only if therapy is still necessary
- services or supplies covered to any extent by any other part of the UPS Health and Welfare Package or any other group plan sponsored by UPS

**Speech Therapy**

Benefits are paid only for speech therapy needed to restore speech lost as a result of an illness or injury. For example, children who have not fully developed their speech skills are not eligible for these restorative services. However, someone who loses speech capacity as a result of an accident could receive benefits under this provision.

Speech problems can be unique, varying in severity from individual to individual, and frequently diagnoses can be subjective. To help determine if the condition is covered by the Plan, you may want to submit information to the network manager or claims administrator for advance review. This way, you’ll know what benefits can be paid before treatment begins.

Certain speech problems, such as stuttering in children, may be covered by Public Law 94-142, The Education for All Handicapped Children Act of 1975. This law provides public schools with language and speech services for all children between the ages of three and 21, including help in identifying and diagnosing speech and language disorders as well as rehabilitative and preventive treatment. As a result, treatment is not covered for these kinds of speech problems.

To be eligible for benefits, treatment of a speech problem must be prescribed, controlled and directed by a doctor, and approved by the network manager or claims administrator.

Besides the exclusions noted in the section “What’s Not Covered by Your Medical Benefits” later in this section and situations covered by Public Law 94-142, there are other conditions not covered by the medical options. These include:

- certain speech problems in children that are classified as developmental delays that may correct themselves without treatment
- services rendered for the treatment of delays in speech development, unless resulting from injury or illness
- speech problems caused by learning disabilities or articulation disorders (if there is an underlying psychological reason for the condition, that underlying condition may be covered as a mental or nervous disorder)
- services or supplies that any school system is required by law to provide
- services of a speech therapist who lives in your home
- special education, including lessons in sign language, to teach a covered person whose ability to speak has been lost or impaired to function without that ability
**Individual Case Management**

While none of us likes to think about a complicated long-term illness or a serious accident, sometimes it can happen.

The Individual Case Management (ICM) program can offer you and your dependents help with:

- understanding treatment plans and alternatives,
- monitoring claims payments, and
- evaluating alternative treatment facilities and options

Here are some medical conditions that may be appropriate for ICM:

- quadriplegia, paraplegia
- AIDS and certain associated symptoms
- newborn respiratory distress, newborn apnea
- brain injury, including traumatic brain injury
- spinal cord injury

The principles of ICM are an automatic feature of in-network care. If you receive out-of-network care or participate in the Traditional Program, a nurse consultant contacts your doctor or a social worker at the hospital to determine if alternative care, based on the ICM program, is available. Or, you may call Member Services to discuss whether case management is appropriate for your situation. Early identification allows the patient, family, physician, social worker and case manager to work together to arrange appropriate care in a timely manner.

Your doctor must approve any alternative care arrangement. You also have a say in planning what type of alternative care best fits the needs of you and your family. You do not forfeit any benefits, whether or not you choose the proposed treatment plan.

**Alternatives to a Hospital Stay**

Rather than a stay as a hospital inpatient, an alternative course of medical care may be more appropriate, cost-effective and comfortable. Expenses are covered by each of the options for the following alternatives to a hospital stay.

**Skilled Nursing Facility**

Skilled nursing facilities provide intermediate care following a hospital stay, when a patient may still require 24-hour nursing care for a limited period, but not on the level of care provided by a hospital. In these circumstances, benefits for a skilled nursing facility (or convalescent care facility) will be paid by Options 1, 2 and the Traditional Program.

There are no limits to the number of days of skilled facility care if provided in-network. Up to 60 days per calendar year are covered out-of-network or in the Traditional Program. Any in-network days will be counted toward your out-of-network limit.

**Outpatient Private Duty Nursing**

Benefits may be paid for medically skilled private duty nursing at home if it’s prescribed by your doctor. Benefits cover the home services of registered nurses, licensed practical nurses and licensed vocational nurses to a maximum of 560 hours per calendar year (70 eight-hour shifts). The 560 hours are counted as they are used. For example, a two-hour visit will be counted as two hours, rather than an eight-hour shift. *Call the toll-free 800 number on your medical identification card before you make any arrangements for outpatient private duty nursing.*

To be covered, outpatient private duty nursing services must:

- be medically necessary for treatment of a disease or injury
- require the medical training and technical skills of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) and
- be ordered by the attending physician as necessary treatment

The charges of private duty nurses in a hospital are not covered because the hospital provides a staff of registered nurses for care given during hospitalization. These charges are part of the room and board charges.

If you have a private duty nurse in the hospital, you’ll be responsible for those charges.
Skilled nursing care is not the same as custodial care. Custodial care is not covered, even if given by an RN, LPN or LVN. Custodial care includes such things as meal preparation, bathing the patient, acting as a companion and other services that may be necessary for the normal activities of daily living, but that do not require the medical training and technical skills of a nurse. Daily nursing notes will be reviewed to determine the portion of the nursing care that qualifies for benefits.

It’s also important to understand that while skilled nursing care may be necessary initially, alternate caregivers may be encouraged to learn the skills necessary for ongoing medical care. Once alternate caregivers have demonstrated their proficiency in a particular procedure, skilled nursing coverage for that procedure may cease.

No benefits are paid for services given by a nurse who lives with you.

Home Health Care
Charges made by a home health agency for a covered family member in the home in accordance with a home health care plan are covered by this benefit. For these expenses to be eligible, the home health care plan must be outlined by your physician.

Covered home health care expenses include:
- part-time or intermittent nursing care by an RN or LPN when prescribed by your physician
- part-time or intermittent home health aide services, consisting primarily of caring for the patient in conjunction with skilled nursing care
- physical, occupational or speech therapy
- drugs and most medical supplies prescribed by a physician
- laboratory services

Home health care benefits are calculated on a per-visit basis. Each visit by a nurse, therapist or aide is considered one visit; four hours is the maximum length of one visit. There are no limits on the number of home health care visits when the service is provided in-network. Up to 120 home health care visits per calendar year are covered when provided out-of-network or through the Traditional Program.

The following expenses are not covered by home health care:
- services or supplies not included in the home health care plan outlined by your physician
- services of a person who ordinarily lives in your home or who is a member of your or your spouse’s family
- custodial care
- transportation

Hospice Care
Hospice care provides terminally ill patients and their families with an alternative to hospital care while assuring them of a specialized program tailored to each individual. Terminally ill patients require specialized care, both medical and psychological, that may not be readily available from the regular hospital staff.

For purposes of this program, a terminally ill patient has a medical prognosis of approximately six months or less to live.

Charges for room and board made by a hospice facility, hospital, convalescent facility or physician are allowable when furnished on a full-time inpatient basis for pain control and other acute and chronic symptom management.

The following services and supplies are allowable when furnished to a person receiving outpatient hospice care coordinated by the hospice program administrator:
- part-time intermittent nursing care by an RN or LPN for up to eight hours in any one day
- medical social services under the direction of a physician, including:
  — assessment of the person’s social, emotional and medical needs and of the home and family situation
  — identification of community resources needed to meet his or her assessed needs
  — assisting the person to obtain the resources needed to meet his or her assessed needs
psychological and dietary counseling
consultation or case management services by a physician or nurse
physical and occupational therapy
medical supplies prescribed by a physician
part-time or intermittent home health aide services for up to eight hours in any one day. These consist mainly of caring for the person.

Benefits are not provided for the following hospice care services and supplies:
— any charge for daily room and board in a private room in excess of the institution’s semi-private room rate
— charges made for the following services:
  — bereavement counseling
  — funeral arrangements
  — pastoral counseling
  — financial or legal counseling, including estate planning or the drafting of a will
  — homemaker or caretaker services that are not solely related to care of the person (sitter or companion services for the patient or other members of the family, transportation, house cleaning and maintenance of the house)
  — respite care (care furnished when the patient’s family or usual caretaker cannot or will not attend to his or her needs)

What’s Not Covered by Your Medical Plan
Except as specifically noted otherwise in this booklet, benefits are not provided by the UPS Health and Welfare Package or the UPS Health and Welfare Package for Retired Employees for the services and supplies listed below. Excluded charges will not be taken into account in determining benefits. If you are not sure whether an expense is covered by your Plan, call Member Services.
— charges that exceed the reasonable and customary limit, as determined by the network manager or claims administrator (see page 26)
— services and supplies that are not medically necessary, as determined by the network manager or claims administrator (see page 25), even if prescribed, recommended or approved by the attending physician or dentist
— services and supplies the benefits administrator determines to be unnecessary for the diagnosis, care or treatment of the condition involved
care, treatment, services or supplies not prescribed, recommended and approved by the attending physician
hospital care for diagnostic purposes unless the covered person’s condition or type of test requires hospitalization
services or supplies not provided in accordance with medical or professional standards and practice
treatments or procedures and related materials that are investigational or experimental in nature, as determined by the network manager or claims administrator (see page 26)
occasional conditions, ailments or injuries for which coverage is provided by Workers’ Compensation or a similar law
additional expenses for a private room in a hospital, unless medically necessary
private duty nursing while confined
custodial care, rest centers, nursing homes or assisted living centers
treatment of a condition caused by war (declared or undeclared) or any act of war
treatment for conditions caused by committing an unlawful act of aggression, including a misdemeanor or a felony
services or supplies that are provided under any government law
services or supplies that are provided because of past or present service in any armed forces of any government
services provided before coverage becomes effective or after coverage ends
dietary supplements, including any supplement for newborn infants except as described in “Total Parenteral Nutrition and Enteral Nutrition” and PKU supplements
services or supplies related to any eye surgery performed mainly to correct refractive errors (e.g., radial keratotomy) unless vision acuity cannot be corrected to 20/50 with corrective lenses
services or supplies for or related to sex change surgery or any treatment of gender-identity disorders
services or supplies intended to induce pregnancy, such as artificial insemination, in vitro fertilization or embryo transfer procedures, including surrogate parenting
reversal of voluntary sterilization
expenses related to the purchase of orthopedic shoes or related corrective devices and appliances, except where the shoes or devices are permanently fastened to an orthopedic brace and are medically necessary or used in the place of surgery
personal hygiene, comfort or convenience items, such as air conditioners, humidifiers, whirlpools, waterbeds, home blood pressure monitor, televisions and physical fitness equipment
items to accommodate your home, office or vehicle as a result of an injury or illness, such as wheelchair lifts, hand rails or stair risers
acupuncture therapy, except when performed by a physician as a form of anesthesia in connection with surgery covered by this Plan
weight reduction programs, unless preapproved by the network manager or claims administrator
plastic surgery, reconstructive surgery or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons. However, benefits are paid if cosmetic/plastic surgery is needed to:
— improve the function of a body part that is not a tooth or structure that supports the teeth, or
— correct a severe birth defect, including hare lip or webbed fingers or toes, provided the surgery is necessary to improve the functionality of the body part, or
— correct a malformation as a direct result of disease, surgery performed to treat a disease (including reconstructive surgery following a mastectomy), or an accidental injury. The injury must occur while the person is covered by the UPS Health and Welfare Package or the UPS Health and Welfare Package for Retired Employees, and surgery must be performed in the same calendar year as the accident causing the injury, or in the next calendar year.
charges for a missed or broken appointment
charges for the doctor’s travel
administrative or office service fees, such as copying and mailing expenses and state and local taxes
claims received more than 12 months past the date of service
charges for or related to services, treatment, educational testing or training related to learning disabilities or developmental delays
services and supplies for which you are not legally obligated to pay
services and supplies provided by a personal injury protection or compulsory medical payments provision of any motor vehicle insurance contract required by federal or state law, whether or not the participant properly asserts his or her rights under the motor vehicle insurance contract
charges made only because coverage exists
charges for care furnished mainly to provide surroundings free from exposure to conditions that can worsen a person’s disease or injury
services of a physician who is still a resident or intern, when services are billed in that capacity
items listed in the following sections as not covered expenses:
— Enteral Nutrition and Total Parenteral Nutrition
— Infertility Treatment
— Special Types of Therapy
— Home Health Care
— Hospice Care
— Prescription Drug Benefits
— Solutions

How to File a Medical Claim
See page 72, Information About Filing Claims.

Prescription Drug Benefits
Prescription drug benefits for participants of medical Options 1, 2 and the Traditional Program are administered by Medco Health Solutions. (HMO participants receive their prescription drug coverage from the HMO.) The program gives you and your family three ways to save money on prescription medications:
You may have your prescriptions filled at pharmacies that participate in the PAID Prescriptions Program (called participating pharmacies). When you do, you'll pay nothing or a low copayment for your medication. There are no claim forms to worry about.
You may have your prescriptions filled at non-participating pharmacies, but you’ll need to pay the full amount of the prescription, then file a claim for reimbursement.
You may order maintenance medications through the Home Delivery Pharmacy Service.
Using Participating Pharmacies

Medco Health maintains a network of more than 40,000 pharmacies nationwide, including many major pharmacy chains and independent pharmacies. When you enroll in either Plan, you’ll receive a prescription ID card. To find a participating pharmacy near you, find a link to Medco Health from UPSers.com, or call 1-800-UPS-1508.

Simply present your ID card to the pharmacist along with your doctor’s prescription. You don’t have to file any claims. You’ll pay:
- $5 copayment for brand name medications
- $0 copayment for generic medications

Your benefits cover up to a 30-day supply of medication with each prescription. If you need more than a 30-day supply, you might want to order your medication through the Home Delivery Pharmacy Service.

Using Non-Participating Pharmacies

When using a non-participating pharmacy, you’ll have to pay the pharmacy’s regular charge for the medication and submit a completed claim form to be reimbursed. It’s important to remember that participating pharmacies charge UPSers a lower price for prescriptions. Your reimbursement will be based on this lower amount when you use a non-participating pharmacy. You’ll pay the difference between the lower (discounted) amount and the pharmacy’s regular price, plus any applicable copayment.

Home Delivery Pharmacy Service

The Home Delivery Pharmacy Service gives you and your family a convenient, money-saving way to purchase maintenance medications. Maintenance medications are those prescribed for long-term or ongoing conditions, such as high blood pressure, allergies or diabetes. When you use the Home Delivery Pharmacy Service:
- You can order up to a 90-day supply of medication at no cost to you.*
- You won’t need to file a claim or wait for reimbursement.

*If your prescription is for a controlled substance, you’ll receive only up to a 30-day supply. Also, a signature is necessary for the prescription when it’s delivered to you.

Ordering is easy. This is what you do:
- Ask your physician to prescribe up to a 90-day supply, plus refills, of your medication.
- Complete the Patient Profile Questionnaire included with your PAID information kit (or call PAID at 1-800-346-1327 for a questionnaire).
- Mail the questionnaire in the special mail service order envelope (included with the questionnaire), along with your original prescription.

Medication is delivered to your home by UPS within 14 days from the day you mail your prescription.

Prescriptions are filled by registered pharmacists who check your prescription against your personal medical profile to safeguard you against adverse reactions.

Refill Prescriptions Online

You may also order home delivery prescription refills over the internet by using Medco Health’s Web site anytime 24 hours a day, seven days a week. You’ll find a link at UPSers.com.

Prior Authorization Program

PAID Prescriptions and the Home Delivery Pharmacy Service have a Prior Authorization Program that evaluates the medical necessity of using certain drugs in certain situations.

Your pharmacist will tell you if your prescription requires prior authorization. Then you or your physician must call PAID Prescriptions to request authorization for coverage of these drugs. The list of drugs requiring prior authorization may change from time to time; contact PAID Prescriptions at 1-800-UPS-1508 for more information.

Drugs Covered by the Prescription Program
- drugs approved by the federal government
- state-restricted drugs
- insulin — by prescription only
- insulin needles, syringes and chem strips — by prescription only
- over-the-counter diabetic supplies
- compounded medications
- smoking deterrents (with a lifetime limit of one 90-day supply)
- oral contraceptives

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Drugs Excluded by the Prescription Program
The Prescription Program does not cover the following:
- contraceptive devices
- drugs not approved by the federal government
- therapeutic devices or appliances
- drugs used for cosmetic purposes
- infertility drugs without prior authorization (see page 35)
- drugs labeled “Caution: limited by federal law to investigational use,” or experimental drugs, even though a charge is made to the individual
- medication for which the cost is recoverable by Workers’ Compensation, occupational disease law, any state or government agency, or medication provided by any other drug or medical service for which no charge is made to the participant
- medication taken by or administered to a person, in whole or in part, while he or she is a patient in a licensed hospital, nursing home or similar institution which has a facility for dispensing pharmaceuticals on its premises
- any prescription refilled more than the number of times specified by the prescribing physician or any refill dispensed after one year from the physician’s original order
- Viagra and Levitra
- dietary supplements, including any supplement for newborn infants
- growth hormones without prior authorization (see page 35)
- over-the-counter medications (other than diabetic supplies)

Prescription Formulary
To help contain the increasing cost of prescription drug coverage and continue the UPS commitment to quality care, your prescription drug benefit has a voluntary formulary feature.

A formulary is simply a list of commonly-prescribed medications that have been selected because of their combination of effectiveness and cost. The Preferred Prescriptions Formulary operates in conjunction with the Home Delivery Pharmacy Service.

All participating pharmacies in the Medco Prescription Program will be aware of drugs currently on the formulary. Your doctor and non-participating pharmacies should call Medco toll-free at 1-800-UPS-1508 to learn which drugs are formulary drugs.

You should always encourage your physician to prescribe formulary drugs whenever possible, because their cost is less and their effectiveness has been established.

How to File a Prescription Claim
See page 72, Information About Filing Claims.

About Generic Drugs
It’s a good idea to ask your physician to prescribe generic medications whenever possible. The generic name of a drug is its chemical name (for example, ibuprofen). The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand-name drugs are required to meet the same standards for safety, purity, strength and effectiveness.
Mental Health and Substance Abuse Benefits

When you or covered family members need help with a mental health or substance abuse problem, you can turn to Solutions, a special UPS program administered by ValueOptions that provides confidential mental health and substance abuse counseling, treatment and referrals through a network of trained professionals.

If you choose medical Option 1, 2 or the Traditional Program, your mental health and substance abuse coverage is administered by ValueOptions. You don’t need a referral from your doctor or PCP to take advantage of the program’s services. Furthermore, the Solutions network is nationwide, so you can get the advice and care you need no matter where you live.

If you choose HMO coverage, your mental health and substance abuse coverage is administered by that HMO, except for Humana, Humana/Choice Care and Network Blue New England. In those HMOs, your coverage is administered by ValueOptions, and is described in this section and in the Option 1 chart on page 41.

It’s important to remember that the Solutions program complements, but does not replace, your UPS Employee Assistance Plan (EAP).

Solutions provides benefits for mental health and substance abuse treatment that is medically necessary. Medically necessary means care that, as determined by ValueOptions:

- is appropriate and necessary to evaluate or treat a disease, condition or illness as defined by standard diagnostic nomenclatures (the American Psychiatric Association’s Diagnostic and Statistical Manual IV as revised or updated in the future)
- can reasonably be expected to improve an individual’s condition or level of functioning
- is in keeping with national standards of mental health professional practice as defined by standard clinical references and valid empirical experience for efficacy of therapies, and
- is provided at the most appropriate and cost effective level of care

The Solutions Network

ValueOptions maintains a national network of mental health providers — therapists, treatment programs and hospitals. ValueOptions’ providers meet strict membership requirements, have proper credentials and are regularly reviewed by ValueOptions to ensure that standards are met.

You will receive maximum benefits if you call Solutions for a referral. You and your covered dependents can contact Solutions 24 hours a day, 365 days a year by calling 1-800-336-9117. If you seek emergency treatment, you must contact Solutions within 48 hours. You can call Solutions directly, or your PCP, another doctor or the EAP may refer you to Solutions.

Out-of-Network Treatment

If you seek treatment outside the Solutions network, Solutions will pay benefits only if treatment is provided by one of these core providers:

- psychiatrist (MD, DO)
- licensed clinical psychologist (doctoral level)
- licensed masters-level clinical social worker (e.g., licensed MSW)
- masters-prepared psychiatric registered nurse (e.g., MA, MS, MSN)

The core provider must hold the highest level of licensure or certification that the state in which they are practicing offers, and have a current state license.
When you first call Solutions, you’ll talk with a trained professional who will discuss your situation confidentially with you. You may then be referred to an appropriate provider for a more complete evaluation and development of a treatment plan. After a treatment plan is developed, Solutions will monitor the care to ensure the treatment you receive is appropriate and medically necessary.

All medically necessary outpatient visits to a ValueOptions network provider will be covered.

**Mental health** treatment is covered as follows:
- all inpatient mental health treatment must be provided through the Solutions network
- outpatient mental health treatment may be provided through Solutions or a provider who is not part of the Solutions network
- if you seek outpatient treatment outside the Solutions network, Solutions will pay benefits only if treatment is provided by one of these core providers:
  - psychiatrist (MD, DO)
  - licensed clinical psychologist (doctoral level)
  - licensed masters-level clinical social worker (e.g., licensed MSW)
  - masters-prepared psychiatric registered nurse (e.g., MA, MS, MSN)

The core provider must hold the highest level of licensure or certification that the state in which they are practicing offers.

In addition, all providers must have a current state license. Because licensing requirements vary from state to state, call Solutions before you start treatment to verify that you’re seeing an appropriate provider.

ValueOptions must always precertify the following services, regardless of whether or not you use a Solutions provider:
- psychological testing
- electroconvulsive therapy (ECT)
- biofeedback
- hypnotherapy
- aversion therapy
- individual therapy for chemical dependency (only available through Solutions network)

If you or your provider don’t precertify these procedures, no benefits are payable.

**Substance abuse** treatment — whether inpatient or outpatient — is covered only through Solutions. Substance abuse treatment not approved by ValueOptions before the treatment is provided is not covered. For substance abuse treatment arranged through Solutions, you are responsible for one fee or copayment per course of treatment, regardless of the setting (or settings) for the treatment. This is called a Treatment Plan Fee.

---

**Precertification Required**

ValueOptions must always precertify the following services, regardless of whether or not you use a Solutions provider:
- psychological testing
- electroconvulsive therapy (ECT)
- biofeedback
- hypnotherapy
- aversion therapy
- individual therapy for chemical dependency (only available through Solutions network)

If you or your provider don’t precertify these procedures, no benefits are payable.
Confidentiality
Information regarding your or an eligible dependent’s participation in Solutions will be kept confidential, except with your written consent or where disclosure is required by law or specific company policy with regard to safety-sensitive positions. In the latter instance, disclosure will be made only to designated persons and will be limited to information for which there is a need to know.

