Summary Plan Description

UPS National Health Plan for Part-Time Employees

Member Services

UPSSers.com
- The online link to all your benefits and more
  My Life and Career tab

eHR
- Toll-free phone access to all your benefits and vendors
  1-800-UPS-1508

Benefits Service Center
- Enrollment
- Verify eligibility
- Add or remove dependents
- Request benefits material
- COBRA administration
  1-800-UPS-1508

Aetna
- Medical PPO
  1-800-237-0575
- Medical Traditional Plan
  1-800-237-0575
- Dental
  1-877-263-0659
- Short-term disability
  1-866-825-0186
- Spending Accounts
  1-888-238-6226
  www.wkabsystem.com

BlueCross BlueShield
- Medical PPO
  1-800-516-1270

ValueOptions
- Behavioral health
  1-800-336-9117
- Employee Assistance Program (EAP)
  1-800-336-9117

Medco Health Solutions
- Prescription drugs
  1-800-346-1327

Vision Service Plan (VSP)
- Vision
  1-800-877-7195

Prudential Insurance Company
- Life insurance and AD&D
  1-877-877-2955
  1-877-889-2070 (conversions only)

Healthy Connections — Informed Choices
- Health coaches and condition management
  www.upshealthyconnections-informedchoices.com

Quit For Life
- Tobacco cessation program
  1-866-QUIT-4-LIFE

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UPS National Health Plan for Part-Time Employees

Maintaining Coverage

Once you gain initial eligibility, coverage for each week is based on hours worked during that week. If no hours are worked during the week, then you are not eligible for coverage that week.

If you lose coverage due to insufficient hours worked, you may elect to continue coverage through COBRA. If you do not submit COBRA payments by the due date, you will not be eligible for benefits that month. Please see your Summary Plan Description booklet for details about COBRA continuation.

This rule applies while you are an active employee. If you terminate employment, retire or go on a leave of absence, there are other Plan rules that impact when coverage ends. See the Life Events section of your Summary Plan Description for more information.

Short-Term Disability

Your short-term disability income benefit is the standard benefit described in your Summary Plan Description.

Prescription Drug Benefits

Your prescription drug benefits are administered by Medco. You must show your Medco ID card to the pharmacist at the time you fill your prescription to receive the highest Plan benefits.

Participating Pharmacies

Simply present your ID card to the pharmacist along with your doctor’s prescription. You don’t have to file any claims. The Plan covers up to a 34-day supply at a retail pharmacy and up to a 90-day supply through the Medco by Mail home delivery program.

You are required to use the Medco by Mail home delivery program for maintenance medication. Maintenance prescription drugs filled at a retail pharmacy after the second refill are covered at 50 percent and are not subject to the per-prescription out-of-pocket maximum.

<table>
<thead>
<tr>
<th>Type of Medication</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail generic or brand name without generic equivalent (30-day supply)</td>
<td>25% coinsurance up to $200 out-of-pocket per RX</td>
</tr>
<tr>
<td>Retail brand name with generic equivalent (30-day supply)</td>
<td>25% coinsurance up to $200 out-of-pocket per RX, plus difference between brand and generic*</td>
</tr>
<tr>
<td>Retail maintenance medication (30-day supply), after second refill</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Mail delivery (90-day supply; mandatory for maintenance medications)</td>
<td>20% coinsurance up to $200 out-of-pocket per RX</td>
</tr>
</tbody>
</table>

*The difference in cost between the brand and generic drugs does not apply to the maximum out-of-pocket per RX.
**Specialty Drugs**

There is an annual $1,000 out-of-pocket maximum per participant for injectable drugs only. Once this out-of-pocket maximum is met, the Plan covers 100 percent of the cost of injectable drugs for the participant for the remainder of the calendar year.

Call Medco at 1-800-UPS-1508 for more information on specialty drugs.