What’s Not Covered
The following mental health and substance abuse services and treatments are not covered in Options 1, 2 and the Traditional Program:

- treatment not provided by one of the core providers or a Solutions network provider
- court-ordered treatment, unless assessed and certified by ValueOptions to be in accordance with medically necessary standards
- services and treatment for the purpose of maintaining employment or insurance, unless assessed and certified by ValueOptions to be in accordance with medically necessary standards
- services and treatments which are:
  — educational or vocational in nature
  — required by law to be provided by a school system for a child (such as evaluation for attention deficit disorder)
  — for personal growth and development
  — for adjudication of marital, child support and custody cases
- services and treatment that are experimental, investigational, mainly for research or not in keeping with national standards of practice as determined by ValueOptions, for example, treatment of sexual addiction, codependency, or any other behavior that does not have a psychiatric diagnosis
- regressive therapy, megavitamin therapy, nutritionally based therapies for chemical dependency treatment, and non-abstinence based chemical dependency treatment
- custodial care, including, but not limited to, treatment not expected to reduce the disability to the extent necessary to enable the patient to function outside a protected, monitored or controlled environment
- services and treatment for mental retardation (except initial diagnosis), autism (which may be covered by the medical plan), pervasive developmental disorders, chronic organic brain syndrome, learning disability
- treatment for transsexualism
- treatment for smoking cessation
- treatment for obesity and/or weight reduction
- treatment for stammering or stuttering
- treatment for chronic pain except for psychotherapy, biofeedback or hypnotherapy provided in connection with a psychiatric disorder

In addition to this list, certain medical services or supplies are not covered (for a general list of what’s not covered, see page 33). To determine if specific mental health or substance abuse treatment will be covered, call Solutions at 1-800-336-9117.

How to File a Solutions Claim
See page 72, Information About Filing Claims.

Right of Recovery Provision
In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See page 77 for details on the Plans’ right of recovery provisions.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Traditional Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Care Physician Network</td>
<td>Preferred Provider Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>Outside Network Area</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network</td>
<td>Out-of-Network</td>
<td></td>
</tr>
<tr>
<td>Medical Basic Provisions Plan Deductible</td>
<td>None</td>
<td>None</td>
<td>$50/person</td>
</tr>
<tr>
<td></td>
<td>$250/person</td>
<td>$250/person</td>
<td>$100/family</td>
</tr>
<tr>
<td></td>
<td>$500/family</td>
<td>$500/family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All out-of-network benefits except emergency room, prescriptions and mental health/substance abuse are subject to deductible.</td>
<td>All out-of-network benefits except emergency room, prescriptions and mental health/substance abuse are subject to deductible.</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$1,000/person Only in-network out-of-pocket expenses are applied to this maximum.</td>
<td>$3,000/person Only in-network out-of-pocket expenses are applied to this maximum.</td>
<td>$1,000/person Only out-of-network out-of-pocket expenses are applied to this maximum.</td>
</tr>
<tr>
<td></td>
<td>$3,000/person</td>
<td>$3,000/person</td>
<td>$3,000/person</td>
</tr>
<tr>
<td></td>
<td>Only in-network out-of-pocket expenses are applied to this maximum.</td>
<td>Only in-network out-of-pocket expenses are applied to this maximum.</td>
<td>Only in-network out-of-pocket expenses are applied to this maximum.</td>
</tr>
<tr>
<td></td>
<td>$1,000/person</td>
<td>$1,000/person</td>
<td>$1,000/person</td>
</tr>
<tr>
<td></td>
<td>Only in-network out-of-pocket expenses are applied to this maximum.</td>
<td>Only in-network out-of-pocket expenses are applied to this maximum.</td>
<td>Only in-network out-of-pocket expenses are applied to this maximum.</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>UPS Health and Welfare Package – $1,000,000/person; UPS Health and Welfare Package for Retired Employees – $500,000/person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>Physician Office Visit</td>
<td>$10/visit, remainder at 100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>In-Hospital Physician Services</td>
<td>100%</td>
<td>80% after deductible</td>
<td>100%</td>
</tr>
<tr>
<td>Surgery</td>
<td>100%</td>
<td>80% after deductible</td>
<td>100%</td>
</tr>
<tr>
<td>Allergy Testing and Treatment Services (including pre-admission testing)</td>
<td>$10/visit, injection only at 80%</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90%/visit, injection only at 80%</td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-ray and Laboratory</td>
<td>Included in $10 copayment if part of office visit, 100% if out-of-office</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>$10/visit, remainder at 100%</td>
<td>Not Covered</td>
<td>90%</td>
</tr>
<tr>
<td>Routine Physical Evaluation</td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Well-Child Care</td>
<td>$10/visit, remainder at 100%</td>
<td>Not Covered</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100%</td>
<td>Not Covered</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Ob/Gyn Exam</td>
<td>$10/visit, remainder at 100%</td>
<td>80% after deductible, covers Pap smear and related lab fees only</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$1,000 maximum per year</td>
<td>80% after deductible to a maximum of $40/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90% to a maximum of $40/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% after deductible to a maximum of $40/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90% after deductible to a maximum of $40/visit</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>= $10/initial visit</td>
<td>= 80% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>= None</td>
<td>= 90% initial visit</td>
<td>80% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>= 80% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>= 80% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% after deductible initial visit, 100% thereafter</td>
<td></td>
</tr>
<tr>
<td>Ambulance – Emergency</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ambulance – Non-Emergency</td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*If a chiropractic network is not available in your area, in-network benefits will be paid for each visit to the chiropractor of your choice.

All out-of-network and Traditional Plan medically necessary services are reimbursed at reasonable and customary amounts.
### Hospital Services

**Hospital Admission Fee**
This is paid each time a covered individual is admitted to the hospital.

**Inpatient Coinsurance**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Option 1 Preferred Provider Network</th>
<th>Out-of-Network</th>
<th>Traditional Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Admission Fee</td>
<td>None</td>
<td>$250</td>
<td>100%</td>
<td>100%</td>
<td>100% after $100 copay</td>
</tr>
<tr>
<td>Inpatient Coinsurance</td>
<td>100%</td>
<td>80% after deductible</td>
<td>100%</td>
<td>80% after deductible</td>
<td>100% after $100 copay</td>
</tr>
<tr>
<td>Outpatient Coinsurance</td>
<td>100%</td>
<td>80% after deductible</td>
<td>100%</td>
<td>80% after deductible</td>
<td>100% after $100 copay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td></td>
<td></td>
<td>100% when treatment is within 72 hours of an accident or patient is hospitalized, otherwise $25 copay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Use of Emergency Room</td>
<td>100% after $100 copay</td>
<td>100% after $100 copay</td>
<td>100% after $100 copay</td>
<td>100% after $100 copay</td>
<td>100% after $100 copay</td>
</tr>
<tr>
<td>Other Covered Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care – Outpatient</td>
<td>100%</td>
<td>80% after deductible</td>
<td>100%</td>
<td>80% after deductible</td>
<td>100%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100%</td>
<td>80% after deductible, limited to 60 days/year</td>
<td>100%</td>
<td>80% after deductible, limited to 60 days/year</td>
<td>100%, limited to 60 days/year</td>
</tr>
<tr>
<td>Outpatient Private Duty Nursing</td>
<td>100%</td>
<td>80% after deductible, maximum 60 hours per year</td>
<td>90%</td>
<td>80% after deductible, maximum 60 hours per year</td>
<td>80% after deductible, maximum 60 hours per year</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
<td>80% after deductible, limited to 120 four-hour visits/year</td>
<td>90%</td>
<td>80% after deductible, limited to 120 four-hour visits/year</td>
<td>80% after deductible, limited to 120 four-hour visits/year</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Defined as services consisting of physical, occupational or speech therapy that are expected to improve a body function lost or impaired due to an injury, disease or congenital defect.</td>
<td>$10/visit, remainder at 100%</td>
<td>80% after deductible, limited to 60 visits/year combined inpatient and outpatient</td>
<td>90%</td>
<td>80% after deductible, limited to 60 visits/year combined inpatient and outpatient</td>
<td>80% after deductible, limited to 60 visits/year combined inpatient and outpatient</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100%</td>
<td>80% after deductible</td>
<td>90%</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Prescription Drug Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 home delivery, $0 generic, $5 brand name</td>
<td>$0 home delivery, $0 generic, $5 brand name</td>
<td>$0 home delivery, $0 generic, $5 brand name</td>
<td>$0 home delivery, $0 generic, $5 brand name</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call Solutions for in-network benefits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Fee</td>
<td>$100</td>
<td>Not available, Solutions network available throughout the U.S.</td>
<td>$100</td>
<td>Not available, Solutions network available throughout the U.S.</td>
<td>$100</td>
</tr>
<tr>
<td>= Coinsurance</td>
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<td>100%</td>
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<tr>
<td>Mental Health</td>
<td></td>
<td></td>
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<tr>
<td>Inpatient</td>
<td>$100</td>
<td>Not available, Solutions network available throughout the U.S.</td>
<td>$100</td>
<td>Not available, Solutions network available throughout the U.S.</td>
<td>$100</td>
</tr>
<tr>
<td>= Admission fee</td>
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<tr>
<td>Mental Health</td>
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<tr>
<td>Outpatient</td>
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<td>$10</td>
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<td>90%</td>
<td>90%</td>
<td>100%</td>
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</tbody>
</table>

**Failure to precertify hospital admission results in a $250 fee.**

This chart represents a summary of the actual benefits available as detailed in both Plan documents. If, in the process of abbreviating the descriptions, any coverages were summarized differently than detailed in either Plan, each Plan’s documents will govern.
Dental

Both Plans offer you coverage from the Aetna Dental PPO.

The dental program covers four categories of necessary dental care:
- preventive services — including check-ups, cleanings and routine X-rays
- basic services — including fillings, simple extractions, space maintainers and root canal therapy
- major services — including inlays, onlays, crowns and dentures
- orthodontia — the straightening of your children’s teeth

The Aetna Dental PPO is a preferred provider dental plan. This means you can choose to use a dentist participating in the network or a non-participating dentist each time you need dental care.

To help you understand the dental coverage, we defined some of the key terms used in this section at the bottom of the next several pages.

Aetna Dental PPO

A central feature of the Plan is access to a national network of preferred dental care providers. If you live within the boundaries of the network and use a network dentist you will receive the in-network benefit level. You may also choose to see a dentist that does not participate in the network, but your benefit level is less and your out-of-pocket costs will generally be higher.

If you live outside the dental network boundaries you can choose to travel to a network provider and receive all the benefits of the network, or you can receive care from a non-network provider and be reimbursed at the in-network benefit level. If you wish to “opt-in” to the dental network call the UPS Benefits Service Center at 1-800-353-9877 for additional information.

Advantages of Using the Dental Network

Network providers must meet National Committee for Quality Assurance (NCQA) credentialing standards. This includes verification of license, DEA or state narcotics certification, graduation and completion of residency, board certification status, current levels of malpractice insurance and professional liability claims history.

Network providers will bill Aetna Dental PPO for claims. Network providers have agreed to bill you only the coinsurance amount due.

No balance billing. After you have paid your coinsurance, network providers must accept the Aetna Dental PPO negotiated fee as payment in full. You cannot be billed for the difference between the negotiated fee and the provider’s usual and customary fee.

Services not covered. If a service is performed that is not covered under the dental Plan, the network provider may charge you their usual and customary fee. However, the provider must inform you in advance that the service is not covered, and you must give your written consent to pay the provider’s usual and customary fee for the service.

The following information will help you use the dental network:
- Selecting a network dentist. A list of local participating dentists is available from a link at UPSers.com, by calling the UPS Benefits Service Center, or by calling the number on your dental ID card. You may use any dentist in the network to receive the in-network benefit. You may also select a non-participating dentist.

Necessary dental care means preventive dental care and certain other care necessary to diagnose and treat dental disease (as determined by Aetna). The Plan limits benefits to those services and supplies which are customarily used nationwide for treatment and deemed by the profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice. The patient's total current oral condition will be taken into account when determining benefits.
Scheduling an appointment. When you call your participating dentist to make an appointment, make sure to identify yourself as a Plan participant. When you visit the dentist’s office, please be sure to show your dental ID card.

Specialty treatment. Although your participating dentist will provide most dental care, occasionally you may require a specialist’s services for more complex dental work. The network includes a listing of specialty dentists.

Member Services
Member Services is your link to the dental network. You can call Member Services toll-free at the number on the back of your dental or combination medical/dental ID card to:
- ask questions about your benefits
- obtain information about a network provider or service
- obtain help in filing claims

Important Dental Coverage Features
Maximum Benefits
The portion of your claim paid by your dental Plan counts toward the individual annual dental maximum. The cost of preventive services also counts toward your annual maximum. When the combination of claims paid by the Plan for services from in- and out-of-network dentists reaches $2,500, out-of-network coverage for the remainder of that year is not available.

For example, assume you incur $100 in eligible expenses and the Plan pays 80 percent. That means you pay $20 and the Plan pays $80. The $80 counts toward the annual maximum.

Reasonable and Customary
All eligible dental expenses from a non-participating dentist are subject to reasonable and customary limits — charges within the normal range of fees in your geographic area for similar services and similar supplies (as determined by Aetna). If your non-participating dentist charges more than the reasonable and customary limit, you’re required to pay any amounts over the limit. Since Aetna Dental PPO providers have agreed to accept the negotiated fee schedule amount as payment for services, reasonable and customary does not apply to services provided through a participating dentist.

Summary of Dental Benefits
For the summary of dental benefits, see your Insert.

Covered Expenses
The following describes the types of services and supplies covered. The exact amount paid for services and supplies depends on whether or not you go to a participating dentist and if it is necessary dental care. All eligible dental expenses must be necessary as preventive care or to diagnose and treat dental disease.

Preventive Services
Covered preventive services are:
- oral exams (twice a year*)
- prophylaxis — any type (twice a year*)
- topical fluoride applications for children, until the end of the year in which the child turns 15 (twice a year)

*If additional examinations and scaling are necessary each year, your dentist should submit a letter to Aetna explaining the request. Aetna will respond directly to your dentist. No more than four examinations will be covered per calendar year.

Network means a group of dentists who have contracted with Aetna Dental PPO to provide dental benefits to eligible participants of the Plans.

Participating dentist is a network dentist who has agreed with Aetna to provide care at negotiated rates. You may use any participating dentist for yourself and each of your covered dependents each time you seek treatment.
X-rays:
- full-mouth or panoramic (once every three years)
- bitewing (twice a year)

Sealants for children, until the end of the year in which the child turns 14:
- one application per tooth per 36-month period
- permanent first and second molars only

Basic Services
- visits and exams
  - professional visit after hours
  - emergency palliative treatment
  - routine postoperative care
- X-ray and pathology
  - single films (up to 13)
  - intra-oral, occlusal view, maxillary or mandibular
  - upper or lower jaw, extra-oral
- extractions
  - uncomplicated
  - postoperative visit (sutures and complications) after multiple extractions and impaction
- emergency treatment
- periodontics
  - root planing and scaling, per quadrant (not prophylaxis), limited to four quadrants per year
  - correction of occlusion related to periodontal surgery, per quadrant
- endodontics
  - pulp capping
  - therapeutic pulpotomy (in addition to restoration)
  - vital pulpotomy
  - remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only
  - root canals (devitalized teeth only), including necessary X-rays and cultures but excluding final restoration
    - canal therapy (traditional or Sargenti method)
    - single rooted
    - bi-rooted
    - tri-rooted
    - apicoectomy (separate procedure)

Basic restorative — excludes inlays, crowns and bridges; multiple restorations in one surface will be considered as a single restoration
- pins
  - pin (retention) when part of the restoration used instead of gold or crown restoration
- repairs — crowns and bridges
- special tissue conditioning, per denture
- recementation
- inlay
- crown
- bridge
- restorations (involving one, two or three or more surfaces)
  - amalgam filling
  - silicate cement filling
  - plastic filling
  - composite filling — the alternate benefit of an amalgam filling will be given when placed on posterior teeth

Major Services
- oral surgery — includes local anesthetics
  - extractions
  - surgical removal of erupted tooth
  - impacted teeth
  - removal of tooth
  - alveolar or gingival reconstructions
  - alveoectomy (edentulous) per quadrant
  - alveoectomy (in addition to removal of teeth) per quadrant
  - alveoplasty with ridge extension, per arch
  - removal of exostosis
  - excision of hyperplastic tissue, per arch
  - excision of pericoronal gingiva
  - odontogenic cysts and neoplasms
  - incision and drainage of abscess
  - removal of odontogenic cyst or tumor
  - other surgical procedures
    - sialolithotomy — removal of salivary calculus
    - closure of salivary fistula
- transplantation of tooth or tooth bud
- removal of foreign body from bone
  (independent procedure)
- maxillary sinusotomy for removal of tooth
  fragment or foreign body
- closure of oral fistula of maxillary sinus
- sequestrectomy for osteomyelitis or bone
  abscess, superficial
- condylectomy of temporomandibular joint
- meniscectomy of temporomandibular joint
- radical resection of mandible with bone graft
- crown exposure to aid eruption
- removal of foreign body from soft tissue
- frenectomy
- suture of soft tissue injury
- treatment of trigeminal neuralgia by injection
  into second and third divisions
- anesthetics
  — general, only when provided in conjunction
  with an eligible surgical procedure
- periodontics
  — subgingival curettage
  — gingivectomy (including post-surgical visits)
    per quadrant
  — gingivectomy, treatment per tooth (fewer than
    five teeth)
  — osseous or muco-gingival surgery (including
    post-surgical visits)
  — crown lengthening — reviewed on a per claim
    basis. Predeterminations are suggested.
- major restorative — gold restorations, inlays, onlays
  and crowns are covered only as treatment for decay
  or traumatic injury and only when teeth cannot be
  restored with a filling material or when the tooth
  is an abutment to a fixed bridge or partial denture.
  Only restorations needed for severe attrition, abrasion
  or erosion are covered.
  — inlays and onlays
    • one or more surfaces
    — crowns
      • stainless steel (when tooth cannot be restored
        with a filling material)
      • crown build-up — will be reviewed by a dental
        consultant for necessity
      • acrylic
      • acrylic with gold
      • acrylic with non-precious metal
      • porcelain
      • porcelain with gold
      • porcelain with non-precious metal
      • non-precious metal (full cast)
      • gold (full cast)
      • gold (3/4 cast)
      • gold dowel pin
- prosthodontics
  — bridge abutments (see inlays and crowns)
  — pontics
    • cast gold (sanitary)
    • cast non-precious metal
    • slotted facing
    • slotted pontic
    • porcelain fused to gold
    • porcelain fused to non-precious metal
    • plastic processed to gold
    • plastic processed to non-precious metal
  — removable bridge (unilateral)
    • one piece casting, chrome cobalt alloy clasp
      attachment (all types), including pontics
  — dentures and partials (Fees for dentures, partial
    dentures and relining include adjustments within
    six months after installation. Specialized techniques
    and characterizations are not eligible.)
    • complete upper denture
    • complete lower denture
    • partial acrylic upper or lower with chrome cobalt
      alloy clasps, base, all teeth and two clasps

Coinsurance means the percentage of covered expenses that you pay after the dental option has paid its share and the
deductible (if there is one) is met.
● partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two clasps
● additional clasps
● office reline, cold cure, acrylic
● laboratory reline
● adjustment to denture more than six months after installation
   — full and partial denture repairs
   — broken dentures, no teeth involved
   — partial denture repairs (metal)
   — replacing missing or broken teeth except congenitally missing teeth
   — adding teeth to partial denture to replace extracted natural teeth
● teeth and clasps
● space maintainers — includes all adjustments within six months after installation
   — fixed space maintainer (band type)
   — removable acrylic with round wire rest only
● other services
   — implants (if specifically approved in advance and the teeth are extracted or become missing while covered under the Plan)

Orthodontia
Benefits are allowed for teeth straightening for your dependent children under 19 years of age. Services provided by December 31 of the year in which your child turns 19 are covered, as long as treatment began before the child’s 19th birthday. The plan pays 50 percent of the reasonable and customary charge for orthodontia, up to a $1,500 lifetime maximum for each child. Orthodontic payments are made on a monthly basis. The first payment is equal to 50 percent of the member's down payment plus 50 percent of the fee for the diagnostic records. The monthly installments are released automatically each month on or after the same day of the month in which the bands are placed. However, quarterly certification is required to verify that treatment is continuing. Payments begin when an active appliance is installed in your dependent child's mouth.

Covered orthodontic services are:
● initial consultation
● moldings and impressions

● installation of braces
● regular visits
● removable inhibiting appliance to correct thumbsucking
● fixed or cemented inhibiting appliance to correct thumbsucking

Before treatment begins, the orthodontist should submit a total treatment plan to Aetna for approval. In this way, you and the orthodontist will know what treatment will be covered.

If you are a newly hired employee and if your child is involved in a course of orthodontic treatment when your coverage becomes effective, the dental Plan will not pay benefits toward that treatment.

Accidents
Coverage for treatment and repair of sound teeth and gums caused by an accidental injury (as determined by Aetna) will be covered as a regular dental expense. For this treatment and repair of accidental injuries only, the annual maximum will be waived for 12 months from the date of injury. (Under certain circumstances this waiver may be extended for dependent children). All other dental care will continue to be subject to the annual deductible and annual maximum during these treatment periods.

An example of a covered accident would be being hit by an external force, such as a baseball. An example not covered by this provision would be breaking a decayed tooth by biting down on hard food.

Temporomandibular Joint (TMJ) Therapy
Both Plans cover temporomandibular joint dysfunction for adults and dependent children. This coverage is for TMJ appliance therapy (bite splints) and adjustments only. Diagnostic materials, including impressions, are not covered.

The Plan covers 50 percent of the reasonable and customary cost of TMJ therapy up to a $1,500 lifetime maximum. The $1,500 lifetime maximum limit for children’s TMJ benefits is combined with the orthodontia maximum.
What’s Not Covered by Your Dental Benefits

In addition to services not specifically listed in the “Covered Expenses” section, the following expenses are not covered by the dental options:

- services not required for the treatment of a specific condition or to maintain good dental hygiene
- services not reasonably necessary or customarily performed, as determined by Aetna
- charges for services not furnished by a licensed dentist, except services provided by a licensed hygienist under the direction of a dentist or X-rays ordered by a dentist
- services for which you would not be required to pay in the absence of dental coverage
- charges covered by the medical options
- treatment of a work-related injury
- a charge for a service furnished by or for the United States government, including a service that may be covered under a government plan
- charges for your missed or broken appointment
- charges for the dentist’s travel
- occlusal adjustment (unless following periodontal surgery) or retainers if charged separately from orthodontic treatment
- IV sedation, except in certain circumstances. Call Aetna at 1-877-263-0659
- appliances, restorations or procedures needed to alter vertical dimensions or restore occlusion or for the purpose of splinting or correcting non-severe attrition or abrasion
- dentures and bridgework when they are for the replacement of teeth that were extracted before the patient was covered by a UPS dental option
- orthodontic treatment begun before covered by a UPS dental option
- root canal therapy, if the pulp chamber was opened before the patient was covered by a UPS dental plan
- relines and adjustments of dentures and partial dentures within six months after installation
- cosmetic dental services and supplies, including personalization or characterization of dentures
- prosthetic devices and appliances, including bridges and crowns, and expenses for fitting or modifying them, if the patient is not covered by either the UPS Health and Welfare Package or the UPS Health and Welfare Package for Retired Employees when they are ordered, when an impression was made or when a tooth was prepared. The above are also not covered if installed or delivered more than 30 days after the patient’s coverage ends
- replacement of lost, stolen or broken appliances
- replacement of congenitally missing teeth
- dental implants (unless specifically approved in advance)
- educational programs, such as plaque control or oral hygiene instruction
- a charge for a replacement or modification of a partial or fully removable denture, a removable bridge or fixed bridgework, or for adding teeth to any of these, or for a replacement or modification of an inlay, onlay, crown or cast processed restoration, within five years after installation
- Actisite
- local anesthesia or nitrous oxide, as a separate charge
- any prescription drug
- full mouth debridement
- guided tissue regeneration
- desensitization treatment
- precision attachments except as noted under “Major Restorative Services”
- infection control
- behavior management
- canal preparation, if submitted as a separate charge
- rubber dam
- claims received more than 12 months past the date of service
**Alternate Treatment**

In some circumstances, an alternate service or supply may be suitable to treat or restore a dental condition, other than the service or supply recommended by your dentist. If alternate services or supplies may be used to treat a dental condition, covered dental expenses will be limited to those services and supplies which:

- are customarily used nationwide for treatment, and
- are deemed by the profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice. The person’s total current oral condition will be taken into account.

If you choose the recommended course of treatment, you will be responsible for the difference between the recommended course and the alternate benefit. For example, your dentist may recommend a composite (white) filling for a posterior tooth. An appropriate alternate treatment is an amalgam filling. The Plans will only pay for the amalgam filling. If you wish to have the composite filling, you will pay the difference between the composite and the amalgam filling.

**Predetermination of Benefits**

If you seek care from an Aetna Dental PPO participating provider, your provider will automatically, when necessary, submit predetermination information to the network. If you seek care from a non-participating dentist and you anticipate that charges for a course of dental treatment will be more than $300, you should submit an itemization of the proposed treatment (including recent pretreatment X-rays) before work is begun. A dental consultant will review the proposed treatment, and Aetna will inform you and your dentist of the amount of covered charges. That way, you’ll understand the benefits that will be paid and have the opportunity to discuss possible treatment options with your dentist. While predetermination is not required, unless it’s an emergency, you may not wish to begin the course of treatment until you know what amount your dental plan will pay.

**Preauthorization of Benefits**

You will not need to seek pre-authorization from Aetna for covered services, except in the case of dental implants, which must be preauthorized in advance by Aetna. Your dentist will be required to provide all necessary or requested documentation for review. If implants are not approved in advance, no expenses or related expenses will be covered.

**Right of Recovery Provision**

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See page 77 for details on the Plans’ right of recovery provisions.

**How to File a Claim**

See page 72, *Information About Filing Claims*.
Vision
All participants in both Plans receive coverage for an annual eye exam and vision materials, such as frames and lenses or contact lenses, to help you cover expenses for vision care.

Non-routine vision coverage is provided through your medical carrier. If you experience a medical problem with your eyes, you should consult your PCP or primary doctor (See the Medical section for coverage of services.)

For routine vision care, you have the choice of using a Vision Service Plan (VSP) network provider or any provider you choose. However, the Plans pay higher benefit levels when you use a VSP provider.

How Your Vision Benefits Work
VSP has more than 22,000 member doctor locations that provide professional eye care, including eye examinations and the necessary corrective lenses. In order to access vision care benefits, simply contact your VSP participating doctor to make an appointment. If you need help locating a VSP participating doctor, find a link to VSP’s Web site at UPSers.com, or call VSP at 1-800-877-7195.

When calling the doctor’s office to make an appointment for you or your covered dependents, identify yourself as a VSP patient. Indicate that UPS provides your benefits, and then provide your VSP identification number (your Social Security number). The VSP participating doctor will obtain the necessary authorization and information about your eligibility and coverage.

If You Don’t Use a VSP Provider
If you do not use a VSP provider, you and your covered dependents can receive vision care services from any provider and be reimbursed up to the limits of the fee schedule. Contact lenses are also covered — in lieu of glasses — up to the fee schedule limit (see chart below). To be reimbursed, you must submit a claim form.

You can use a non-VSP provider for an eye examination, and then use a VSP provider for frames and lenses — if that VSP provider agrees to fill the prescription without an exam.

A Summary of Vision Coverage

<table>
<thead>
<tr>
<th>Benefit</th>
<th>VSP</th>
<th>Non-VSP*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>100%</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Single-vision lenses</td>
<td>100%</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Bifocal lenses</td>
<td>100%</td>
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</tr>
<tr>
<td>Trifocal lenses</td>
<td>100%</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Frames</td>
<td>100%**</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Standard daily-wear contact lenses</td>
<td>100%</td>
<td>Up to $60</td>
</tr>
</tbody>
</table>

*Non-VSP providers subject to R&C
**Over 11,000 frames are covered in full by the current frame allowance

Special Benefit If You Use a VSP Provider
If you use a VSP provider, the Plans will cover in full the cost of corrective lenses and standard frames. If you choose a more expensive frame or cosmetic lenses, you’ll be responsible for additional charges, but at reduced VSP prices.

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Covered Expenses
Vision coverage pays 100 percent of the cost of an exam from a VSP provider once each calendar year. It will also pay for either a new pair of glasses and frames or contact lenses (but not both) once each calendar year. If you receive services from a non-VSP provider you will be reimbursed up to the maximums listed above.

Disposable contact lenses are covered under the vision plan. However, the entire benefit amount for exam, fitting and lenses must be used at one time.

The reasonable and customary cost of contact lenses required after cataract surgery or for special medical conditions is provided whether through VSP or any provider.

Vision Benefit Limitations
The following limitations are in addition to the general guidelines previously described.

Available at an Additional Cost
Vision benefits are designed to cover your corrective visual needs and not cosmetic materials. If you select any of the following items, you will be responsible for additional charges (at reduced prices if you use a VSP provider):
- frames costing more than the Plan allows
- coated lenses
- contact lenses costing more than the Plan allows (except as noted earlier)
- no-line, blended bifocal lenses

You can also get a 20 percent discount on additional pairs of glasses and a 15 percent discount on contact lens professional services — fitting, evaluation and follow-up — from your VSP provider, if purchased within 12 months of your examination.

Discounts on Laser Vision Correction Surgery
As a VSP member, laser vision correction surgery is available at discounted prices through VSP’s Laser VisionCare™ network of doctors.

Visit VSP’s Web site from a link at UPSers.com to learn more about laser vision correction and participating doctors. Or, call VSP at 888-354-4434 for more information.

Not Covered by Vision Benefits
The vision plan will not pay benefits for professional services or materials connected with:
- visual analysis that does not include a complete eye refraction
- orthoptics or vision training
- subnormal vision aids
- aniseikonic lenses
- two pairs of glasses instead of bifocals
- replacement of lost or broken lenses or frames (unless you have not already received a pair of lenses or frames that year)
- medical or surgical treatment of eyes
- services or materials provided as a result of Workers’ Compensation or similar legislation or provided through a government agency or program
- eye exams, glasses or contacts provided by any other vision care plan
- duplicate or spare glasses
- vision care services, materials or procedures covered by other provisions of the Plans. For example, vision therapy after cataract surgery is covered by the medical benefits.

How to File a Claim
See page 72, Information About Filing Claims.
Life Insurance and AD&D

Life insurance is primarily a benefit for your family or anyone who depends on you for support. Its purpose is to help provide your beneficiary with some measure of financial security in the event of your death. Accidental death and dismemberment (AD&D) insurance provides financial protection if you’re seriously injured or die in an accident.

The UPS Health and Welfare Package provides group term life insurance benefits through the following programs:
- employee life insurance
- spouse’s life insurance
- children’s life insurance
- employee accidental death and dismemberment insurance

Life insurance and AD&D benefits are provided through an insurance contract with Prudential Insurance Company of America. If there is any conflict between the Prudential Insurance Group Contract-Certificate and this description or the Prudential Supplemental Life brochure, the Contract-Certificate provisions apply. The terms of the Prudential Supplemental Life brochure are incorporated in and become part of this Summary Plan Description. You can obtain a copy of the Contract-Certificate by calling the UPS Benefits Service Center at 1-800-353-9877.

When Is Coverage Effective?

As a bargaining unit employee of UPS, basic employee, spouse’s and children’s life insurance and basic employee AD&D coverage begins on the day you become eligible for the UPS Health and Welfare Package.

Optional supplemental coverage may be elected at:
- your group’s initial enrollment period if you were eligible for coverage prior to your group’s initial effective date
- the first annual enrollment after your coverage begins if you are a newly hired employee or a rehired employee who was not previously eligible in the current year

Coverage for annual enrollment elections begins on January 1 of the following calendar year.

For change in status elections, increases in coverage are retroactive to the date of the event. Decreases in coverage are effective on the first day of the first full pay period following your election.

In all cases, the following exceptions apply:
- If you’re ill or injured and absent from work on the date your coverage should start, coverage starts on the first day after you return to work for at least one full day. Your dependents’ coverage is also delayed until your coverage starts.
- If you increase your coverage for any reason and are ill or injured and absent from work on the date the increased coverage should start, the incremental amount of the increased coverage will not be effective until after you return to work for at least one full day. If the increased coverage never becomes effective because you do not return to work, you will continue to be covered at the lower level of coverage that was in effect prior to the requested increase.
- If evidence of insurability is required, any amounts requiring approval will be delayed until approval is granted by Prudential. See “Evidence of Insurability” later in this section.

Basic Life Insurance

UPS pays the full cost of basic life insurance. The benefit amount of basic life insurance is:
- for full-time employees — 2080 hours times the hourly rate of your base job, to a maximum of $100,000
- for part-time employees — 1040 hours times the hourly rate of your base job, to a maximum of $100,000
- for your spouse — $5,000
- for your children — $2,500
Your coverage amount is automatically updated with any changes to your hourly rate. Basic employee life insurance is group term life coverage. It can be converted to an individual policy if you leave or retire from UPS. If you are unsure of your basic coverage amount, contact the UPS Benefits Service Center.

Imputed Income
The value (as defined by the Internal Revenue Service) of your basic employee life insurance coverage over $50,000 is taxable and is reported to the federal government on your W-2 form. This value is called “imputed income.”

For example, if you had $55,000 in basic employee life insurance, you would be taxed on the value of $5,000 of insurance. For most people this amount is nominal.

Supplemental Life Insurance
If you want more insurance than your basic coverage, you can purchase Supplemental Term Life Insurance in $1,000 increments up to a maximum of $1,000,000. For more details about this coverage, see the Prudential Supplemental Life brochure.

Evidence of Insurability (Good Health)
For life insurance that requires evidence of insurability, Prudential will ask you to complete a form showing evidence of insurability (good health) before approving you for coverage.

For life insurance that requires evidence of insurability, coverage will not be effective until the insurance is approved by Prudential and you meet the “active at work” requirements. Coverage and payroll deductions will be set at the highest requested level available without evidence of insurability. Once approved, the coverage level and payroll deduction increase retroactive to the date of approval.

Premium Rates
Your annual premium rate is based upon your age and smoking status. The premium rate for your spouse is based upon his or her age and smoking status. This rate per $1,000 of coverage is multiplied by the amount of coverage you elect.

Portability
If you leave UPS for any reason, the portability option lets you continue your Supplemental Life Insurance on a direct-billed basis. Since you are no longer a UPS employee, your group rates will no longer be the same as rates available to active UPSers, but will be based on a group made up of many Prudential customers. You can keep up to your current amount of insurance without providing any evidence of insurability.

You can also elect to convert the basic or supplemental coverage to an individual life policy without providing evidence of insurability.

If you use the portability option and are later rehired or transferred to a UPS position that allows you to elect supplemental coverage under this or another UPS-sponsored plan, you must surrender the ported policy in order to elect supplemental coverage under the UPS-sponsored plan as an active employee.

Living Benefit Option
The living benefit option provides you a portion of your life insurance benefit before your death if you are terminally ill with a life expectancy of less than 12 months.

Refer to the Prudential Supplemental Life brochure for more details about life and AD&D insurance.
**Spouse’s Life Insurance**

You may purchase spouse’s supplemental coverage through the following options:

<table>
<thead>
<tr>
<th>Option</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,000 of coverage (basic + $5,000 supplemental)</td>
</tr>
<tr>
<td>2</td>
<td>$25,000 of coverage (basic + $20,000 supplemental)</td>
</tr>
<tr>
<td>3</td>
<td>$50,000 of coverage (basic + $45,000 supplemental)</td>
</tr>
</tbody>
</table>

Please refer to the Prudential Supplemental Life brochure for premium rates and coverage details.

If your spouse or child is eligible as an employee for supplemental life insurance through the UPS Health and Welfare Package or another UPS-sponsored plan that offers supplemental life insurance (i.e., the Flexible Benefits Plan or UPS Crewmembers Benefit Package), you are not eligible to cover your spouse or child for supplemental life insurance through the UPS Health and Welfare Package. Your spouse or child must elect employee supplemental life insurance through her/his own employee plan.

You are always the beneficiary of this insurance. This coverage ends when coverage under the UPS Health and Welfare Package ends for your spouse. You may continue your spouse’s coverage by converting it to a Prudential individual policy or by exercising the portability option.

**Children’s Life Insurance**

Coverage for newborns is effective on the date of birth, except as stated in “When Is Coverage Effective?” on page 51. However, stillborn deliveries are not covered.

The cost per $1,000 of coverage is the same regardless of how many children are covered. Please see the Prudential Supplemental Life brochure for the premium rate. An incapacitated child over age 25 will continue coverage at the child’s rate as long as the child otherwise meets the eligibility rules of the Plan.

You are always the beneficiary of this insurance. This coverage ends when coverage under the UPS Health and Welfare Package ends for your child. You may continue your child’s coverage by converting it to a Prudential individual policy (there is no portability provision for children’s coverage).

You may purchase children’s term life coverage through the following options:

<table>
<thead>
<tr>
<th>Option</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$5,000 of coverage (basic + $2,500 supplemental)</td>
</tr>
<tr>
<td>2</td>
<td>$10,000 of coverage (basic + $7,500 supplemental)</td>
</tr>
</tbody>
</table>

**Accidental Death and Dismemberment (AD&D) Insurance**

Accidental death and dismemberment insurance pays a benefit for certain injuries resulting from a covered accident. If you die, your beneficiary receives the full amount. If you are injured, you receive all or a portion of the benefit, depending on the nature of the injury. AD&D coverage ends when your UPS Health and Welfare Package coverage ends. It cannot be converted to an individual policy.
Basic AD&D Insurance
UPS pays the full cost of basic employee AD&D coverage, up to a maximum of $100,000. The benefit amount of basic AD&D coverage is:
- for full-time employees — 2080 hours times the hourly rate of your base job
- for part-time employees — 1040 hours times the hourly rate of your base job

Your coverage amount is automatically updated with any changes to your hourly rate. If you are unsure about your basic AD&D coverage amount, contact the UPS Benefits Service Center.

Supplemental AD&D Insurance
You may purchase supplemental AD&D coverage in $1,000 increments up to a maximum of $1,000,000. Evidence of insurability is not required.

Standard AD&D Benefits
Benefits are paid at certain percentages of your coverage amount for specific accidental losses. Not more than 100 percent of the coverage amount for the standard AD&D benefit is payable for all losses due to the same accident. The loss must be incurred within 90 days of the accident (paralysis within 365 days of the accident).

Standard benefits apply to basic and supplemental coverage. For more information and the Schedule of Losses, see the Prudential Supplemental Life brochure.

Additional AD&D Benefits
If you are injured or die as a result of a covered accident, the Plan pays the following benefits in addition to the Standard AD&D benefits. Please refer to the Prudential Supplemental Life brochure for more details. These additional benefits apply to basic and supplemental coverage.
- Seat Belt Benefit
- Air Bag Benefit
- Rehabilitation Benefit
- Continuation of Medical Funding Benefit
- Brain Damage Benefit
- Emergency Medical Evacuation/Return of Remains Benefit

AD&D Exclusions
AD&D benefits (basic and supplemental) do not cover a loss if it results from any of these:
- suicide or attempted suicide, while sane or insane
- intentionally self-inflicted injuries or any attempt to inflict such injuries while sane or insane
- sickness, whether the loss results directly or indirectly from the sickness
- medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment
- any infection, unless pyogenic and occurring at the same time as the accident, cut or wound; or bacterial infection unless it results from accidental ingestion of a contaminated substance
- war or any act of war, declared or undeclared, including resistance to armed aggression
- an accident occurring while serving on full-time active duty for more than 30 days in any armed forces (does not include Reserves or National Guard active duty for training)
- commission of or attempt to commit a felony

General Provisions — Life and AD&D
Your Beneficiary
You may name anyone you choose as beneficiary for your life insurance and AD&D benefits. (AD&D benefits other than for your death are payable directly to you.) To name a beneficiary or change your current beneficiary at any time, call the UPS Benefits Service Center at 1-800-353-9877 for instructions.

Your beneficiary designation is not effective until the UPS Benefits Service Center receives your Beneficiary Designation form.

Refer to the Prudential Supplemental Life brochure for more details about life and AD&D insurance.
If you name more than one beneficiary, and do not indicate the percentage of your coverage you want for each individual, benefits will be divided equally between or among your beneficiaries.

If you do not name a beneficiary, or if the beneficiary(ies) you name is not living at your death, payments will be made to the following survivors in the following order (e.g., if you didn’t designate a beneficiary, your spouse would receive 100% of the benefit if s/he were living at your death):

- your spouse
- your child(ren)
- your parent(s)
- your sibling(s)
- the executor(s) or administrator(s) of your estate

You are automatically the beneficiary for your spouse’s and children’s life insurance.

If You Leave UPS or Retire…

If you leave UPS or retire, you have the opportunity to continue your, your spouse’s and your children’s basic term life insurance coverage by converting it to self-paid individual policies, without providing evidence of insurability. To obtain a Conversion Kit, call the Prudential Group Conversion Office at 877-889-2070. The conversion application must be returned within 31 days of your last day of coverage. You also have the opportunity to either convert or to continue your supplemental coverage through the portability option. If you choose to continue your coverage under the portability option, your spouse may also continue her/his supplemental coverage under the portability provision. Upon termination or retirement, you will receive portability information directly from Prudential. For more information regarding portability, call Prudential Group Life Services at 1-877-877-2955.

AD&D insurance ends when you leave the company; it cannot be converted to an individual policy.

How to File a Claim

See page 72, Information About Filing Claims.
Short-Term Disability

Short-Term Disability (STD) protects your salary for up to 26 weeks if you have an absence caused by a non-occupational illness or accidental injury, as determined by Broadspire. An absence for maternity is treated like an absence for illness.

Eligibility

STD is available to all full-time and part-time employees when coverage begins under the UPS Health and Welfare Package.

Eligibility for STD benefits will automatically end on the earliest of the date:

- your employment with UPS terminates
- your eligibility for coverage under the Health and Welfare Package ends
- you retire, or
- you enter full-time military service

Short-Term Disability Benefits

STD benefits pay 60 percent of your average weekly base pay, to a maximum of $500 per week, for up to 26 weeks for any one continuous period of disability. Benefits begin on the first work day of an absence caused by an injury and the fourth work day of an absence caused by illness. Broadspire determines if your disability is caused by an illness or an injury. STD benefits are paid on a weekly basis and reduced by all applicable disability benefit offsets.

Average weekly base pay is calculated by averaging the paid hours (maximum of 40 per week) each week during the last quarter in which you worked the complete quarter and multiplying that average by the hourly rate of your base job. A complete quarter is a quarter in which you have paid hours each week of the quarter.

If you did not work the complete quarter, the Plan will look back a maximum of four quarters for the most recently worked complete quarter. If there is no complete quarter in the last four, the Plan uses the quarter with the most hours worked. The number of hours (maximum of 40 per week) and the number of weeks you worked in that quarter (not the total number of weeks in the quarter) are used to calculate your average weekly base pay.

For STD purposes, you are considered disabled if the claims administrator, Broadspire, determines that you are limited from performing the material and substantial duties of your regular occupation because of a non-occupational illness or injury.

Qualification for STD benefits is subject to you (or your physician at your request) providing objective medical information to Broadspire supporting your disability. You may also need medical approval prior to returning to work.

If you can’t return to work when your benefits end, call Broadspire to discuss the situation with your case manager. Broadspire will contact your physician for an update on your condition. You should also contact your supervisor to keep him/her informed of your progress. If you are eligible for long-term disability benefits, Broadspire will automatically review your case for LTD coverage.
If You Have More Than One STD Absence
If you are absent and receiving STD benefits and return to work for at least one day and are later absent for an entirely different cause, you are eligible for a new 26-week period of STD benefits (after the waiting period if an illness). If your second absence is due to the same cause, you must have returned to work for at least 14 calendar days to be eligible for a new 26 weeks of STD. This minimum period cannot include any vacation, personal or discretionary days. Otherwise, your second absence will be considered a continuation of the first disability period, and both periods of absence count toward the 26 weeks.

Disability Benefit Offsets
California and Rhode Island have state-administered disability benefits. In these states, the UPS Plan offsets the state plan benefits so that the combined amount paid by the UPS Plan and the state plan would be no more than the amount the UPS Plan would pay if there were no other coverage. The claims administrator will automatically offset your UPS benefits unless you provide documentation that you are not receiving state disability benefits.

Hawaii, New Jersey, New York and Puerto Rico have state-mandated benefits. In these states, the amount paid to you will be the greater of either the state-mandated benefit or your STD benefit, but not both.