**Non-Participating Pharmacies**

When you use a non-participating pharmacy, you must pay the pharmacy’s regular charge for the medication and submit a claim form for reimbursement. It’s important to remember that participating pharmacies usually charge UPSers a lower price for a prescription. Your reimbursement will be based on this lower amount when you use a non-participating pharmacy. In addition to the regular coinsurance, you also pay the difference between the lesser (discounted) amount and the pharmacy’s regular price.

**Covered Prescription Drugs**

- Federal legend drugs
- State-restricted drugs
- Insulin – by prescription only
- Insulin needles, syringes and chem strips – by prescription only
- Over-the-counter diabetic supplies
- Compounded medications
- Oral contraceptives

**Prescription Drugs Not Covered**

- Non-federal legend drugs
- Drugs used for cosmetic purposes
- Drugs to treat sexual dysfunction
- Therapeutic devices and appliances
- Drugs labeled “Caution-limited by federal law to investigational use,” or experimental drugs
- Medication for which the cost is recoverable by Workers’ Compensation, occupational disease law, or any state or governmental agency; or medication furnished by any other drug or medical service for which no charge is made to the participant
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed more than one year from the physician’s original order
- Over-the-counter medications other than diabetic supplies
- Drugs whose sole purpose is to promote or stimulate hair growth
- Dietary supplements, including any supplements for newborn infants
- Growth hormones without prior authorization
- Immunizing agents, blood and blood plasma or medication prescribed for parenteral administration
- Charges incurred for which a claim is not received within 12 months
Summary of Material Modifications
UPS National Health Plan for Part-Time 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 National Health Plan for Part-Time 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.

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.

Grandfathered 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
This notice is intended to fulfill UPS’s legal obligation to notify employees of material changes to the UPS National Health Plan for Part-Time Employees. This notice formally amends the coverage available under the Plan.

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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 National Health Plan for Part-Time Employees
September 2010

This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2011, unless otherwise noted. You should keep this with your UPS National Health Plan for Part-Time 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 incapacity 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

**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 and click the Privacy link at the bottom of each page of the site;
- Log on to 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.
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211-0009
Summary of Material Modifications
UPS National Health Plan for Part-Time Employees
September 2009

This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2009, unless otherwise noted. Items noted with an asterisk (*) do not apply to retirees or their covered dependents. You should keep this with your UPS National Health Plan for Part-Time 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. As a result, your medical claims administrator under the Plan may be changing. This change will not affect your plan coverage—benefits provided by the Plan remain the same. 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. If your claims administrator is changing, you will receive new medical ID cards prior to January 1, 2010.

If you have a covered dependent who is a non-resident or who 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.

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 Summary Plan Description 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.

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 table below 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>Inpatient</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Hospital &amp; Facility Admission Fee</td>
<td>None</td>
<td>$250</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>100% after $10 copay</td>
<td>80%</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.

**Eligibility: Temporary Layoff**

If you are temporarily laid off (and are recorded as such in the UPS eligibility system) before you become initially eligible for benefits under the Plan and later return to work, the time you worked prior to your temporary layoff period is credited toward your initial eligibility requirements.

If you became eligible for benefits under the Plan prior to a temporary layoff, you will be given the opportunity to re-enroll in the Plan when you return to work, without a waiting period.

**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.

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.
**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 lymphedemas.

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

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**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 National Health Plan for Part-Time Employees. This notice formally amends the coverage available under the Plan.

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Summary of Material Modifications
UPS National Health Plan for Part-Time 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 National Health Plan for Part-Time Employees Summary Plan Description for future reference.

The following are clarifications of current Plan administration.

Preventive Care
The Plan covers well-child care and routine physicals according to the following schedule:

- Birth to age one – 7 visits per year
- Age one to two – 3 visits per year
- Age two to six – 1 visit per year
- Age seven to age fifty – 1 visit every 24 months
- Age fifty and over – 1 visit per year

Rehired Employee Eligibility
If you are a rehired employee, you must requalify for Plan coverage under the UPS National Health Plan for Part-Time Employees, regardless of whether you are rehired within the same or a different Plan year. Once you meet the initial eligibility requirements, you may enroll in the Plan as a new employee.