Additionally, your STD benefit will be reduced in full by other disability income or retirement income you may receive, or be eligible to receive, including:
- any amount received from a retirement plan or pension plan that UPS contributes to or sponsors (other than the Teamster — UPS National 401(k) Tax Deferred Savings Plan)
- any amount you receive from another group insurance plan (individual insurance plans are not offset)
- any no-fault or third-party settlement
- any benefits (primary and family) received under the Social Security Act
- any work-loss provision of a no-fault or third-party benefit or settlement
- any disability benefits received from the Veterans Administration

It is a requirement of the Plan that you apply for the Social Security disability insurance benefit as well as any state-provided disability benefits to which you may be entitled. You are also required to appeal any denials. If you do not apply, or appeal denials, the claims administrator, Broadspire, will estimate the Social Security amount that you could have received and offset your benefit by that amount. Should you receive a lump sum payment (e.g., from Social Security or a no-fault or third-party settlement related to your injury or illness), the portion of that total payment (less any attorney fees) that represents disability benefits will be offset over the period for which the sum is given. If no period is given, the sum will be prorated as an offset over the 26-week STD period. If Broadspire is unable to determine the exact amount of the award that represents disability benefits, 50 percent of the award will be considered disability benefits. This includes retroactive awards. Prorated offsets will begin when the lump sum payment is made.
In the event that you receive STD benefits for an illness or injury that is later determined to be an occupational illness or injury, you will be required to reimburse the Plan for any STD benefits you have received to date for that condition.

**Exclusions and Limitations**
No STD benefits are payable from this Plan for any disability that results from:

- an on-the-job illness or injury*
- intentionally self-inflicted injuries
- participation in a felony
- war, or act of war (whether such is declared or not), insurrection, rebellion, or participation in a riot or civil commotion
- serving on active duty in any armed forces of any government
- any vague or undefinable condition that cannot be described by a standard medical nomenclature diagnosis

No STD benefits are payable for days when you receive:

- sick pay
- holiday pay
- optional holiday pay
- vacation pay
- Workers’ Compensation benefits

*STD benefits will not be paid out concurrently with Workers’ Compensation benefits, even if you are also disabled because of an off-the-job injury or illness. However, if you are still disabled because of an off-the-job injury or illness when you are released to return to work from the occupational injury or illness, you will be eligible to apply for STD benefits at that time.

**Benefit Termination**
There are certain conditions which could cause your STD benefits to be terminated. These occur when you:

- cease to have a disability as defined by the Plan and determined by the claims administrator
- fail to provide objective medical documentation requested by the claims administrator. Broadspire can request additional medical documentation of an ongoing disability as often as it deems reasonably necessary
- fail to comply with a reasonable course of medical treatment and care necessary and appropriate to treat and/or resolve the condition for which you’re receiving disability benefits
- fail to comply with an independent medical examination or other evaluation as may be required by the claims administrator
- have been paid 26 weeks of STD benefits

**Taxes and Your STD Benefit**
STD benefits are taxed when paid to you. The claims administrator, Broadspire, will create all W-2 forms for any benefits received under the STD Plan.

**How to File a Claim**
See page 72, *Information About Filing Claims*.

Keep in mind that you must file a claim within 30 days of the initial date of disability in order to receive a benefit.
Long-Term Disability

Long-Term Disability (LTD) provides protection from disabilities caused by non-occupational illnesses or injuries that last longer than 26 weeks. It is an optional benefit available to eligible full-time employees.

Eligibility

Full-time employees are eligible to elect the long-term disability option at their first annual enrollment after coverage under the Health and Welfare Package begins. Elected LTD coverage then becomes effective January 1 of the following year.

Eligibility under the Plan will automatically end for any disability that occurs after the earliest of these events:
- your employment with UPS terminates
- you retire
- you cease to be an eligible employee
- you enter full-time military service
- you die, or
- you cease making contributions for the benefit

If your participation ends, you may enroll only during the annual enrollment period.

LTD Benefits

LTD benefits pay 60 percent of your average weekly base pay, to a maximum of $500 per week, for up to 60 months (five years). Long-term disability benefits begin when short-term disability coverage ends, or after 26 weeks, whichever is later. During this waiting period, you must continue to pay your portion of LTD premiums. LTD benefits are paid on a monthly basis and will be reduced by all applicable disability benefit offsets.

Average weekly base pay is calculated by averaging the paid hours (maximum of 40 per week) each week during the last quarter in which you worked the complete quarter and multiplying that average by the hourly rate of your base job. A complete quarter is a quarter in which you have paid hours each week of the quarter.

If you did not work the complete quarter, the Plan will look back a maximum of four quarters for the most recently worked complete quarter. If there is no complete quarter in the last four, the Plan uses the quarter with the most hours worked. The number of hours (maximum of 40 per week) and the number of weeks you worked in that quarter (not the total number of weeks in the quarter) are used to calculate your average weekly base pay.

For the first 24 months of disability under LTD, you are considered disabled if the claims administrator determines that you:
- are limited from performing the material and substantial duties of your regular occupation due to a non-occupational illness or injury

After 24 months of payments, you will be considered disabled if the claims administrator determines that you:
- are unable to perform the material duties of any gainful occupation for which you are reasonably qualified based on your education, training or experience. Gainful occupation means any occupation for which you are reasonably qualified based on education, training or experience at which you could earn at least 60 percent of your pre-disability earnings.
Qualification for LTD benefits is subject to you (or your physician at your request) providing objective medical information to Broadspire supporting your disability. You may also need medical approval prior to returning to work.

If you are absent and receiving LTD benefits and return to work for at least one day and are later absent for an entirely different cause, you are eligible for a new 60-month period of LTD benefits (after the STD waiting period). If your second absence is due to the same cause, you must have returned to work for at least six months to be eligible for a new LTD period. Otherwise, your second absence will be considered a continuation of the first LTD period.

Disability Benefit Offsets

Your LTD benefit will be reduced in full by other disability income or retirement income you may receive, or be eligible to receive, including:
- any amount received from a compulsory state disability plan
- any amount received from a retirement plan or pension plan to which UPS contributes or sponsors (except the Teamster — UPS National 401(k) Tax Deferred Savings Plan)
- any amount received from another group insurance plan (individual insurance plans are not offset)
- any no-fault or third-party settlement
- any benefits (primary and family) received under the Social Security Act
- any incorrectly paid STD or LTD benefits

It is a requirement of the Plan that you apply for the Social Security disability insurance benefit as well as any state-provided disability benefits to which you may be entitled. You are also required to appeal any denials. If you do not apply, or appeal denials, the claims administrator, Broadspire, will estimate the Social Security amount that you could have received and offset your benefit by that amount. Should you receive a lump sum payment (e.g., from a no-fault or third-party settlement or Social Security), the portion of that total payment (less any attorney fees) that represents disability benefits will be offset over the period for which the sum is given. If no period is given, the sum will be prorated as an offset over the 60-month LTD period. If Broadspire is unable to determine the exact amount of the award that represents disability benefits, 50 percent of the award will be considered disability benefits. This includes retroactive awards. Prorated offsets will begin when the lump sum payment is made.

Exclusions and Limitations

No LTD benefits are payable from this Plan for any disability that results from:
- an on-the-job illness or injury
- intentionally self-inflicted injuries, while sane or insane
- participation in a felony
- war, or act of war (whether such is declared or not), insurrection, rebellion, or participation in a riot or civil commotion
- any vague or undefinable condition that cannot be described by a standard medical nomenclature diagnosis
- any disability that begins prior to LTD coverage under the Plan
- psychiatric/nervous conditions or substance abuse and/or alcoholism, except during the first 24 months of LTD. After 24 months, coverage will only be continued if and for as long as you remain confined in an accredited hospital for the treatment of a psychiatric/nervous condition.
Benefit Termination
There are certain conditions which could cause your LTD benefits to be terminated. These occur when you:

- cease to have a disability as defined by the Plan and as determined by the claims administrator
- fail to provide objective medical documentation requested by the claims administrator
- fail to comply with a reasonable course of medical treatment and care necessary and appropriate to treat and/or resolve the condition for which you’re receiving disability benefits
- fail to comply with an independent medical examination or other evaluation as may be required by the claims administrator
- refuse an offer or fail to continue participation in a rehabilitation program, modified duty, limited duty, alternative employment or retraining
- have been paid 60 months of LTD benefits

Taxes and Your LTD Benefit
Federal regulations that govern the taxability of your benefits state that any LTD coverage that is paid for by the employer will be taxed when paid to you as a benefit. Benefits that are purchased with after-tax dollars will be paid out to you without taxes being withheld. This means that one half of your LTD benefit — the portion UPS purchases — will be taxed when you receive the benefit. The portion that you purchase, after-tax, will not be taxed when you receive the benefit.

The claims administrator, Broadspire, will create all W-2 forms for any benefits received under the LTD Plan.

Right of Recovery Provision
In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See page 77 for details on the Plans’ right of recovery provisions.

How to File a Claim
See page 72, Information About Filing Claims.
Spending Accounts

Spending accounts let you set aside a portion of your annual earnings on a before-tax basis to pay for many of your out-of-pocket health, child and elder care expenses that you incur during the year. You are eligible for this benefit at the first annual enrollment after gaining health care coverage.

You can use the Health Care Spending Account for expenses not covered by the medical, dental or vision options, including:
- your deductibles and copayments
- charges that exceed reasonable and customary levels
- expenses not covered by UPS options, such as adult orthodontia

The Child/Elder Care Spending Account lets you save on the cost of care for your eligible dependents so you and your spouse, if you’re married — can work or attend school.

How the Spending Accounts Work

You may enroll in the Health Care Spending Account, the Child/Elder Care Spending Account, both accounts — or neither. Your elections will be in effect during the entire calendar year. The amount you choose to contribute to your account(s) will be deducted from your regular pay in equal amounts throughout the year.

All eligible health, child or elder care expenses must be incurred during the year for which you make your account deposits or during the Grace Period. (See the Grace Period section for more information on terms and conditions.) An expense is considered incurred when the service is provided, not when you are billed or when you pay for it.

Unused Account Balance

It’s important that you carefully estimate your expenses before you enroll in either the Health Care or Child/Elder Care Spending Accounts because the Internal Revenue Service (IRS) requires that you forfeit any account balance not used to pay eligible expenses incurred during the year, or — with the Health Care Spending Account — during the Grace Period. In addition, you cannot:
- receive a refund of any unused balances
- transfer your funds from one account to the other
- carry funds over from one year to the next (except during the Grace Period), or
- stop making deposits until the following January 1 unless an eligible change in status occurs

Changing Your Elections

In exchange for the tax advantages provided by the spending accounts, the IRS limits your ability to make changes during the year. As a result, you can only change your spending account elections during the course of the year if you have an eligible change in status. The type of change you can make must be consistent with your change in family status (see the Life Events section).

You must request a change in coverage within 60 days of your change in status. For more details about allowable changes, see the Life Events section. Contact the UPS Benefits Service Center for instructions on initiating a change in coverage.

Spending Account Tax Advantages

You don’t pay federal or Social Security (FICA) taxes, and, in most locations, state or local income taxes, on the portion of your pay that you contribute to a spending account.

If you’re a highly compensated employee (as defined by the IRS), the maximum amount you can contribute to the Child/Elder Care Spending Account may be limited. You’ll be notified if these limits apply to you.
**Health Care Spending Account**

The Health Care Spending Account (HCSA) lets you pay for eligible expenses with before-tax dollars, thereby reducing your taxable income.

**How Much Can You Contribute?**

You may contribute up to $3,500 a year to your HCSA. The amount will be taken in equal amounts from each paycheck you receive during the year. You can contribute a minimum of $50 annually.

**Eligible Dependents**

For the HCSA, you may claim eligible health care expenses for anyone you claim as a dependent on your federal income tax return (e.g., dependent children or elderly parents). These dependents do not have to be covered by the UPS Health and Welfare Package.

**How the Health Care Spending Account Works**

You can use your HCSA to pay for health care expenses incurred by you and your eligible dependents if the expenses are not covered by a medical, dental or vision option. The IRS specifies the kinds of expenses that may be paid through a health care spending account. You cannot take a deduction on your federal income tax return for any health care expenses for which you have been reimbursed through your HCSA.

The following eligible — and ineligible — health care expenses are based, in part, on Internal Revenue Service Publication 502, “Medical and Dental Expenses.” To order a copy of the entire list, call the IRS toll-free at 1-800-829-3676, or visit the IRS Web site at www.irs.gov.

**Eligible Health Care Expenses**

You may receive reimbursement from your HCSA for health care expenses that have not been reimbursed from other sources. Here are some examples of eligible health care expenses:

- your deductibles and copayments (including those from other employers’ plans)
- fees for doctors, dentists and hospital services not covered by a medical, dental or vision option (e.g., adult orthodontia)
- charges that exceed reasonable and customary amounts (see the medical or dental section for explanations of the term reasonable and customary)
- medical equipment and supplies (must be prescribed and not available over the counter)
- reconstructive cosmetic surgery (surgery that is medically necessary to correct a deformity from a hereditary abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease)
- infertility treatment
- capital expenses to install special equipment or make home improvements if the main purpose is medical care (such as installing entrance and exit ramps)
- equipment and materials required for using contact lenses, such as saline solution and enzyme cleaners
- over-the-counter medications used for “medical care” and not for general well-being

**Ineligible Health Care Expenses**

You may not receive reimbursement from your HCSA for expenses that are not considered deductible for income tax purposes. Following are some examples of ineligible expenses:

- payroll deduction amounts and/or premiums for your or your dependents’ coverage
- athletic club expenses to keep physically fit (even if suggested by doctor)
- cosmetic surgery of a non-reconstructive nature (i.e., not necessary to correct a deformity arising from, or directly related to, a hereditary abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease)
- transportation costs of a disabled person to and from work
- medical/dental expenses of a former spouse or dependent
Child/Elder Care Spending Account

The Child/Elder Care Spending Account (C/ECSA) lets you deduct money from your pay before taxes to cover your eligible child or elder care expenses.

How Much Can You Contribute?

Generally, you may contribute up to $5,000 a year to your C/ECSA. The amount will be taken in equal amounts from each paycheck you receive during the year. You can contribute a minimum of $50 per year.

If you’re married and you and your spouse file separate tax returns, the maximum you can set aside for child/elder care reimbursement is $2,500. If you file a joint tax return, the amount you can contribute to a C/ECSA cannot exceed the lesser of your earned income or your spouse’s earned income.

Earned income means your annual gross earnings (less certain pre-tax deductions) less your annual deposit to the C/ECSA. Your earned income (plus your spouse’s earned income) must be greater than the C/ECSA contribution.

If your spouse doesn’t work, you cannot use the C/ECSA unless your spouse is disabled or a full-time student for at least five months of the year, or is looking for work. In these cases, the law assumes that your spouse has a monthly income of $250 if you have one dependent, or $500 if you have two or more dependents. If your spouse works part time, you can be reimbursed for child/elder care expenses — but only for work-related time, such as the time he or she spends at work and commuting to and from work.

Eligible Dependents

Eligible dependents for the C/ECSA include the following if they reside with you:

- children age 12 or younger
- your spouse who is physically or mentally incapable of caring for himself or herself
- dependent of any age (including a parent) residing in your home for at least eight hours a day, who is physically or mentally incapable of self-care and dependent on you for at least 50 percent of his or her financial support

How the Child/Elder Care Account Works

You can use the C/ECSA to pay for eligible dependent care expenses necessary for you — and your spouse, if married — to work. Child/elder care expenses are often regular, budgeted expenses — the cost of day care while you and your spouse work, for example. By being reimbursed for these expenses through the C/ECSA, you can increase your take-home pay.

Eligible Child/Elder Care Expenses

The following information is based on Internal Revenue Service Publication 503, “Child and Dependent Care Expenses.”

Expenses eligible for payment through your C/ECSA include expenses for:

- wages or salary paid to a care provider (whether inside or outside your home) except your dependent, your dependent child under age 19 or your spouse
- expenses for household services (such as preparing meals) related to the care of an eligible dependent
- FICA and other taxes you pay on behalf of the care/service provider
- nursery schools, pre-kindergartens, day camps and day care and elder care centers that meet state or local regulations, provide care for more than six nonresident people and receive fees for services provided
Ineligible Child/Elder Care Expenses

Services that do not qualify for reimbursement through your C/ECSA include:

- dependent care provided by your spouse, by your dependent child under age 19, or by anyone you list as a dependent on your federal income tax return
- dependent care for non-work-related reasons
- dependent care provided if your spouse does not work or works different hours than you, unless your spouse is disabled or a full-time student
- any expense you plan to take as a credit on your income tax return
- transportation to and from a dependent care location
- care provided in a full-time residential institution
- overnight care expenses (unless the parents work nights)
- late payment fees
- expenses for a provider’s food, clothing and entertainment
- expenses that are primarily educational in nature (such as kindergarten)

To receive reimbursements from the C/ECSA, you must provide written receipts showing the caregiver’s name and taxpayer identification number or Social Security number. (However, if the provider is a charitable organization — such as the YMCA, a church or similar organization — it is not necessary to provide the organization’s taxpayer identification number.)

Tax Credit vs. Child/Elder Care Spending Account

Your participation in the spending accounts can affect the way you calculate your federal income tax return at the end of the year. For every dollar of reimbursement you receive through the C/ECSA, your dependent care tax credit is reduced by a dollar. So if you elect to participate in the C/ECSA, you are making a decision not to take the federal dependent care tax credit for those expenses.

In most cases, the C/ECSA will offer you the greater tax savings. However, it is important to note that in some cases, your tax savings may be greater if you use the dependent care tax credit rather than the spending account for part or all of your dependent care expenses.

The following table compares the C/ECSA and the federal income tax credit. You may want to consult your personal tax advisor to see which method makes the most sense for you.

<table>
<thead>
<tr>
<th>Using the Child/Elder Care Spending Account</th>
<th>Using the Federal Income Tax Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum annual contribution is $50</td>
<td>No minimum annual expense for using the tax credit</td>
</tr>
<tr>
<td>Maximum annual contribution is $5,000</td>
<td>Maximum annual expenses applicable toward tax credit is $3,000 for one child; $6,000 for two or more children</td>
</tr>
<tr>
<td>(2,500 each if married filing separately)</td>
<td></td>
</tr>
<tr>
<td>Contributions are excluded from taxable income</td>
<td>A percentage of eligible expenses is applied as credit against taxes owed</td>
</tr>
<tr>
<td>Contributions are free from Social Security taxes</td>
<td>Tax credit doesn’t affect Social Security taxes</td>
</tr>
<tr>
<td>You must decide contribution amount before expenses are incurred and you forfeit the unused amount</td>
<td>You determine tax credit at the end of the year after all expenses are incurred; there’s no risk of forfeiture</td>
</tr>
</tbody>
</table>
Impact on Other Benefits

Your spending account participation has no effect on your UPS-sponsored benefit amounts. Although spending accounts lower your pay for tax purposes, your other company benefits under this Plan — such as life insurance and disability — are based on your earnings before spending account contributions have been withheld.

Please keep in mind that if you pay less Social Security (FICA) tax because of your participation election, then your Social Security benefits at retirement, death or disability may also be lower. You will pay less FICA tax if your pay is at or below the wage base for Social Security taxes. However, whether your Social Security benefits will actually be lower depends on a number of factors, such as your current age, your earnings before participation in the accounts and future pay levels.

Grace Period

You now have the advantage of a “Grace Period” that follows the end of the Plan year in which you allocated Health Care Spending Account (HCSA) funds. Any unused HCSA funds may be used to reimburse eligible expenses incurred during the Grace Period. The Grace Period does not apply to the Child/Elder Care Spending Account.

The Grace Period will begin on the first day of the next Plan year and will end two months and fifteen days later. For example, if the Plan year ends December 31, 2006, the Grace Period begins January 1, 2007 and ends March 15, 2007.

To take advantage of the Grace Period, you must be:

- A participant in the HCSA on the last day of the Plan year to which the Grace Period relates, or
- A qualified beneficiary who is receiving COBRA coverage under the HCSA on the last day of the Plan year to which the Grace Period relates.

The following additional rules also apply to the Grace Period:

- Eligible expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan year to which the Grace Period relates, and then from any amounts that are available to reimburse expenses incurred during the current Plan year.
- Claims will be paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the Plan year to which the Grace Period relates to the extent such expenses have not yet been submitted for reimbursement.
- Previous claims will not be reprocessed or recharacterized so as to change the order in which they were received.

You may not use HCSA amounts to reimburse eligible child or elder care expenses and C/ECSA amounts may not be used to reimburse Eligible Medical Expenses.

For example, let’s assume $200 remains in your HCSA at the end of the 2006 Plan year and you elected to allocate $2,400 to your HCSA for the 2007 Plan year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred on January 15, 2007, $200 of your claim will be paid out of the unused amounts remaining in your HCSA from the 2006 Plan year and the remaining $300 will be paid out of amounts allocated to your HCSA for 2007.
Run-Out Period
Expenses incurred during a Grace Period must be submitted before the end of the Run-Out Period described below (see End-of-Year Claims/Run-Out Period section on page 74). This is the same Run-Out Period for expenses incurred during the Plan year to which the Grace Period relates. Any unused amounts from the end of a Plan year to which the Grace Period relates that are not used to reimburse eligible expenses incurred either during the Plan year to which the Grace Period relates or during the Grace Period will be forfeited if not submitted for reimbursement before the end of the Run-Out Period.

If You Take a Leave of Absence...
...refer to the Life Events section.

If You Have a Status Change...
...refer to the Life Events section.

If You Terminate Employment...
...see page 74, “Termination of Employment,” for details about what happens to the spending account when you terminate employment.

Account Statements
To help you keep track of spending account balances, you’ll receive a statement about 45 days after the end of each calendar quarter. The statements will show deposits, payments made and account balances as of the end of the quarter. Or, online, find a link to information about your spending account claims and account balance at UPSers.com.

How to File a Claim
See page 72, Information About Filing Claims.

LegalCare
The legal option is available as a supplemental benefit at the first annual enrollment after gaining eligibility under the UPS Health and Welfare Package. LegalCare helps protect you from the financial expenses that may arise if you need legal services. The option offers a range of commonly needed legal services as well as access to a legal hotline and individual consultation administered by Signature LegalCare. You and your covered family members (if you choose family coverage) can use an attorney who participates in the Signature network of attorneys. You will then receive full coverage for most covered services from a Signature network attorney. You may also use any attorney of your choice; however, benefits are limited if you use a non-participating attorney.

How the Legal Benefits Work
If you enroll for legal coverage, you have access to legal services from three sources:
- Telephone Service — You have unlimited access to advice, consultation and direction regarding personal legal matters that are not specifically excluded under the Plan. There’s no cost for this service.
- Signature LegalCare Attorneys — If you need an attorney, you can choose one from Signature’s national network of attorneys throughout the United States who have agreed to provide covered services to LegalCare participants. If you use a Signature LegalCare network attorney, you will receive benefits for most covered matters.
- Non-Participating Attorneys — You can also receive legal counsel from an attorney who does not participate in the Signature LegalCare attorney network. When you use a non-participating attorney, you are reimbursed for covered legal services up to a scheduled maximum amount. You’ll be responsible for any costs in excess of the scheduled benefit amount.
Covered Legal Services
Examples of covered services include:
- administrative hearings
- adoptions
- debt collection defense
- consumer protection
- defendant civil action
- document review and preparation
- estate administration and estate closings
- guardianship/conservatorship
- lawyer office work
- matrimonial matters
- preparation of a will, living will
- real estate matters
- telephone advice

Excluded Legal Services
Examples of excluded services include services related to:
- participation in business ventures
- preparing or filing income tax returns
- estate planning matters
- Workers’ Compensation Law, unemployment matters
- judicial appeal proceedings, group or class actions
- civil actions pursued in court where the covered person is plaintiff
- consultations, civil or criminal legal actions which involve the Company or its affiliates
- legal services which began before coverage under LegalCare began
- services performed by attorney related to the covered person
- services provided outside the United States

Signature LegalCare Service Center
You may call the Signature LegalCare Service Center from 5:00 a.m.-11:00 p.m. (Eastern time), Monday-Saturday and 5:00 a.m.-4:00 p.m. on Sundays by dialing 1-800-UPS-1508 when a legal issue or concern arises. Once transferred, your call will be handled by the Interactive Customer Assistance System, which offers the following options:
- verify your membership in the Plan
- order a Participating Attorney Directory
- order a claim form
- check the status on your claim

During your call, you may choose to speak directly with a customer service representative between the hours of 8:00 a.m. and 9:00 p.m. Monday-Friday (except holidays) to obtain answers to other questions or to speak with a Signature LegalCare attorney.

You may also visit the Signature LegalCare Web site at www.legalcareplan.com. You’ll be asked to enter your Company name and this password: 38162

Signature LegalCare Benefits for Adoption Assistance
You may use Signature LegalCare to cover any legal service related to adoption of a child, if the adoption is eligible for reimbursement under the Adoption Assistance Program (see next page). Legal services will be covered up to the LegalCare Plan’s benefit levels, even if you did not elect coverage through Signature LegalCare. Any legal expenses for adoption provided through the LegalCare plan do not count toward, nor are they reimbursable from, the Adoption Assistance Program’s $3,500 benefit limit.

How to File a Claim
See page 72, Information about Filing Claims.
Adoption Assistance
To help UPS employees realize the dream of having a family, UPS offers eligible employees financial assistance through its Adoption Assistance Program. You are eligible for this benefit as part of the comprehensive basic coverages under the UPS Health and Welfare Package.

Benefit Amount
UPS will reimburse 100 percent of reasonable and customary costs, as determined by the Plan Administrator, up to $3,500 per child, associated with the adoption of a child less than age 18. If both parents are UPS employees, expenses are reimbursed only one time per child, up to $3,500.

Children with Special Needs
If you adopt a child with a special need, the program will reimburse an additional $1,500 in eligible expenses. A child with special needs often has a physical or emotional disability. As a result, the child is often difficult to place and may be more costly to raise.

For the Adoption Assistance Program, documentation is required from the state in which the child is adopted certifying that the child qualifies for a special needs adoption in that state. Check with the applicable state social services division for information on that state’s definition of special needs. International adoptions cannot be considered for the special needs benefit.

Eligible Expenses
The Adoption Assistance Program covers the following adoption-related expenses:
- legal/court fees
- adoption agency fees (public or private, foreign or domestic)
- medical expenses (when not covered by another source), including the following:
  - newborn expenses
  - maternity expenses for the birth mother
- charges for temporary foster care before placement
- state-required home study program and other required adoptive parental counseling
- expenses to transport the child to the home

Call the Adoption Assistance Program at 404-828-6044 if you have any questions about what the program covers.

Signature LegalCare Benefits for Adoption Assistance
You may use the Signature LegalCare Plan to cover any legal service related to the adoption of a child. Legal services will be provided through the Signature LegalCare network of attorneys and covered up to the LegalCare plan’s benefit levels, even if you did not elect coverage through Signature LegalCare. These legal expenses do not count toward (nor are they reimbursable from) the Adoption Assistance Program’s $3,500 benefit limit.
What's Not Covered by the Program

The following expenses are not covered by the Adoption Assistance Program:

- expenses incurred prior to the effective date of this Plan or your eligibility for this Plan
- any costs when an adopting parent is related to or a stepparent of the child being adopted
- adoptions that are not legally recognized
- personal items for the parents or child (food, clothing, etc.)
- charges associated with legal guardianship
- expenses related to the adoption of a person 18 years of age or older
- donations or contributions
- any costs for expenses of a surrogate mother (woman who is acting solely as a host of a fertilized egg)

Adoption Assistance and Taxes

Adoption assistance expenses are not subject to federal income tax withholding, but are subject to withholding of FICA taxes. Additionally, state or local income tax may also be required if the state or municipality does not treat the reimbursement as nontaxable.

Certain amounts of your reimbursement may be subject to income tax if your income is over a certain level, as defined by the federal government. You may want to consult a tax advisor.

Taxable amounts are not grossed up to offset the tax liability.

Employees may be eligible for a tax credit for expenses not reimbursed by the Company. Employees with unreimbursed adoption expenses should consult their tax advisor to determine the availability of tax credits.

How to File a Claim

See page 72, Information about Filing Claims.
Personal Lines Insurance

To help UPS employees purchase discounted auto and homeowners insurance and pay for coverage through convenient payroll deductions, UPS offers Liberty Mutual’s Liberty for All program of personal lines insurance. You are eligible for this optional supplemental coverage January 1 of the year following the date your coverage began from the UPS Health and Welfare Package.

Coverage is available through a program of individual policies. For information about the Liberty for All program, link to their Web site from UPSers.com or call 1-800-368-3621 and identify yourself as a UPS employee. Current policyholders should call 1-800-713-7377.

Enrollment

You can enroll in Liberty for All at any time of the year by contacting Liberty Mutual directly. The program is voluntary. Enrollment in any Liberty for All coverage is separate from enrollment in the UPS Health and Welfare Package.

Available Coverage

The program offers you a variety of personal insurance coverages:
- automobile insurance (discounts available*)
- homeowners insurance (discounts available*)
- personal catastrophe liability insurance (local laws may affect the availability of this coverage in some states. Check with a Liberty Mutual representative for availability in your specific area.)
- valuable possessions protection
- yacht and motorboat insurance
- protection for seasonal dwellings and recreational vehicles

*Group discounts, other discounts and credits are available where state laws and regulations allow and may vary by state. To the extent permitted by law, applicants are individually underwritten and not all applicants may qualify.

How to Purchase Insurance

To obtain a quote from Liberty Mutual, visit their site from a link at UPSers.com, or call the company directly at 1-800-368-3621. Liberty Mutual’s voice response system will give you a choice of speaking with a representative located in your community or a representative in Liberty Mutual’s Insurance Counseling and Service Center. This service is available 7 a.m. to 7 p.m. local time, Monday through Saturday.

The Liberty Mutual representative will provide a quote, reflecting all available discounts, no later than 72 hours after the call.

Keep in mind that the rates quoted by Liberty Mutual may not be the lowest in your area. You are encouraged to shop around and compare prices and services before making a selection.

If you elect to purchase a policy, the paperwork is also handled by Liberty Mutual, including notification of the appropriate payroll deductions. All Liberty for All payroll deductions are on an after-tax basis.

If You Have Concerns

If you have concerns about any aspect of your relationship with Liberty Mutual, you should contact your local Liberty Mutual office, or call 1-800-713-7377.

UPS does not interpret Liberty Mutual’s insurance policies, claims payment procedures, or any other administrative procedures. All questions and claim inquiries about personal lines insurance are between you and Liberty Mutual. Although summarized in this booklet, Personal Lines coverage is not part of the UPS Health and Welfare Package.

How to File a Claim

If you need to file a claim, contact your Liberty Mutual representative for instructions or call 1-800-713-7377.
Information About Filing Claims

This section reviews what you need to do to file claims for the different benefit options in the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. If you have any questions about filing claims, please call the appropriate carrier or your Human Resources department.

Medical

When to File a Claim

If you participate in the Primary Care Physician or Preferred Provider Network and receive care through network providers, you won’t have to worry about filing medical claims. On your first visit to your network provider, you’ll sign a form to assign benefits. From then on, your in-network provider will take care of claims for you.

You will be responsible for filing your own claims if:
- you participate in the Primary Care Physician or Preferred Provider Network and receive care from an out-of-network provider
- your Primary Care Physician refers you to an out-of-network specialist or hospital
- you participate in the Traditional Program (even if you see a network provider)
- you have a dependent living permanently outside the network area, and he or she receives services from an out-of-network provider
- you use the allergy treatment benefit — you’ll pay for the injection at the time of service and receive reimbursement by filing a claim

You should file medical claims as soon as possible after the date you are billed. If your medical claim is not received within 12 months after the date the service or treatment was provided, no benefits will be paid.

Completing a Medical Claim Form

The claim form must be completed by you and the provider of services. In completing the form, be sure to:
- provide all the information requested
- use a separate form for each family member
- indicate whether you want payment to be made to you or assigned to your health care provider

You can either attach itemized bills or have your doctor complete the physician’s section of the form. Either way, the following information must be provided:
- patient’s full name, date of birth and relationship to you
- your Social Security number
- doctor’s full name, address and tax identification number
- diagnosis
- date and charge for each service

Send the completed form to the network manager or claims administrator at the address shown on your medical ID card.

Claims must be received within 12 months from the date the service or treatment is given, or no benefits will be paid. Reimbursement checks that are not cashed within 12 months of the date of the check are void.

Prescriptions

The procedure for filing prescription drug claims depends on whether you fill your prescription at a participating pharmacy, a non-participating pharmacy or through the Home Delivery Pharmacy Service.

At a Participating Pharmacy

If you fill your prescription at a participating Medco pharmacy, you do not have to file a claim form. You simply present your Medco ID card and pay any copayment at the pharmacy.
At a Non-Participating Pharmacy
If you fill your prescription at a non-participating pharmacy, you have to pay the full amount for each prescription and file a claim form to be reimbursed. Your cost will equal the difference between the full retail price and the discounted amount (as if you had used a participating pharmacy), plus your copayment. Call 1-800-UPS-1508 to obtain claim forms. Mail your completed and signed claim form with the necessary documentation to the address on the claim form.

Home Delivery Pharmacy Service
You don’t file claim forms if you fill your maintenance drug prescriptions through the Home Delivery Pharmacy Service. To order drugs through the program, send your prescription with your copayment (if payment is necessary) and your patient questionnaire (for first-time users) to the address on the claim form.

Claim forms are also available at www.medcohealth.com or through a link available under the My Life and Career tab at UPSers.com.

Your prescription will be immediately filled and sent to you. You will not be charged for shipping expenses.

Claims must be received within 12 months from the date the service or treatment is given, or no benefits will be paid. Reimbursement checks that are not cashed within 12 months of the date of the check are void.

Solutions
If your provider does not file a claim for you, send your invoice to ValueOptions, P. O. Box 142648, Irving, TX 75014-2648. If you have a question about a claim, you may call 1-800-UPS-1508.

Claims must be received within 12 months after the date the service or treatment is given or no benefits will be paid. Reimbursement checks that are not cashed within 12 months of the date of the check are void.

Dental
If you seek care from a participating provider, the provider will submit your claim to the Aetna Dental PPO. You will need to file a claim if you use a non-participating dentist. Send the completed claim form to the address shown on your ID card. You may obtain a claim form by calling 1-800-UPS-1508.

Claims must be received within 12 months after the date the service or treatment is given or no benefits will be paid. Reimbursement checks that are not cashed within 12 months of the date of the check are void.

Vision
In order to access vision care benefits, simply contact your VSP participating doctor to make an appointment. If you need help locating a VSP participating doctor call VSP at 1-800-UPS-1508 or visit their Web site from a link at UPSers.com.

When calling the doctor’s office to make an appointment for you or your covered dependents, identify yourself as a VSP patient. Indicate that UPS provides your benefits, and then provide your VSP identification number (your Social Security number). The VSP participating doctor will obtain the necessary authorization and information about your eligibility and coverage.

If you use a non-VSP provider, attach an itemized statement of services and supplies to the benefit form and send it to:
Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Claims must be received within 12 months after the date the service or treatment is given or no benefits will be paid. Reimbursement checks that are not cashed within 12 months of the date of the check are void.
**Spending Accounts**
Claim forms for the Health Care Spending Account and Child/Elder Care Spending Account are available at UPSers.com, from your local Human Resources representative or by calling 1-800-UPS-1508. Complete and return the form together with written proof of payment of the expenses to:
Aetna
151 Farmington Avenue
Hartford, CT 06156

**Health Care Spending Account**
Send a completed spending account claim form and proof of payment (including an Explanation of Benefits (EOB) form or itemized receipt for non-reimbursed expenses) to Aetna. Reimbursements from the Health Care Spending Account will equal the lesser of:
- the actual amount of your claim,
- the total amount you’ve elected to put in the account for the year, less any reimbursement you’ve already received

If you submit claims for less than $50, Aetna will hold them until they total $50 before making a payment (except at the end of the year, when you can submit smaller claims in order to clear the funds in your account). HCSA reimbursement checks are sent twice monthly.

**Child/Elder Care Spending Account**
Reimbursement from the Child/Elder Care Spending Account will equal the lesser of:
- the actual amount of your claim,
- the amount of your account balance at the time the reimbursement is made

If you submit claims for less than $50, Aetna will hold them until they total $50 before making a payment (except at the end of the year, when you can submit smaller claims in order to clear the funds in your account). C/ECSA reimbursement checks are sent weekly.

**End-of-Year Claims/Run-Out Period**
Claims for expenses incurred during the prior year must be received by the end of the Run-Out Period, which is May 31 following the end of the Plan year. After that date, any amount left in your account will be forfeited. This money will be used to offset future costs of administering the accounts, and then according to applicable rules and regulations.

By January 31 of each year after you participate in the Child/Elder Care Spending Account, you’ll receive a statement showing the amount of assistance you received during the prior calendar year. You will have to file a Form 2441 and attach it to your 1040 federal income tax return if you participate in the C/ECSA.

**Termination of Employment**
When you terminate employment from the company, claims for expenses that were incurred prior to your termination date must be received within 90 days from the termination date. You may elect, through COBRA, to continue your HCSA on an after-tax basis through the end of that calendar year (and the Grace Period, if applicable). If you do so, claims for expenses that were incurred prior to the termination of your HCSA COBRA coverage must be received within 90 days from the termination of your HCSA COBRA coverage.

Reimbursement checks that are not cashed within 12 months from the date of the check are void.

**Legal**
After legal services have been provided, you must file a claim form. When completing the claim form, you must indicate whether you want Signature to pay the attorney directly or reimburse you. Claim forms are available by calling the Signature LegalCare Service Center at 1-800-UPS-1508.

**Life Insurance and AD&D**
Contact your Human Resources department for information about filing life insurance and AD&D claims, or call the UPS Benefits Service Center at 1-800-UPS-1508.

Claims must be received within 12 months of the date of the death or accident, or no benefits will be paid. Reimbursement checks that are not cashed within 12 months of the date of the check are void.
**Short-Term Disability**

If you become unable to work because of an off-the-job injury or illness, you may file a claim online from a link at UPSers.com, or go directly to www.choosebroadspire.com. You’ll need to enter the company name (ups) and a password (broadspire).

Or, call Broadspire at 1-866-825-0186. A representative will:
- **ask you for information:**
  - name and address of UPS, date of hire and supervisor’s name and phone number
  - your name, phone number, home address and Social Security number
  - the date of your injury or illness and the first day you were absent from work
  - your doctor’s name, address and phone number, the date you were first treated for this condition, and your next appointment
- **verify how you became disabled**
- **explain the claim process, including the need to obtain medical information from your doctor**

The representative will send you a release form that allows Broadspire to obtain information about your condition. Your claim will then be assigned to a case manager, who will assist you in gathering the required documentation from your doctor. If you do not return the release form in the time specified, you may not be eligible for benefits. It is your responsibility to obtain and submit information to Broadspire that supports your disability.

Claims must be received (phone or Web) within 30 days of the initial date of disability in order to receive STD benefits.

**If your claim is approved,** you will receive an approval letter providing you a number to call if you have questions about your coverage, and indicating your expected return-to-work date. Broadspire will notify UPS of your anticipated return-to-work date and your claim approval. You should receive your first weekly payment within two weeks from the date of your call.

**If your claim is denied,** you’ll receive a letter providing specific reasons for the denial, with specific instructions for how to appeal the denial. Broadspire will notify UPS that your claim has been denied. You should contact your manager to schedule your return to work.

**Long-Term Disability**

If you have been receiving STD benefits, your case manager will automatically review your case for LTD eligibility. If you are not receiving STD benefits, refer to the **Short-Term Disability** section of this booklet.

Remember that STD benefits are paid weekly, while LTD benefits are paid monthly, near the end of each month.

**Adoption Assistance**

Eligible expenses are reimbursed after legal custody is obtained from a court of law. Follow these steps to file for reimbursement:
- **Contact the UPS Benefits Service Center at 1-800-UPS-1508 to request an Adoption Assistance Reimbursement form**
- **Complete the form and attach all itemized bills and legal documentation (must be translated into English if necessary)**
- **Send the form and documentation to:**
  Adoption Assistance Program
  55 Glenlake Parkway, N.E.
  Atlanta, GA 30328

Once reimbursement is approved, you will receive a check from your local Human Resources department with applicable taxes deducted. Allow three weeks for processing your reimbursement request.

Claims must be received within 12 months after the date of legal custody or no benefits will be paid. Reimbursement checks that are not cashed within 12 months of the date of the check are void.
Maintenance of Benefits

Both Plans have a maintenance of benefits (MOB) provision. That means that benefits from the option you select, when added to the benefits paid by another group plan for the same services, will not exceed the amounts that would have been paid by the UPS option you select. This provision does not apply to prescription drug benefits.

If a person is covered by two plans, one of the plans is considered primary and the other is considered secondary. When a claim is made, the primary plan pays benefits first.

A plan without a maintenance of benefits provision is always the primary plan. If all plans have this provision, the primary plan will be determined in this order:

- The plan covering the person as an employee rather than the plan covering the person as a dependent (or a Qualified Beneficiary under COBRA) is primary
- If a person is covered as an employee by two plans, the plan covering the person the longest is the primary plan
- If a child is covered by both parents’ plans, the plan of the parent whose birthday falls first in the calendar year is considered the primary plan
- In the case of divorce or separation:
  - First, the plan covering the child as a dependent of the parent legally declared financially responsible by court decree is primary
  - Second, the plan covering the parent who has custody of the child (if there is no court decree) is primary
  - Third, in the event there is no court decree and the parent who has custody has remarried, the order of priority is:
    - The plan covering the parent who has custody is primary
    - The plan covering the spouse of the parent who has custody is primary
    - The plan covering the parent without custody is primary

If the Plan is secondary in accordance with these provisions, but the primary plan attempts to reduce its responsibility under the primary plan solely because you or your family is covered under another plan, the Plan will only pay benefits under this Plan in accordance with the maintenance provisions of this Plan as though the primary plan paid benefits without regard to other coverage you may have.

The plan administrator has sole discretion to determine the amount that the primary plan would have paid — taking into account the other plan’s governing documents.

When a determination cannot be made, the plan covering the eligible dependent longer is considered primary.

Any other situation will be handled in accordance with guidelines established for coordination of benefits by the National Association of Insurance Commissioners.

An Example

To show how maintenance of benefits works, let’s assume your spouse is covered by another plan that is primary and also covered by the UPS option you select. Let’s also assume your spouse has covered expenses of $100, the other plan would pay benefits of $75 and the UPS option would pay benefits of $90. Since the other plan is primary, your spouse will receive $75 from the other plan first. The UPS Plan will pay an additional $15 to make the total reimbursement $90, or the amount that would have been paid by the UPS option if there were no other coverage. However, if the other plan had paid $95 and the UPS option would pay $90, the UPS option would not pay any additional amount because the benefit paid by the other plan exceeds the UPS benefit amount.

In determining the amount of benefits from the medical option you select, if services are provided by a non-network provider, benefits will be considered as out-of-network. For example, assume your spouse has an office visit to a provider who participates in the network for your spouse’s medical plan, but is not a PCP in the network for the medical option you select. For purposes of the maintenance of benefits provision, that visit will be an out-of-network visit when calculating what you have to pay and what the medical option you select will pay.

Maintenance of benefits also applies to dental and vision coverage.
Coordination With Medicare
Medicare benefits will be primary to the extent permitted under applicable law. As a general rule, if you or your covered dependent becomes eligible for Medicare benefits, there are rules that determine whether the UPS Plans pay benefits first, or whether Medicare is primary.

Health and Welfare Package
Covered individuals who are covered under the Health and Welfare Package based on criteria other than current employment status — e.g., COBRA continuees, certain disabled employees — will have Medicare as their primary coverage. Individuals with End Stage Renal Disease (ESRD) may be subject to a coordination period during which the Plan is primary, after which Medicare will become primary.

If you are an active employee covered by the UPS Health and Welfare Package, the Health and Welfare Package would be primary for you and your covered dependent who is eligible for Medicare (for example, due to a disability or being age 65 or older).

If you are disabled and not actively working, the UPS Health and Welfare Package would be primary for you and any covered dependents who may be eligible for Medicare (for example, due to a disability or being age 65 or older).

Right of Recovery Provision
This section describes the Plan’s right to seek reimbursement of expenses that are paid by the Plan on behalf of you or your covered dependents (referred to in this section as a “Covered Individual”) if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident). The Plan may seek reimbursement of these expenses from any recovery you may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. The terms of the Plan’s reimbursement rights are described below:

If a Covered Individual incurs expenses covered by the Plan as a result of the act of a third party (person or entity) you may receive benefits pursuant to the terms of the Plan. However, the Covered Individual shall be required to refund to the Plan all benefits paid if the Covered Individual recovers from any other party (such as proceeds from a settlement, judgment, lawsuit or otherwise as a result of the act). The Covered Individual may be required to:

a) Execute an agreement provided by the Company or the claims administrator acknowledging the Plan’s right of recovery, agreeing to repay any claims paid by the Plan, pledging amounts recovered by the Covered Individual from the third party as security for repayment of any claims paid by the Plan, and to the extent provided below, assigning the Covered Individual’s cause of action or other right of recovery to the Plan. If the Covered Individual fails to execute such an agreement, by filing claims (assigning benefits or having claims filed on your behalf) related to such act of a third party, the Covered Individual shall be deemed to agree to the terms of this reimbursement provision;
b) Provide such information as UPS, the network manager or claims administrator may request;
c) Notify UPS and/or the network manager or claims administrator in writing by copy of the complaint or other pleading of the commencement of any action by the Covered Individual to recover damages from a third party;
d) Agree to notify UPS and/or the network manager or claims administrator of any recovery.