Same Sex Partner Eligibility
In order for your same-sex partner and his or her eligible dependents to be eligible for coverage under the UPS National Health Plan for Part-Time 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 National Health Plan for Part-Time Employees
April 2008

This notice details Plan improvements, clarifications, and required notifications effective April 1, 2008. You should keep this with your UPS National Health Plan for Part-Time Employees Summary Plan Description for future reference. Items marked with an asterisk (*) do not apply to COBRA participants or their covered dependents.

Same-Sex Domestic Partner 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 and accidental death and dismemberment (AD&D) 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.

In-Network Vision Benefits
As a clarification of current Plan administration, your vision coverage for frames and standard contact lenses from Vision Services Plan (VSP) providers is subject to the maximum benefit allowed by 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.
## Table of Contents

Overview of the Plan ..................................................... 2
Eligibility ................................................................. 5
Enrollment ................................................................. 9
Life Events ............................................................... 11
Summary of Benefits .................................................. 18
Medical Benefits ......................................................... 23
Behavioral Health Benefits ......................................... 40
Prescription Drug Benefits ........................................... 43
Dental Benefits ......................................................... 45
Vision Benefits ......................................................... 52
Life Insurance and AD&D ............................................ 54
Short-Term Disability .................................................. 60
Solutions — Your EAP and Work/Life Benefit ..................... 63
Healthy Connections — Informed Choices ......................... 65
Quit For Life Tobacco Cessation Program ......................... 68
Spending Accounts ..................................................... 69
Legal Plan ................................................................. 76
Adoption Assistance .................................................... 78
Personal Lines Insurance (Auto and Home) ......................... 80
Filing a Claim ............................................................ 81
If a Claim Is Denied ..................................................... 88
Continuation of Coverage under COBRA ......................... 93
ERISA and Other Important Information ......................... 97
Member Services ........................................................ Back Cover
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 the UPS National Health Plan for Part-Time Employees. The Plan is designed to ensure that you receive value for the benefit dollars spent.

The Plan also offers you the opportunity to elect certain supplemental benefits, 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.

Up to Two Medical Networks

If you live within the following Preferred Provider Organization (PPO) network(s), you have up to two medical options from which to choose:

- Aetna® PPO Network
- BlueCross® BlueShield® PPO Network

If only one network is available in your area, you have only one PPO option available.

The Traditional Program, administered by Aetna, is available if you do not live within either of the PPO network areas.

See A Guide to Network-Based Health Care in the Medical Benefits section for information about PPO options and medical networks.

PPO Network Service Areas

You may live in a location that the PPO network service areas do not cover, according to the network managers. These locations are therefore considered to be “out of area.” If you live in one of these locations outside both network areas, but you feel you have reasonable access to the doctors in a 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 administered by Aetna.

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.

<table>
<thead>
<tr>
<th>If you live...</th>
<th>You can choose...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within a PPO network service area or close enough to “opt in” to the network</td>
<td>• Aetna PPO network or • BlueCross BlueShield PPO network</td>
</tr>
<tr>
<td>Outside both PPO network service areas</td>
<td>The Traditional Plan, administered by Aetna</td>
</tr>
</tbody>
</table>

The Plan determines what networks are available to you based on the providers available within your home ZIP Code. You may fall into one network or the other or you may have both network options available to you. During your initial enrollment period, your enrollment worksheet will indicate which options are available to you. Since providers included in each network may change over time, network availability is reviewed periodically.