The Plan’s right to recover the benefits it has paid is subject to reduction for attorney’s fees or other expenses of recovery. The reduction is limited to the lesser of the actual attorney fees and other expenses or one-third of the Plan’s lien. The Plan’s right of recovery shall apply to the entire proceeds of any recovery by the Covered Individual. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Plan’s right to recover shall not be limited by application of any statutory or common law “make whole” doctrine (i.e., the Plan has a right of first reimbursement out of any recovery, even if the Covered Individual is not fully compensated) or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained.

The Plan shall have a lien against the proceeds of any recovery by the Covered Individual and against future benefits due under the Plan in the amount of any claims paid. The lien shall attach as soon as any person or entity agrees to pay any money to or on behalf of any Covered Individual that could be subject to the Plan’s right of recovery if and when received by the Covered Individual. If the Covered Individual fails to repay the Plan from the proceeds of any recovery, the Plan Administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

If the Covered Individual fails to take action against a responsible third party to recover damages within one year or within 30 days after the Plan requests, the Plan shall be deemed to have acquired, by assignment or subrogation, a portion of the Covered Individual’s claim equal to the amounts the Plan has paid on the Covered Individual’s behalf. The Plan may thereafter commence proceedings directly against any responsible third party. The Plan shall not be deemed to waive its rights to commence action against a third party if it fails to act after the expiration of one year nor shall the Plan’s failure to act be deemed a waiver or discharge of the lien described above.

The Covered Individual shall cooperate fully with the Plan in asserting claims against a responsible third party and such cooperation shall include, where requested, the filing of suit by the Covered Individual against a responsible third party and the giving of testimony in any action filed by the Plan. If a Covered Individual fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator may deny payment of claims and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator.

In addition, the Plan has a right to recover benefits that were paid in error (e.g., benefits paid to an ineligible person) or benefits that were obtained in a fraudulent manner, as determined by the Plan Administrator. Benefits may be recovered by either direct payment to the Plan by you or a beneficiary (through voluntary payments or legal action) or by an offset of future benefits equal to the amount of the overpayment.
If a Claim Is Denied

If your claim for benefits under the Plan is denied, you may have it reviewed in accordance with the following claims review procedures. The procedures will vary depending on the type of benefit claim it is.

Denial of Insured Claims

Certain benefits offered under the Plan are provided through an insurance contract issued to UPS by an insurance carrier. In this case, the insurance carrier is the applicable claims fiduciary with respect to claims for benefits provided under the insurance contract. This means that UPS has no discretionary authority with respect to benefit claims that are insured by an insurance carrier. If your claim for an insured benefit is denied under the Plan, you should refer to the applicable policy or Certificate of Coverage provided by the carrier, or contact the insurance carrier for more information on the applicable claims procedures. The Fiduciary Chart below identifies which claims should be submitted to the insurance carrier.

Denial of Other Claims

If the denied claim is one for which the UPS Claims Review Committee (the Committee) makes the final decision (see chart below), the following claims review procedures apply.

Medical, Dental, Vision and Health Care Spending Accounts

The Plan has established special claims review procedures for medical, dental, vision and HCSA benefits (“group health benefits”). The claims review procedures vary depending on the type of claim you have.

Types of Claims

There are three types of claims: Pre-Service, Concurrent Care, and Post Service Claims. Also, certain Pre-Service or Concurrent Care Claims may involve “urgent care.” See page 83 for a detailed description of the types of claims.

Fiduciary Chart

<table>
<thead>
<tr>
<th>If you are covered by:</th>
<th>Appeal 2nd level to UPS</th>
<th>If you are covered by:</th>
<th>Appeal to insurance carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>x</td>
<td>Kaiser Permanente</td>
<td>x</td>
</tr>
<tr>
<td>CIGNA</td>
<td>x</td>
<td>Life Insurance, AD&amp;D (Aetna)</td>
<td>x</td>
</tr>
<tr>
<td>Blue Cross/Blue Shield</td>
<td>x</td>
<td>Signature LegalCare</td>
<td>x</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>x</td>
<td>Liberty Mutual</td>
<td>x</td>
</tr>
<tr>
<td>Solutions</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medco Health Solutions</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Service Plan</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spending Accounts</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humana, Choice Care/Humana</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-/Long-Term Disability</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appeals Procedures
Generally, the following steps describe your appeal procedures (regardless of the type of claim — pre-service, concurrent care, etc.):

**Step 1:** Notice is received from claims administrator.
If your claim is denied, you will receive written notice from the claims administrator that your claim is denied (in the case of urgent claims, notice may be oral). The time frame in which you will receive this notice is described in the chart beginning on page 82 and will vary depending on the type of claim. In addition, the claims administrator may take an extension of time in which to review your claim if necessary for reasons beyond the claims administrator’s control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The time period during which the claims administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

**Step 2:** Review your notice carefully. Once you have received your notice from the claims administrator, review it carefully. The notice will contain:
- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan’s appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your appeal;
- a statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request;
- if the denial is based on a medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
- if the claim was an Urgent Care Claim, a description of the expedited appeal process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you not later than three days after the oral notification.

**Step 3:** If you disagree with the decision, file a 1st Level Appeal with the claims administrator. If you do not agree with the decision of the claims administrator and wish to appeal, you must file a written appeal with the claims administrator within 180 days of receipt of the claims administrator’s letter (or oral notice if an urgent care claim) referenced in Step 1. If the claim involves urgent care, your appeal may be made orally. In addition, you should submit all information referenced in Step 2 with your appeal. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

**Step 4:** 1st Level Appeal notice is received from claims administrator. If the claim is again denied, you will be notified by the claims administrator within the time period described in the chart beginning on page 82, depending on the type of claim.

**Step 5:** Review your notice carefully. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the claims administrator.
Step 6: If you still disagree with the claims administrator’s decision, file a 2nd Level Appeal with the Committee. If you still do not agree with the claims administrator’s decision and wish to appeal, you must file a written appeal to the Committee within 60 days after receiving the 1st Level Appeal denial notice from the claims administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim. The appeal should be sent to:
UPS Claims Review Committee
55 Glenlake Parkway, N.E.
Atlanta, GA 30328

If the Committee denies your 2nd Level Appeal, you will receive notice within the time period described in the chart beginning on page 82, depending on the type of claim. The notice will contain the same type of information that was referenced in Step 2 above.

A claim is not deemed “filed” for purposes of these claims review procedures until it is filed in accordance with the “Information About Filing Claims” section of this SPD and it is received by the claims administrator, or where applicable, the UPS Claims Review Committee.

Important Information
Other important information regarding your appeals:
- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have the right to request documents or other records relevant (as defined by ERISA) to your claim.
- If a claim involves medical judgment, then the claims administrator and the Claims Review Committee will consult with an independent health care professional during the 1st and 2nd level appeal who has expertise in the specific area involving medical judgment.
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Short- and Long-Term Disability
The same steps described above for group health claims apply to short- and long-term disability claims; however, the time periods for making a decision for disability claims are different. See the chart on page 83 for information.

Child/Elder Care Spending Account and Adoption Assistance
If your claim for the Child/Elder Care Spending Account or adoption assistance is denied, you will be notified by the claims administrator within the time periods described in the chart on page 83. You may appeal to the claims administrator, and then to the UPS Claims Review Committee. See the chart for further information.
**Claims and Appeals Procedures Chart**

This chart shows the time limit for you to submit appeals, and for the claims administrator or UPS Claims Review Committee to respond to your claim or appeal. This chart is intended to be used in conjunction with the remainder of information in this section.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Initial Claims</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service</strong></td>
<td>You’ll be notified of determination as soon as possible but no later than...</td>
<td>Extension period* allowed for circumstances beyond claims administrator’s control...</td>
<td>You must file your appeal within...</td>
</tr>
<tr>
<td><strong>Pre-Service involving Urgent Care</strong></td>
<td>15 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
<tr>
<td><strong>Concurrent: To end or reduce treatment prematurely</strong></td>
<td>72 hours (24 hours if additional information is needed from you)</td>
<td>None</td>
<td>48 hours (claims administrator must notify you of determination within 48 hours of receipt of your information)</td>
</tr>
<tr>
<td><strong>Concurrent: To deny your request to extend treatment</strong></td>
<td>Notification to end or reduce will allow time to finalize appeal before end of treatment</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Post-Service</strong></td>
<td>30 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
</tbody>
</table>

*The extension period is measured from the end of the original determination due date.*

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Pre-Service Claim — a claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you precertify hospital admissions.

Concurrent Care Claim — a previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.

Post-Service Claim — a claim for care that has already been received, any claim for which the Plan does not require pre-authorization and Health Care Spending Account claims.

Urgent Care Claims — a Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would: — seriously jeopardize the life of the claimant (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant’s medical condition) or — subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant’s condition).
Retired Employee Health Care Coverage

Eligible retired employees have medical, dental and vision coverage from a separate plan called the UPS Health and Welfare Package for Retired Employees. Like the UPS Health and Welfare Package, it offers medical option choices at each annual enrollment. Option 1 for retirees is the Primary Care Physician Network. Option 2 is the Preferred Provider Network. If you do not live in a network area, you will receive Traditional Program coverage. If you initially live in a network area and move to a non-network area, then you will receive the Traditional Program. If you initially live in a non-network area but later move to a network area, you will be given the opportunity to choose medical Option 1 or Option 2. You may also have the HMO Option available.

There is a new lifetime maximum that begins when you retire and become eligible for benefits from the UPS Health and Welfare Package for Retired Employees (see page 85).

In addition to medical coverage, retirees also receive:
- dental coverage equal to the coverage for employees under the UPS Health and Welfare Package (see page 42 for details)
- vision coverage equal to the coverage for employees under the UPS Health and Welfare Package (see page 49 for details)

Eligibility

If you take early or normal retirement and begin receiving a benefit based on the provisions of your pension plan, you and your eligible dependents may become eligible for retired employee medical, dental and vision coverage from the UPS Health and Welfare Package for Retired Employees.

If you retire:
- at any age with 30 or more years of credited service, or
- at age 50 or older with 25 or more years of credited service, or
- at age 55 or older with 20 or more years of credited service

And
at least 10 years of the credited service were earned while a UPS employee

And
you begin receiving a benefit based on the early or normal pension provisions of your pension plan,

Then
you and your eligible dependents will become eligible for medical, dental and vision coverage from the UPS Health and Welfare Package for Retired Employees.

A year of credited service is defined as:
- any year worked as a full-time or part-time UPS employee
- any year earned and credited by your pension plan prior to becoming a UPS employee
- any year you are receiving long-term disability payments from the Plan

You may enroll your dependents for coverage if the dependent is:
- your legal spouse, as defined by applicable state law, at the time of your retirement*
- an unmarried child who is:
  - a natural child; an adopted child (or a child placed for adoption); a stepchild living with you at least half of the time; a stepchild who is a full-time student away from home, provided that the stepchild lived with you at least one half of the time in the year immediately prior to the year the stepchild became a full-time student away from home; or
  - a child living with you for whom you are a court-appointed legal guardian or custodian, and
  - under age 19 and financially dependent on you, or up to age 25 if a full-time student and still financially dependent on you, or an incapacitated child (see page 85).

*If your spouse is your legal spouse under the common law of the state in which you reside, you will be required to provide evidence of the state’s law on common law marriages and evidence that you meet such legal requirements.
The Plan Administrator may periodically request proof of dependent status. Failure to provide proof may result in termination of dependent coverage.

For the UPS Health and Welfare Package for Retired Employees, “placed for adoption” means that you have become legally obligated to support the soon-to-be-adopted child as a result of beginning the adoption process.

A student is considered full-time if s/he meets the requirements of full-time status for the school s/he attends. You must certify your child’s student status each year during annual enrollment or s/he will lose coverage for the following year.

Incapacitated Children
A child who becomes incapacitated before age 19 (or before age 2, if a full-time student) is eligible to continue certain coverages as long as the incapacitation exists. This continuing coverage is available as long as the child becomes incapacitated while covered by the Plan, is unmarried and depends primarily on you for support and maintenance.

The child must have a mental or physical incapacitation that renders the child unable to care for herself/himself, as determined by the network manager or claims administrator. For this purpose, the incapacitation needs to be verified before coverage can be continued. In addition, periodic medical documentation of the continuing incapacitation is required as determined by the network manager or claims administrator.

QMCSO
Medical, dental and vision coverage will comply with the terms of a Qualified Medical Child Support Order (QMCSO) to the extent that a QMCSO does not require the Plan to provide coverage it does not otherwise provide. A medical child support order is a judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction or an administrative process established under state law which has the force and effect of law or a judgment from a state court directing a plan administrator to cover a child by a company’s group health plans.

Federal law requires that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child covered by the order will be notified of the implementation procedure to determine if the order is valid. If you have any questions or would like to receive a copy of the UPS written procedure for determining whether a QMCSO is valid, please contact your Human Resources department.

Life Events
The Plan allows you to make certain changes to your coverage when the following events occur:

- divorce or legal separation
- new child gains eligibility (includes stepchildren living with you)
- child loses eligibility
- death of a dependent
- your death

Changes in coverage are administered by the UPS Benefits Service Center. Call 1-800-UPS-1508 to report any changes in status.

The Lifetime Benefit Maximum
Up to $500,000 in lifetime medical benefits (unlimited in HMO Option) can be paid for each person participating in the UPS Health and Welfare Package for Retired Employees. Only benefits paid while you receive coverage as a retired employee count toward the $500,000 total. The lifetime maximum includes your medical benefits and benefits you receive from the Solutions program for mental health/substance abuse care. Each January, up to $1,000 in individual benefits paid during the preceding year will automatically be restored.
**When Coverage Begins**
Coverage begins on the later of the date of your retirement or the date your active plan coverage ends, if you are still covered by your active plan when you retire. Coverage for your spouse and dependents begins when yours does, provided they are still eligible.

**When Coverage Ends**
Coverage ends when you become eligible for Medicare (except as a result of a disability, see below). Coverage for your spouse ends at the earlier of either your divorce or legal separation or your spouse becoming eligible for Medicare (except as a result of a disability, see below).

You become eligible for Medicare at the beginning of the month in which you reach age 65 unless your birthday falls on the first day of the month, in which case you’re eligible for Medicare at the beginning of the month prior to your birthday.

Your children’s (and eligible step-children’s) eligibility for coverage ends on December 31 of the calendar year in which they have their 19th birthday (or 25th birthday if full-time students). You must certify your child’s student status each year during annual enrollment or s/he will lose coverage for the following year. If your child graduates from or leaves school before the age limit is reached, coverage continues through December 31 of the year in which s/he graduates or leaves, or until s/he becomes covered through another plan, if earlier. If your dependent loses eligibility for any other reason, for example marriage, coverage ends on the date of the event.

If you divorce or become legally separated, your spouse’s health care coverage may be continued under COBRA provisions. If your children reach the age limit or are otherwise no longer eligible for coverage from your Plan, their health care coverage may be continued under COBRA provisions. (Please see the COBRA section for more information about continuing and converting coverage).

**Disability Into or After Retirement**
For disabled individuals entitled to Medicare as a result of a disability, the Plan will continue to provide coverage, supplemental to Medicare (i.e., Medicare is primary), until the normal coverage end date (see above).

**Enrollment**
If you are eligible for coverage in the UPS Health and Welfare Package for Retired Employees when you retire, you and your eligible dependents will automatically be moved to the same medical option in the retired employee plan that you had as an active employee.

Each year, you will have the option of keeping your present coverage or changing to any of the available options.

If you move to a new location, you may no longer have access to your present medical network. Call the Benefits Service Center at 1-800-UPS-1508 and report your change of address. If you no longer have access to your present medical network, you will be sent enrollment materials so that you may choose from the available options.

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**If you die...**
Your eligible spouse and dependents continue coverage for as long as they remain eligible and make required payments.
When you retire, you can participate in the UPS Health and Welfare Package for Retired Employees or you can elect COBRA coverage from the UPS Health and Welfare Package, but you cannot participate in both at the same time. You can elect COBRA coverage from the active plan and then participate in retired employee coverage from the UPS Health and Welfare Package for Retired Employees when COBRA coverage ends. However, you cannot elect retired employee coverage from the UPS Health and Welfare Package for Retired Employees and then switch to COBRA coverage.

**Contribution**

All retired employees are responsible for a $50 per month contribution for their medical coverage. This contribution covers the retired employee, spouse and any eligible dependent children.

**Average Annual Cost**

The average annual cost per participant is defined as the total claims paid by the Plan in a calendar year, divided by the total number of Plan participants during that year. Each retired employee, each spouse, and each eligible dependent would be considered a Plan participant.

If the average annual cost per participant exceeds $6,250, each retired employee will share equally in the cost above the $6,250 maximum by making an additional contribution.

The $6,250 maximum cost per participant is subject to future negotiations. If required, the additional contributions would not be implemented until after the expiration of the current collective bargaining agreement.
Continuation of Coverage under COBRA

In certain circumstances, health care coverage for you and your dependents (if Qualified Beneficiaries) can continue beyond the date it would otherwise end. This continuation of coverage is required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

A “Qualified Beneficiary” is an employee, spouse and/or dependent child who has health coverage under this Plan immediately preceding a qualifying event. A child born to or adopted by (or placed for adoption with) a covered employee during a continuation period is also a Qualified Beneficiary, provided the child is added to coverage within 60 days of the birth, adoption or placement for adoption. Qualified Beneficiaries have independent COBRA election rights and can elect to continue group health plan coverage for themselves even if you (the covered employee) choose to decline coverage.

The information included here is a general overview of COBRA provisions. If you become eligible for continued coverage (that is, if you have a qualifying event) you’ll be given more information that reflects your situation at the time.

How COBRA Works

Eligibility for COBRA is triggered by a “qualifying event.” The chart on page 91 describes the types of qualifying events and the maximum length of coverage available for each event. The maximum coverage period is measured from the date of the qualifying event.

If you decide to continue coverage, you must pay the full cost of that coverage, plus a two percent administrative cost. The monthly premium amount will be provided to you at the time a qualifying event occurs.

The initial premium must be paid within 45 days of your enrollment date (no Grace Period). Subsequent premiums are due on the first of each month. Failure to make subsequent payments within 30 days of the due date will cause your coverage to terminate retroactive to the end of the last month for which full payment was received.

Continued coverage will be available for either an 18, 29, or 36-month period. If you are on approved Military Leave that lasts longer than 30 days, your coverage may last up to 24 months. However, this continued coverage will end sooner if:

- The premium for continued coverage is not paid
- You become entitled to Medicare after electing COBRA coverage,
- You become covered by another health plan after electing COBRA coverage (except where the person is subject to a pre-existing condition),
- UPS terminates all group health plans, or
- Your coverage would be terminated as an active employee for any other reason

The 60-Day Notice

If you do not notify the Service Center within 60 days of a divorce, legal separation or loss of dependent status (not due to age) you forfeit your right to COBRA coverage.
If you (or a Qualified Beneficiary) are disabled at the time (or within 60 days from the time) you terminate employment or have a reduction in hours, you may extend COBRA coverage for an additional 11 months. This coverage is available at 150 percent of the applicable premium. To be eligible for this extension, you (or the Qualified Beneficiary) must:
  - receive a determination of disability from the Social Security Administration, and
  - notify the Benefits Service Center within 60 days of receiving the disability determination and before the original 18-month period ends.

If during the 11-month extension you’re no longer considered disabled by the Social Security Administration, you must notify the Benefits Service Center at 1-800-353-9877 within 30 days of this determination. COBRA coverage may then continue up to the first day of the month that starts more than 30 days after the Social Security Administration’s decision.

A Qualified Beneficiary (other than covered employees) may extend an 18-month continuation period by an additional 18 months (but not more than a total of 36 months) if they experience one of the following qualifying events during the 18- or 29-month COBRA period. The COBRA Administrator must be notified within 60 days of the date of the event.
  - divorce or legal separation
  - child ceasing to be a dependent child
  - covered employee becomes entitled to Medicare
  - death of the covered employee

If a covered employee becomes entitled to Medicare while an active employee and then loses coverage as a result of termination or a reduction in work hours within 18 months of becoming entitled to Medicare, a Qualified Beneficiary other than the covered employee is eligible for 36 months of continuation coverage (counted from the date that the covered employee became entitled to Medicare).

**COBRA Notification Deadline**
In most cases, you’ll be notified when you become entitled to continue health care coverage. However, for other events, you or your dependent should notify the Benefits Service Center immediately. You must notify the Benefits Service Center within 60 days of the qualifying event or continued coverage will not be available. The chart below shows when UPS will automatically send COBRA enrollment materials and when you or your dependent must notify the Benefits Service Center.

<table>
<thead>
<tr>
<th>Event</th>
<th>Responsible for Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination</td>
<td>Benefits Service Center will automatically send your COBRA enrollment materials to the employee’s address on file.</td>
</tr>
<tr>
<td>Retirement</td>
<td></td>
</tr>
<tr>
<td>Layoff</td>
<td></td>
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<tr>
<td>Layoff</td>
<td></td>
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<tr>
<td>Death of employee</td>
<td></td>
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<tr>
<td>Transfer to ineligible position</td>
<td></td>
</tr>
<tr>
<td>Reaching 12 months on Leave of Absence</td>
<td></td>
</tr>
<tr>
<td>Loss of dependent status due to age</td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td>You or the Qualified Beneficiary should call the Benefits Service Center at 1-800-353-9877 immediately. If you do not notify the Service Center within 60 days, you forfeit any right to COBRA coverage.</td>
</tr>
<tr>
<td>Legal Separation</td>
<td></td>
</tr>
<tr>
<td>Loss of dependent status not due to age</td>
<td></td>
</tr>
</tbody>
</table>
Enrollment
As with active employees, there are two types of enrollment: initial enrollment, when you first become eligible, and annual enrollment.

Initial Enrollment
When you become eligible for COBRA, you and your covered eligible dependents may each independently choose to continue medical, dental and vision coverage for up to the entire coverage period. You may choose to continue the Health Care Spending Account on an after-tax basis until the end of that calendar year. You must make your election within 60 days of the date of your enrollment notice or the date coverage is lost, if later.

During initial COBRA enrollment, you may not make changes to your coverage (options) except to stop coverage in the dental and vision plans. You may, however, decrease your coverage level (you only or you plus family).

A change in status at the time of your qualifying event may allow you to change certain coverage during initial COBRA enrollment (see the Life Events section for more information).

Annual Enrollment
At each annual enrollment, you can make new choices. An enrollment kit will be sent to you and must be returned by the deadline indicated on the enrollment forms.

Life Events
During a COBRA continuation period, coverage may be modified based on Plan rules if you experience a change in status. See page 8 for details on allowable changes in status.

If a spouse is dropped from coverage during annual enrollment and later becomes divorced or legally separated from the covered employee, the spouse may be entitled to COBRA continuation coverage if the termination of coverage is deemed by the Plan Administrator to be “in anticipation of” the divorce or legal separation and the former spouse notifies the COBRA Administrator within 60 days of the divorce or legal separation.
The COBRA Administrator

The UPS Benefits Service Center is the COBRA administrator and will handle all COBRA enrollment and billing. The Service Center can be reached at 1-800-353-9877.

Your Right to Obtain Individual Coverage

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires all health insurance carriers offering coverage in the individual market to accept any eligible individuals who apply for coverage, without imposing a preexisting condition exclusion. To take advantage of this HIPAA right you must complete your 18-, 29- or 36-month COBRA coverage period under the Health and Welfare Package or Health and Welfare Package for Retired Employees and apply for coverage with an individual carrier before you have a 63-day lapse in coverage. Since this coverage is not sponsored by UPS, you should contact your state’s department or commission of insurance or see your independent insurance specialist to secure coverage.

<table>
<thead>
<tr>
<th>Qualifying Events</th>
<th>You</th>
<th>Your dependent spouse</th>
<th>Your dependent child</th>
</tr>
</thead>
<tbody>
<tr>
<td>You terminate UPS employment before retiring</td>
<td>18 months</td>
<td>18 months</td>
<td>18 months</td>
</tr>
<tr>
<td>Your work hours are reduced*</td>
<td>18 months</td>
<td>18 months</td>
<td>18 months</td>
</tr>
<tr>
<td>You retire</td>
<td>18 months</td>
<td>18 months</td>
<td>18 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
<td>36 months**</td>
<td>36 months**</td>
</tr>
<tr>
<td>You become divorced or legally separated</td>
<td>N/A</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Your child ceases to be a qualified dependent</td>
<td>N/A</td>
<td>N/A</td>
<td>36 months</td>
</tr>
</tbody>
</table>

*And, as a result, you’re ineligible for health care coverage.
**Includes six-month extension period paid by UPS (see page 12).

For further information, please contact the UPS Benefits Service Center.

Notifying the COBRA Administrator

If you are required to notify the COBRA administrator, as indicated within this section and elsewhere in the SPD, you must call the Benefits Service Center at 1-800-353-9877.
ERISA and Other Important Information

Plan Administration

The information contained in this booklet, including the schedule of benefits, is a summary of the applicable administrative and legal documents relating to the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. For insured benefits, in the event there is any difference between this booklet and the applicable contracts or certificates, the insurance documents will govern.

United Parcel Service, as Plan Administrator, shall have the exclusive right and discretion to interpret the terms and conditions of the Plan, and to decide all matters arising in its administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the Plans. Any such interpretation or decision shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plans’ terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents. The Plan Administrator may delegate certain discretionary authority to one or more committees.

Your participation in the UPS Health and Welfare Package does not guarantee your continued employment with the company. If you quit, are discharged or laid off, this Plan does not give you a right to any benefit or interest in the Plan except as specifically provided in the Plan document.

All benefits described in this booklet — both for you and your family — are paid for by you and UPS, and are made available to you as part of the compensation you receive or received for your work with the company. Certain HMOs, life insurance, accidental death and dismemberment, personal lines and LegalCare are provided to UPS Health and Welfare Package participants by means of insurance contracts, for which you and/or the company pay the premiums. With regard to the Plan’s other benefits, UPS has established a special trust, called a voluntary employee beneficiary association trust, to serve as the funding vehicle. All contributions to this trust are made from the general assets of UPS. Depending on the coverage you select, you may be required to pay a portion of the cost of providing those benefits.

The Plan Administrator for both Plans is United Parcel Service, which is authorized to delegate its administrative duties to one or more individuals or committees within UPS, or to one or more outside administrative services providers. Presently, certain administrative services with regard to the processing of claims and the payment of benefits are provided under contract as follows:

Medical coverage for both Plans is administered by:
Aetna
151 Farmington Avenue
Hartford, CT 06156

Blue Cross and Blue Shield of Illinois
300 East Randolph Street
Chicago, IL 60601

CIGNA
900 Cottage Grove Road
Bloomfield, CT 06002

United Healthcare
9900 Bren Road East
Minnetonka, MN 55343

Kaiser Permanente
1950 Franklin
Oakland, CA 94604

Humana
500 West Main Street
Louisville, KY 40202
Prescription drug coverage for both Plans is administered by:
Medco Health Solutions
1900 Polliit Drive
Fair Lawn, NJ 07410

Mental health/substance abuse coverage for both Plans is administered by:
ValueOptions
3110 Fairview Park Drive
Falls Church, VA 22042

Dental coverage for both Plans is administered by:
Aetna
151 Farmington Road
Hartford, CT 06156

Vision coverage for both Plans is administered by:
Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Disability coverage is administered by:
Broadspire
1601 SW 80th Terrace
Plantation, FL 33324

Health Care and Child/Elder Care Spending Accounts are administered by:
Aetna
151 Farmington Avenue
Hartford, CT 06156

Life and AD&D Insurance are administered by:
Prudential Life Insurance Company
751 Broad Street
Newark, NJ 07102

Legal coverage is administered by:
Signature LegalCare
30851 W. Agoura Rd Suite 300
Agoura Hills, CA 91301-4343

Personal Lines coverage is administered by:
Liberty Mutual
175 Berkeley Street
Boston, MA 02117

General Information
Name of Plan:
The UPS Health and Welfare Package

Plan Number: 524

Plan Year: January 1 through December 31

Employer and Plan Sponsor:
United Parcel Service of America, Inc.
55 Glenlake Parkway, N.E.
Atlanta, GA 30328
(404) 828-6044

Employer Identification Number (EIN):
95-1732075

Plan Administrator:
UPS Health and Welfare Package
United Parcel Service of America, Inc.
55 Glenlake Parkway, N.E.
Atlanta, GA 30328

Name of Plan for Retired Employees:
The UPS Health and Welfare Package for Retired Employees

Plan Number: 525

Plan Year: January 1 through December 31

Employer and Plan Sponsor:
United Parcel Service of America, Inc.
55 Glenlake Parkway, N.E.
Atlanta, GA 30328
(404) 828-6044

Employer Identification Number (EIN):
95-1732075

Plan Administrator:
UPS Health and Welfare Package for Retired Employees
United Parcel Service of America, Inc.
55 Glenlake Parkway, N.E.
Atlanta, GA 30328
Your ERISA Rights
Both the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees are employee welfare benefit plans covered by the Employee Retirement Income Security Act of 1974 (ERISA). As a participant in either Plan, you are entitled to certain rights and protection based on ERISA.

ERISA provides that, as a Plan participant, you are entitled to...

...receive information about your Plan and benefits
You may examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

You may obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

...continue Group Health Plan coverage
You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. You should review this Summary Plan Description for information concerning your COBRA continuation coverage rights.

You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your Group Health Plan, if you move to another plan and you have creditable coverage from this Plan. The UPS Health and Welfare Package and the Health and Welfare Package for Retired Employees do not contain any exclusionary periods of coverage for pre-existing conditions. You will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

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

...enforce your rights
If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance,
if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court 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, for example, if it finds your claim is frivolous.

...assistance with your questions
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 U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or
- Division of Technical Assistance and Inquiries Pension and Welfare Benefits Administration
  U.S. Department of Labor
  200 Constitution Ave., 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 Pension and Welfare Benefits Administration.

Plan Amendment or Termination
UPS has established each of these Plans with the expectation that they will be continued indefinitely. Nevertheless, UPS reserves the right to amend or terminate either Plan at any time. The right to amend or terminate each Plan applies to all coverage hereunder, including coverage for active, retired and disabled employees. No amendment or termination of either Plan will reduce or eliminate benefits for claims incurred prior to the effective date of the amendment or termination.

This book, as updated by any future summary of material modification, constitutes your Summary Plan Descriptions (SPDs) for the UPS Health and Welfare Package and the UPS Health and Welfare Package for Retired Employees. In addition, these SPDs, as official Plan documents, govern each Plan. UPS reserves the right to amend or terminate either Plan or any portion of either Plan at any time.
Member Services Directory

MEDICAL
Aetna
Blue Cross/Blue Shield
CIGNA
United Healthcare
Kaiser Permanente
Humana HMO (KY)
ChoiceCare/Humana HMO (OH)
ValueOptions (Solutions)

PRESCRIPTION DRUGS
Medco Health Solutions

DENTAL
Aetna

VISION
Vision Service Plan

DISABILITY
Brookspire

LIFE INSURANCE AND AD&D
Prudential Life Insurance

LEGAL
Signature LegalCare

SPENDING ACCOUNTS
Aetna

BENEFITS SERVICE CENTER
Enrollment
Eligibility
Cobra

1-800-UPS-1508
Single-call access to all your benefits.

UPSers.com
Find the link for all your benefits and more. Look for the Personalized Directory of Benefits under the My Life and Career tab.
ENROLLMENT KIT
You Have a Lot to Protect

UPS Health and Welfare Package

Supplemental Term Life Insurance
with Accidental Death & Dismemberment Insurance

Supplemental Dependent Term Life Insurance
What’s Inside

Why you may need more insurance ................................................................. 4
Why you should buy it at work .......................................................................... 6
How much you may need .................................................................................. 7

Plus, plan details and rate sheets
Dear Valued Employee:

The Prudential Insurance Company of America (Prudential) knows how important it is to have enough life insurance coverage to protect your family from the unexpected. That’s why United Parcel Service (UPS) selected Prudential—a name you know and trust—to be the provider of two valuable financial protection plans available to you and your dependents:

**Supplemental Term Life Insurance with Accidental Death & Dismemberment Insurance**

**Supplemental Dependent Term Life Insurance with Accidental Death & Dismemberment Insurance**

Both coverages provide extra security at competitive group rates.

A leading insurance carrier for 137 years, Prudential has financial strength ratings with A.M. Best, Moody’s, Standard & Poor’s, and Fitch.* We have the resources and stability to honor long-term commitments—which means we’ll be there when you need us.

Please take a few minutes to read through this booklet. It contains a general description of your Supplemental Term Life and Dependent Term Life plans and specific information about your coverage options and rates. Plus, there’s information on the advantages of getting insurance at work, how much coverage you can get, and what it will cost. There’s even a worksheet to help you figure out how much life insurance coverage you may need.

Please carefully review all of the information, so you can make an informed decision about participating in the program. If you have any questions, please call Prudential at 877-877-2955.

Sincerely,

The Prudential Insurance Company of America

**Think about this:**

If you participate in any sport, you wear the proper protective gear, not because you anticipate injury but to protect yourself—just in case. The same logic applies to purchasing life and accidental death & dismemberment insurance. No one anticipates an untimely death or a serious accident, but owning the right insurance helps protect your income, your family, and your future—just in case.

*For up-to-date information about our ratings, please visit www.investor.prudential.com.
“Why do I need life insurance?”

Life is full of pleasant surprises and, at the same time, life holds uncertainties. It’s easier to plan for happy events you know will occur, and more difficult to plan for the unexpected—such as a death.

If you were no longer there to help support your family (immediate family, siblings, and parents), how would they be able to...

- **Pay off loans**—credit cards, mortgage, and auto?
- **Maintain their standard of living**—utilities, food, clothing, and personal expenses?
- **Provide for your children’s future**—tuition and weddings?
- **Pay your final expenses**—medical care, burial, estate settlement, and inheritance taxes?

A sufficient amount of life insurance can help your family financially recover from your loss during a stressful time.

“*I already have life insurance—why do I need more?”*

Because, like many people, your life insurance amount may be inadequate.

People who die prematurely without enough life insurance coverage create a financial burden for their surviving family. Approximately 45% of widows and 37% of widowers who responded to a recent survey said that their spouse, same-sex domestic partner, or civil union partner did not have adequate life insurance. The survey also revealed that one to two years after the death of a spouse, same-sex domestic partner, or civil union partner, almost half of the respondents were just getting by financially.*

You may be underinsured if your salary has increased since you last purchased insurance. Plus, when you consider new family responsibilities and inflation, the life insurance coverage you have now may not offer enough protection for your family.

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*“The Need and Value of Life Insurance,” LIMRA, August 2004.*
“Why do I need accident insurance?”

You might be surprised to learn that, in the United States:

■ A disabling injury occurs in the home every four seconds.*

■ A disabling injury is caused by a motor vehicle crash every 14 seconds.*

■ Accidents are the fifth leading cause of death.*

■ A fatal injury occurs every five minutes.†

While no one can prevent every accident, you can help protect yourself and your family from the financial drain of accidental injuries and death with extra coverage provided by Accidental Death & Dismemberment (AD&D) Insurance.

AD&D Insurance ensures coverage to help:

■ Support your family (immediate family, siblings, and parents) with a lump sum payment following a covered accident.

■ Transition your spouse, same-sex domestic partner, or civil union partner into the workplace by covering the cost of job training programs, if you die.

■ Provide child day care, if you die.

■ Pay for college tuition for your children, if you die.

■ Pay you a benefit for loss of a limb resulting from a covered accident.

Peace of Mind from Prudential

Prudential’s resources, financial strength, and stability allow us to honor long-term commitments, which means that we’ll be here when you and your family need us. We’ve been a top insurance provider for 137 years and have received positive insurance claims paying ratings from A.M. Best (A+), Moody’s (A2), Standard & Poor’s (AA-), and Fitch (A+).‡

Plus, we have the advanced technology and caring professionals to provide your beneficiaries with the kind of customer support they want and deserve. Our Customer Service Representatives are well-trained, knowledgeable professionals who can quickly answer your family’s questions.

By choosing Prudential, you give yourself peace of mind, knowing you are providing for your loved ones.

‡ As of February 2012. A.M. Best ratings range from A++ (Superior) to F (In Liquidation); Standard & Poor’s ratings range from AAA (Extremely Strong) to R (Has Experienced Regulatory Action); Moody’s ratings range from Aaa (Exceptional) to C (Lowest Rated); Fitch ratings range from AAA (Exceptionally Strong) to D (Distressed).

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

“What are the advantages of buying insurance at work?”

- **It’s easy.** There are no confusing quotes to sort through. And with automatic payroll deductions, you never have to worry about late payments.

- **It’s guaranteed.** If you enroll in the Supplemental Term Life plan when first hired, you may get a certain amount of coverage without having to answer any health questions or having a medical exam.

- **It’s economical.** The cost of group insurance may be lower than insurance you could find on your own.

- **It’s flexible.** You choose the level of coverage that’s right for you.

Customize coverage to fit your needs.
“How much life insurance is enough?”

The right amount of insurance can help your family. It helps replace your income for a number of years to maintain their standard of living and pay for major financial obligations, such as a home mortgage and college tuition.

The Consumer Federation of America (CFA, 1997) recommends six to eight times your income for a married couple with children. While rules of thumb may be helpful, they do not take each individual’s personal situation into consideration. This worksheet provides a simple method to estimate the amount of life insurance you may need.

**Income Needs**

1. **Your annual income.** (What your family would need if you die today.)
   Enter a number that’s between 60% and 70% of your total income.

2. **Annual replacement income.** (Available to your family after you die.)
   Enter a number that includes Social Security benefits, if applicable.

3. **Total annual income to be replaced.** Subtract line 2 from line 1.

4. **Funds needed to provide income for _____ years.** Choose the number of years your family needs your replacement income. Multiply line 3 by the appropriate factor below.*

   10 yrs x 8.1  15 yrs x 11.1  20 yrs x 13.6  25 yrs x 15.6  30 yrs x 17.3  35 yrs x 18.7  40 yrs x 20.0

**Expenses**

5. **Burial expenses.** (The average cost of an adult funeral is about $10,000.)

6. **Mortgage and other major debts.** Include mortgage, credit card debt, car loan, home equity loans, etc.

7. **College costs.** (Current cost of a four-year education: public—$62,264; private—$127,664.)†
   Multiply the college costs by the appropriate factor, based on the number of years between now and when your child begins college.

   5 yrs x .82  10 yrs x .68  15 yrs x .56  20 yrs x .46

   Child 1: $________________________  Child 3: $________________________
   Child 2: $________________________  Child 4: $________________________

8. **Total capital required.** Add lines 4, 5, 6, and 7.

   $________________________

**Assets**

9. **Savings and investments.** Include bank accounts, CDs, stocks, bonds, mutual funds, real estate/rental property, etc.

10. **Retirement savings.** Include 401(k), Keogh, pension, and profit-sharing plans.

11. **Present amount of life insurance.** Include group insurance and personal insurance purchased on your own.

12. **Total of all assets.** Add lines 9, 10, and 11.

13. **Estimated amount of life insurance needed.** Subtract line 12 from line 8.

   $________________________

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*Inflation is assumed to be 4%. The rate of return on investments is assumed to be 8%.
†The College Board, Trends in College Pricing 2005. Costs include tuition, room, board, books and supplies, transportation, and other expenses.
This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions, and limitations. A Booklet-Certificate, with complete plan information, including limitations and exclusions, will be provided. You may request a Booklet-Certificate by calling the UPS Benefits Service Center at 1-800-UPS-1508. If there is a discrepancy between this document and the Booklet-Certificate issued by Prudential, the terms of the Booklet-Certificate will govern. Contract provisions may vary by state.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Supplemental Term Life, Supplemental Dependent Term Life, and Supplemental Accidental Death & Dismemberment Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. 800-524-0542. Contract Series: 83500.

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Prudential, the Prudential logo and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.
ATTENTION:

Here are your detachable plan details and rate sheets.
YOUR PLAN DETAILS
You Have a Lot to Protect

UPS Health and Welfare Package

Supplemental Term Life Insurance
Supplemental Dependent Term Life Insurance
Supplemental Accidental Death & Dismemberment (AD&D) Insurance

Issued by The Prudential Insurance Company of America

The Prudential Insurance Company of America
IFS-A129729 Ed. 0612
**Employee — Supplemental Term Life**

UPS offers you the opportunity to enroll in a group Supplemental Term Life Insurance plan issued by The Prudential Insurance Company of America (Prudential). You pay the cost of this optional coverage.

<table>
<thead>
<tr>
<th>Eligibility to Participate</th>
<th>Please refer to the UPS Health and Welfare Package Summary Plan Description for specific eligibility requirements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Amounts</td>
<td>You may enroll for increments of $1,000, up to a maximum of $1,000,000.</td>
</tr>
<tr>
<td>Guaranteed Coverage</td>
<td>Certain coverage is available without providing proof of good health. Important Notice: If the acceleration of life insurance benefits offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986-IRC Section 101(g). If the acceleration of life insurance benefits qualifies for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to the acceleration of life income benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration of life insurance benefits excludable from income under federal law. New York Residents: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Minnesota Residents: Please see the Minnesota Insert for information on continuation and conversion.</td>
</tr>
<tr>
<td>Medical Evidence Requirements</td>
<td>Full-time employees: If you enroll within 45 days of your initial eligibility date, you must provide proof of good health satisfactory to Prudential for coverage amounts greater than $150,000. Part-time employees: If you enroll within 45 days of your initial eligibility date, you must provide proof of good health satisfactory to Prudential for coverage amounts greater than $50,000. If you enroll after 45 days from your initial eligibility date, you must provide proof of good health satisfactory to Prudential for all coverage amounts.</td>
</tr>
<tr>
<td>Life Event Changes</td>
<td>If you have a change in family status such as marriage or birth (adoption), you may increase your coverage with proof of good health satisfactory to Prudential. You must notify the UPS Benefits Service Center at 1-800-UPS-1508 within 60 days of the life event.</td>
</tr>
<tr>
<td>Accelerated Benefit Option</td>
<td>If you provide proof satisfactory to Prudential that you are terminally ill with a life expectancy of 12 months or less, you may elect to receive up to 50% of your combined Term Life benefit, generally income tax free (under IRC Section 101(g)), while still living, up to a maximum of $300,000. (Subject to a $10,000 minimum and a $300,000 maximum or to state-regulated maximums if less.) This benefit is only available once and is payable in a lump sum. The death benefit payable to your beneficiary will be reduced by the amount you elect under this option.</td>
</tr>
<tr>
<td>Portability†</td>
<td>When you leave the company, you have the opportunity to continue your group life insurance at group rates under the portability provision. Portability will begin on the first of the month following the date of notification of termination from UPS. Portable rates will be 120% of the rate schedule you had as an employee of UPS. You will be billed directly and charged a $3 administration fee by Prudential on a quarterly basis. If UPS’ participation in the master contract terminates, your portability coverage will continue. You will be moved to the Prudential standard portability rate structure after one year and your rates will increase. At age 70 or more, your amount of insurance is limited. It is the greater of $10,000 and 50% of the amount for which you would then be insured if there were no limitation. At age 75 or more, your amount of insurance is further limited. It is the greater of $10,000 and 25% of the amount for which you would then be insured if there were no limitation. If you use the portability provision and are later rehired or transferred to a UPS position that allows you to elect supplemental coverage under another UPS-sponsored plan, you must surrender the ported policy in order to elect coverage under the UPS-sponsored plan as an active employee.</td>
</tr>
<tr>
<td>Termination of Coverage†</td>
<td>Your Supplemental Term Life coverage will end when your UPS Health and Welfare Package coverage ends. You have the opportunity to continue your coverage by either electing to continue group term life coverage under the portability provision or converting to a Prudential individual life insurance policy. Additional information will be sent to you upon termination or retirement.</td>
</tr>
</tbody>
</table>

*Important Notice:* If you provide proof satisfactory to Prudential that you are terminally ill with a life expectancy of 12 months or less, you may elect to receive up to 50% of your combined Term Life benefit, generally income tax free (under IRC Section 101(g)), while still living, up to a maximum of $300,000. (Subject to a $10,000 minimum and a $300,000 maximum or to state-regulated maximums if less.) This benefit is only available once and is payable in a lump sum. The death benefit payable to your beneficiary will be reduced by the amount you elect under this option.

†Minnesota Residents: Please see the Minnesota Insert for information on continuation and conversion.
### Family—Supplemental Dependent Term Life

UPS offers you the opportunity to enroll your dependents in a group Supplemental Dependent Term Life Insurance plan issued by The Prudential Insurance Company of America (Prudential). You pay the cost of this optional coverage. Employee Supplemental Dependent Term Life Insurance coverage is not required in order for the dependent spouse, same-sex domestic partner, or civil union partner and/or dependent child(ren) to have Supplemental Dependent Term Life Insurance coverage.

#### Spouse, Same-Sex Domestic Partner, or Civil Union Partner

| Eligibility to Participate | If your spouse, same-sex domestic partner, civil union partner or child is eligible as an employee for Supplemental Dependent Term Life Insurance through the UPS Health and Welfare Package or another UPS-sponsored plan that offers supplemental life insurance (for example, the Flexible Benefits Plan or UPS Health and Welfare Package Select), you are not eligible to cover your spouse, same-sex domestic partner, civil union partner or child for Supplemental Dependent Term Life Insurance through the UPS Health and Welfare Package. Your spouse, same-sex domestic partner, civil union partner or child must elect employee supplemental life insurance through his or her own employee plan. If your spouse, same-sex domestic partner, civil union partner or child is confined for medical care or treatment at home or elsewhere, coverage will not begin until the confinement ceases. Please refer to the UPS Health and Welfare Package Summary Plan Description for additional information regarding eligibility and when coverage begins. |
| Coverage Amounts | You may enroll your spouse, same-sex domestic partner, or civil union partner for coverage in amounts of $5,000, $20,000, or $45,000. |
| Guaranteed Coverage | If your spouse, same-sex domestic partner, or civil union partner enrolls within 45 days of your date of eligibility, his/her guaranteed coverage amount is up to $20,000. |
| Medical Evidence Requirements | If your spouse, same-sex domestic partner, or civil union partner enrolls within 45 days of your date of eligibility or within 60 days of marriage, same-sex domestic partnership, or civil union, he/she must provide evidence of good health satisfactory to Prudential for coverage amounts greater than $20,000. After the applicable 45- or 60-day period, he/she must provide evidence of good health satisfactory to Prudential for all coverage amounts. |
| Portability* | If your employment ends, and you elect to continue coverage under the portability provision, you may also continue Supplemental Dependent Term Life coverage for your spouse, same-sex domestic partner, or civil union partner under the portability provision. The cost of this coverage will be 120% of the rate schedule your spouse, same-sex domestic partner, or civil union partner had when you were an employee of UPS and will be guaranteed for a period of one year from the time he/she continued coverage. In the event of your death, divorce, or dissolution of your domestic partnership/civil union, your spouse, same-sex domestic partner, or civil union partner may continue his/her Supplemental Dependent Term Life coverage. He/she will be billed directly and charged a $3 administration fee by Prudential on a quarterly basis. If UPS’ participation in the master contract terminates, his/her portability coverage will continue. He/she will be moved to the Prudential standard portability rate structure after one year and your rates will increase. |
| Termination of Coverage* | Your spouse’s, same-sex domestic partner’s, or civil union partner’s Supplemental Dependent Term Life coverage will end when his/her UPS Health and Welfare Package coverage ends. You have the opportunity to continue coverage for your spouse, same-sex domestic partner, or civil union partner by either electing to continue group term life coverage under the portability provision or converting to a Prudential individual life insurance policy. Additional information will be sent to you upon your termination or retirement. |

#### Children

| Eligibility to Participate | You may cover a “Child” through the end of the month in which the child turns age 26. A “Child” is defined as your natural child, your adopted child, a child placed with you for adoption or a child for whom you are the legal guardian (as determined in accordance with applicable law). A covered child who becomes incapacitated while covered under the Plan and before he or she turns age 26 is eligible to continue coverage after turning age 26 as long as you are eligible and as long as the following conditions are satisfied: (i) the incapacity exists, (ii) the child is unmarried, (iii) the child is primarily dependent on you for support and maintenance, and (iv) appropriate certification of disability is provided to the medical claims administrator. You must apply to continue coverage for an incapacitated dependent prior to age 26 or loss of coverage under the Plan. In addition, periodic medical documentation of the continuing incapacity is required as determined by the medical claims administrator. |

*Minnesota Residents: Please see the Minnesota Insert for information on continuation and conversion.*
### Family—Supplemental Dependent Term Life (continued)

<table>
<thead>
<tr>
<th>Coverage Amounts</th>
<th>You may enroll your dependent children for coverage for an amount of $2,500 or $7,500.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Termination of Coverage</strong>*</td>
<td>Your dependent children’s Supplemental Dependent Term Life coverage will end when the UPS Health and Welfare Package coverage ends. You will have the opportunity to continue coverage for your children if you elect to continue your coverage under the portability provision or convert to a Prudential individual life policy. Child-only portable coverage is not permissible. Additional information will be sent to you upon your termination or retirement.</td>
</tr>
</tbody>
</table>

*Minnesota Residents: Please see the Minnesota Insert for information on continuation and conversion.*
**Employee—Supplemental Accidental Death & Dismemberment (Supplemental AD&D)**

UPS offers you the opportunity to enroll in a group Supplemental AD&D Insurance plan (also known as Personal Accident Insurance) issued by The Prudential Insurance Company of America (Prudential). Supplemental AD&D provides a benefit for loss of life and certain injuries resulting from a covered accident. Loss of life benefits are paid in addition to Supplemental Term Life. You pay the cost of this optional coverage.

<table>
<thead>
<tr>
<th>Eligibility to Participate</th>
<th>Please refer to the UPS Health and Welfare Package Summary Plan Description for specific eligibility requirements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Amounts</td>
<td>You may enroll in increments of $1,000, up to a maximum of $1,000,000.</td>
</tr>
</tbody>
</table>

**Standard Benefits**

Benefits are paid at certain percentages of your coverage amount for specific accidental losses as indicated below (not more than 100% of your coverage amount is payable for all losses due to the same accident). The loss must be incurred within 90 days of the accident (paralysis within 365 days of the accident).

<table>
<thead>
<tr>
<th>Accidental Losses</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100%</td>
</tr>
<tr>
<td>One hand or one foot and sight in one eye</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and hearing in both ears</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>75%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>75%</td>
</tr>
<tr>
<td>Sight in one eye</td>
<td>75%</td>
</tr>
<tr>
<td>Speech</td>
<td>75%</td>
</tr>
<tr>
<td>Hearing in both ears</td>
<td>75%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and index finger on the same hand</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Loss Due to Exposure and Disappearance**

Loss due to exposure to the elements or disappearance is considered an accidental loss. The plan pays 100% of your coverage amount if your body is not found within a year of a certain disappearance because you will be presumed to have died.

**Loss Due to Coma**

The plan pays 1% of your coverage amount for each month you remain in a coma that results from a covered accident. The coma must be total, continuous, permanent, begin within three days of the accident, and last for six months. This benefit is payable for up to 100 months while you remain in a coma.

**Permanent and Total Disability Benefit**

The plan pays a benefit of 100% of your coverage amount if you are under age 70 and sustain a permanent and total disability within 100 days after a covered accident.

**Home Modification Benefit**

The plan pays up to $2,000 for required home site changes made within one year of an accident, if you suffer a loss as the result of a covered accident.
### Additional Benefits

These benefits are paid in addition to our Standard Benefits.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Seat Belt Benefit</strong></td>
<td>The plan pays an additional benefit of 10% of the coverage amount, up to $25,000, if an accidental death occurs while you are wearing a seat belt in the prescribed manner.</td>
</tr>
<tr>
<td><strong>Air Bag Benefit</strong></td>
<td>The plan pays an additional benefit of 10% of the coverage amount, up to $25,000, if an accidental death occurs while you are riding in an automobile seat equipped with an air bag system, and you are wearing a seat belt in the prescribed manner.</td>
</tr>
<tr>
<td><strong>Rehabilitation Benefit</strong></td>
<td>The plan pays 20% of your coverage amount, to a maximum of $10,000, for necessary expenses incurred within two years of the accident, if you suffer a loss as the result of a covered accident and require training to return to work or to become independent.</td>
</tr>
<tr>
<td><strong>Continuation of Medical Funding Benefit</strong></td>
<td>The plan pays three annual installments, up to the lesser of 5% of your coverage amount or $10,000, to continue medical coverage for the family if you die as the result of a covered accident. This benefit is to begin after the six-month extension of health care benefit coverage provided by the UPS Health &amp; Welfare Package. If the beneficiary does not provide proof that the payment was used for the purchase of medical coverage, the beneficiary will receive only one payment of 5% or $10,000, whichever is less.</td>
</tr>
<tr>
<td><strong>Brain Damage Benefit</strong></td>
<td>The plan pays 100% of your coverage amount if you sustain brain damage within 60 days of a covered accident. You must be hospitalized for at least seven days within the first 60 days following the covered accident and brain damage must continue for 12 consecutive months and must be non-reversible after that time.</td>
</tr>
<tr>
<td><strong>Emergency Medical Evacuation or Return of Remains Benefit</strong></td>
<td>The plan pays for your emergency medical evacuation to a suitable medical facility upon orders from an attending physician, or the preparation and transportation of your body for cremation or burial if your death occurs outside a 150-mile radius of your home. The benefit amount is the lesser of the actual covered expenses or $2,500.</td>
</tr>
<tr>
<td><strong>Termination of Coverage</strong></td>
<td>Your Supplemental AD&amp;D coverage will end when your UPS Health and Welfare Package coverage ends.</td>
</tr>
</tbody>
</table>

### Exclusions

A loss is not covered if it results from any of these:

- Suicide, attempted suicide, while sane or insane;
- Intentionally self-inflicted injuries or any attempt to inflict such injuries, while sane or insane;
- Sickness, whether the loss results directly or indirectly from the sickness;
- Medical or surgical treatment of sickness, whether loss results directly or indirectly from treatment;
- Any infection (unless pyogenic resulting from an accident or a bacterial infection that results from accidental ingestion of a contaminated substance);
- War, or any act of war, declared or undeclared, and includes resistance to armed aggression;
- Accident that occurs while serving on full-time active duty for more than 30 days in any armed forces (does not include Reserves or National Guard active duty for training); or
- Commission of, or attempt to commit, a felony.

### Important Notice for New York Residents

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

**IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.**
**Rate Sheet**

**UPS Health and Welfare Package**

*Effective Date: January 1, 2013*

### Supplemental Term Life—Employee

**Annual Cost of Insurance (rates per $1,000 of coverage)**

<table>
<thead>
<tr>
<th>Age (As of January 1 of coverage year)</th>
<th>Annual Non-Smoker Rates</th>
<th>Annual Smoker Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$0.44</td>
<td>$0.79</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.44</td>
<td>$0.90</td>
</tr>
<tr>
<td>35–39</td>
<td>$0.56</td>
<td>$1.01</td>
</tr>
<tr>
<td>40–44</td>
<td>$0.90</td>
<td>$1.48</td>
</tr>
<tr>
<td>45–49</td>
<td>$1.58</td>
<td>$2.48</td>
</tr>
<tr>
<td>50–54</td>
<td>$2.60</td>
<td>$3.85</td>
</tr>
<tr>
<td>55–59</td>
<td>$4.52</td>
<td>$6.34</td>
</tr>
<tr>
<td>60–64</td>
<td>$7.45</td>
<td>$10.73</td>
</tr>
<tr>
<td>65–69</td>
<td>$12.88</td>
<td>$18.42</td>
</tr>
<tr>
<td>70–74</td>
<td>$23.28</td>
<td>$34.69</td>
</tr>
<tr>
<td>75–79</td>
<td>$38.42</td>
<td>$55.03</td>
</tr>
<tr>
<td>80–84</td>
<td>$54.01</td>
<td>$77.52</td>
</tr>
<tr>
<td>85–89</td>
<td>$77.75</td>
<td>$111.42</td>
</tr>
<tr>
<td>90–94</td>
<td>$112.66</td>
<td>$161.58</td>
</tr>
<tr>
<td>95+</td>
<td>$229.84</td>
<td>$380.12</td>
</tr>
</tbody>
</table>

### How much does Supplemental Term Life cost?*

1. **Step 1** Enter the amount of coverage you wish to purchase (increments of $1,000, not to exceed $1,000,000). $
2. **Step 2** Divide the coverage amount by $1,000. $
3. **Step 3** Multiply the amount in Step 2 by the cost of coverage that you’ll find in the chart above. $
4. **Step 4** If you are paid biweekly, divide the total annual cost, in Step 3, by 26 to get your biweekly cost. $

**TOTAL COST** $

### Supplemental Accidental Death & Dismemberment—Employee

**Annual Cost of Insurance (rates per $1,000 of coverage, regardless of age or smoker/non-smoker status)**

<table>
<thead>
<tr>
<th>Insured</th>
<th>Annual Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0.25</td>
</tr>
</tbody>
</table>

### How much does Supplemental Accidental Death & Dismemberment coverage cost?*

1. **Step 1** Enter the amount of coverage you wish to purchase (increments of $1,000, not to exceed $1,000,000). $
2. **Step 2** Divide the coverage amount by $1,000. $
3. **Step 3** Multiply the amount in Step 2 by .25. $
4. **Step 4** If you are paid biweekly, divide the total annual cost, in Step 3, by 26 to get your biweekly cost. $

**TOTAL COST** $

---

All coverages are optional, and the entire cost of coverage is employee paid.

Rates may change as the insured enters a higher age category, also rates may change if plan experience requires a change for all insureds.

Cost of insurance rates for all coverages will be deducted from your paycheck. Please note that a summary of plan provisions, exclusions, and limitations is listed on the plan details portion of this kit. All provisions that apply to this coverage are governed by the Booklet-Certificate.
**Supplemental Dependent Term Life—Spouse, Same-Sex Domestic Partner, or Civil Union Partner**

**Annual Cost of Insurance (rates per $1,000 of coverage)**

<table>
<thead>
<tr>
<th>Age (As of January 1 of coverage year)</th>
<th>Annual Non-Smoker Rates</th>
<th>Annual Smoker Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$0.46</td>
<td>$0.80</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.46</td>
<td>$0.89</td>
</tr>
<tr>
<td>35–39</td>
<td>$0.58</td>
<td>$1.01</td>
</tr>
<tr>
<td>40–44</td>
<td>$0.89</td>
<td>$1.46</td>
</tr>
<tr>
<td>45–49</td>
<td>$1.56</td>
<td>$2.47</td>
</tr>
<tr>
<td>50–54</td>
<td>$2.59</td>
<td>$3.83</td>
</tr>
<tr>
<td>55–59</td>
<td>$4.49</td>
<td>$6.30</td>
</tr>
<tr>
<td>60–64</td>
<td>$7.40</td>
<td>$10.66</td>
</tr>
<tr>
<td>65–69</td>
<td>$12.79</td>
<td>$18.29</td>
</tr>
<tr>
<td>70–74</td>
<td>$23.12</td>
<td>$34.46</td>
</tr>
<tr>
<td>75–79</td>
<td>$38.16</td>
<td>$54.66</td>
</tr>
<tr>
<td>80–84</td>
<td>$53.65</td>
<td>$77.00</td>
</tr>
<tr>
<td>85–89</td>
<td>$77.23</td>
<td>$110.68</td>
</tr>
<tr>
<td>90–94</td>
<td>$111.91</td>
<td>$160.52</td>
</tr>
<tr>
<td>95+</td>
<td>$228.31</td>
<td>$377.59</td>
</tr>
</tbody>
</table>

*Spouse, same-sex domestic partner, or civil union partner coverage is available in amounts of $5,000, $20,000, and $45,000.

**How much does Supplemental Dependent Term Life—Spouse, Same-Sex Domestic Partner, or Civil Union Partner cost?**

**Step 1** Enter the amount of coverage you wish to purchase ($5,000, $20,000, or $45,000).

**Step 2** Divide the coverage amount by $1,000.

**Step 3** Multiply the amount in Step 2 by the cost of coverage that you’ll find in the chart above.

**Step 4** If you are paid biweekly, divide the total annual cost, in Step 3, by 26 to get your biweekly cost.

**TOTAL COST**

---

**Supplemental Dependent Term Life—Children**

(Premium covers all eligible children)

<table>
<thead>
<tr>
<th>Amount of Coverage</th>
<th>Annual Cost of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,500</td>
<td>$3.12</td>
</tr>
<tr>
<td>$7,500</td>
<td>$9.36</td>
</tr>
</tbody>
</table>

All coverages are optional, and the entire cost of coverage is employee paid.

Rates may change as the insured enters a higher age category or if plan experience requires a change for all insureds.

Cost of insurance rates for all coverages will be deducted from your paycheck. Please note that a summary of plan provisions, exclusions, and limitations are listed on the plan details portion of this kit. All provisions that apply to this coverage are governed by the Booklet-Certificate.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Supplemental Term Life, Supplemental Dependent Term Life, and Supplemental Accidental Death & Dismemberment Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. 800-524-0542, Contract Series: 83500.

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UPS Health and Welfare Package
Important Notice for Minnesota Residents

The Prudential Insurance Company of America

For Minnesota residents, there are different provisions that apply about your right to continue or convert coverage after your insurance ends. This notice replaces the descriptions of portability and termination of coverage in the “Help Protect the Most Important People in Your Life” brochure and “Your Plan Details” contained in this kit.

Employee—Supplemental Term Life

Continuation of Coverage

You have the right to continue your Supplemental Employee Term Life coverage under the Group Contract at your expense if your UPS Health and Welfare Package coverage ends because (1) your employment ends, or (2) you are laid off, or (3) your work hours are reduced. Proof of good health is not required. Your contributions for this continued coverage will be at the same rate as for other similarly situated employees of UPS. Coverage may be continued until you fail to make a payment for continued coverage or until UPS’ contract with The Prudential Insurance Company of America terminates.

If your continued coverage ends because the UPS contract ends, you may convert all or part of your insurance to an individual life insurance contract (see below).

Conversion

Your Supplemental Term Life Insurance coverage will end when (1) your employment ends or you transfer out of a covered class, or (2) all term life insurance of the Group Contract for your class ends by amendment or otherwise. You have an opportunity to continue your Supplemental Term Life coverage by converting to an individual life insurance contract. The individual contract will be one of the type The Prudential Insurance Company of America normally issues at the age and amount applied for (but not term insurance or a contract with disability or supplementary benefits). Proof of good health is not required.

Additional information will be sent to you upon termination or retirement.

Family—Supplemental Dependent Term Life

Spouse, Same-Sex Domestic Partner, or Civil Union Partner

Continuation of Coverage

You have the right to continue your spouse’s, same-sex domestic partner’s, or civil union partner’s Supplemental Dependent Term Life coverage under the Group Contract at your expense if your UPS Health and Welfare Package coverage ends because (1) your employment ends, or (2) you are laid off, or (3) your work hours are reduced. Proof of good health is not required. Your contributions for this continued coverage will be at the same rate as for other similarly situated employees of UPS. Coverage may be continued until you fail to make a payment for continued coverage or until UPS’ contract with The Prudential Insurance Company of America terminates.

In the event of your death, divorce, or dissolution of your domestic partnership/civil union, your spouse, same-sex domestic partner, or civil union partner may continue his/her Supplemental Dependent Term Life coverage. Your spouse, same-sex domestic partner, or civil union partner will be billed directly. If UPS’ contract with The Prudential Insurance Company of America terminates, your spouse’s, same-sex domestic partner’s, or civil union partner’s continued coverage will end.
If continued coverage for your spouse, same-sex domestic partner, or civil union partner ends because the UPS contract ends, you may convert all or part of your spouse’s, same-sex domestic partner’s, or civil union partner’s insurance to an individual life insurance contract (see below).

**Conversion**

Your spouse’s, same-sex domestic partner’s, or civil union partner’s Supplemental Dependent Term Life Insurance coverage will end when (1) your employment ends or you transfer out of a covered class, or (2) all Term Life Insurance of the Group Contract for your class ends by amendment or otherwise. You have an opportunity to continue your spouse’s, same-sex domestic partner’s, or civil union partner’s Supplemental Dependent Term Life coverage by converting your spouse’s, same-sex domestic partner’s, or civil union partner’s coverage to an individual life insurance contract. Your spouse, same-sex domestic partner, or civil union partner may elect to convert (rather than continue) her/his Supplemental Dependent Term Life coverage to an individual life insurance contract in the event of death, divorce, or dissolution of your domestic partnership/civil union. The individual contract will be one of the type The Prudential Insurance Company of America normally issues at the age and amount applied for (but not term insurance or a contract with disability or supplementary benefits). Proof of good health is not required.

Additional information will be sent to you upon termination or retirement.

**Children**

**Continuation of Coverage**

You have the right to continue your children’s Supplemental Dependent Term Life coverage under the Group Contract at your expense if your UPS Health and Welfare Package coverage ends because (1) your employment ends, or (2) you are laid off, or (3) your work hours are reduced. Proof of good health is not required. Your contributions for this continued coverage will be at the same rate as for other similarly situated employees of UPS. Coverage may be continued until you fail to make a payment for continued coverage or until UPS’ contract with The Prudential Insurance Company of America terminates.

If continued coverage for your children ends because the UPS contract ends, you may convert all or part of each of your children’s insurance to an individual life insurance contract (see below).

**Conversion**

Your children’s Supplemental Dependent Term Life Insurance coverage will end when (1) your employment ends or you transfer out of a covered class, or (2) all Term Life Insurance of the Group Contract for your class ends by amendment or otherwise, or (3) your child ceases to be a qualified dependent. You have an opportunity to continue your children’s Supplemental Dependent Term Life coverage by converting each of your children’s coverage to an individual life insurance contract. Each individual contract will be one of the type The Prudential Insurance Company of America normally issues at the age and amount applied for (but not term insurance or a contract with disability or supplementary benefits). Proof of good health is not required.

Additional information will be sent to you upon termination or retirement.

This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions, and limitations. A Booklet-Certificate, with complete plan information, including limitations and exclusions, will be provided. You may request a Booklet-Certificate by calling the UPS Benefits Service Center at 1-800-UPS-1508. If there is a discrepancy between this document and the Booklet-Certificate issued by Prudential, the terms of the Booklet-Certificate will govern. Contract provisions may vary by state.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Supplemental Term Life, Supplemental Dependent Term Life, and Supplemental Accidental Death & Dismemberment Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. 800-524-0542. Contract Series: 83500.

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