The benefits payable under each network option and the Traditional Program are different. See the Summary of Benefits section for details.
Other Network Providers
The Plan also offers benefits through the following network providers:

- ValueOptions manages the Solutions network for Behavioral Health coverage
- Medco manages the network for prescription drug coverage
- Aetna manages the network for dental coverage
- Vision Service Plan (VSP) manages the network for routine vision benefits

Basic Benefits
These benefits are automatically provided at no cost to participants in the UPS National Health Plan for Part-Time Employees:

- Medical and behavioral health services
- Prescription drug
- Dental
- Vision
- Basic employee life and accidental death and dismemberment (AD&D) insurance
- Basic spouse’s and children’s life insurance*
- Short-term disability
- Employee assistance program (EAP) and work/life benefit
- Adoption assistance program
- Tobacco cessation and other health and wellness programs (you are required to enroll in the tobacco cessation program separately from initial and annual enrollment opportunities)

*This coverage is available to you as long as you are eligible for, and have enrolled eligible dependents in, the UPS National Health Plan for Part-Time Employees.

Supplemental Benefits
Employees eligible for the UPS National Health Plan for Part-Time Employees may also elect and pay for the following types of supplemental coverage:

- Supplemental life insurance for:
  - Employee
  - Spouse*
  - Children*
- Supplemental employee AD&D
- Personal lines insurance (auto and/or home)
- Flexible spending accounts:
  - Health care spending account (HCSA)
  - Child/elder care spending account (C/ECSA)
- Legal plan

*This coverage is available to you as long as you are eligible for, and have enrolled eligible dependents in, the UPS National Health Plan for Part-Time Employees.

How the Plan Works
The key to the UPS National Health Plan for Part-Time Employees is choice, and that’s important because everyone has different lifestyles and different benefit needs. That’s why there are two PPO networks and many supplemental benefit options.

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.

You can change your benefits elections during the year only if you experience a “life event,” such as marriage, birth of a baby or divorce. See the Life Events section for more information on status changes.

See If You Do Not Enroll in the Enrollment section for information about the comprehensive basic coverage you are provided if you do not make an election during the initial enrollment.
Overview of the Plan (cont.)

Levels of Coverage

Medical, Dental, Vision and Legal
If you enroll in the medical, dental, vision and legal plans, you’ll be asked to choose one of the following levels of coverage:

- You only
- You plus family (spouse and/or children), once you become eligible for dependent coverage

You may enroll for legal coverage as long as you are not eligible for another legal plan that UPS administers or makes contributions for.

See the Eligibility section for information about when you become eligible for employee-only and dependent coverage.

Life and AD&D
The Plan automatically provides basic life and AD&D insurance for you. Once you become eligible for dependent coverage, the Plan will also provide basic life insurance for your spouse and eligible dependent children. In addition, you may also choose to purchase:

- Supplemental life and/or AD&D for yourself
- Supplemental life insurance for your spouse, once you become eligible for dependent coverage
- Supplemental life insurance for your children, once you become eligible for dependent coverage

Paying for Supplemental Benefits
With the UPS National Health Plan for Part-Time Employees, UPS doesn’t decide for you 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, after you make your annual benefit elections.

Generally, all contributions you are required to make for supplemental benefits are after-tax. However, the spending accounts under the UPS National Health Plan for Part-Time Employees are part of a “Cafeteria Plan” established by UPS in accordance with Internal Revenue Code Section 125, which allows employees to make spending account contributions with pre-tax salary reductions.

Remember that, if you pay less Social Security (FICA) tax because of your participation in spending accounts, 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.
Eligibility

This section defines eligibility in the UPS National Health Plan for Part-Time Employees for you and your dependents. Refer to your Summary Plan Description insert to determine whether additional eligibility information applies to you.

Eligible Dependents

This section describes which of your dependents may be eligible for coverage under the UPS National Health Plan for Part-Time Employees. It’s important that you know exactly what “dependent” means. The term has the same meaning for medical, dental, vision, life insurance, the employee assistance program, and legal coverage, but it has different meanings for the health care spending account and the child/elder care spending account.

Eligibility information provided in the Summary Plan Description is for your legal opposite-sex spouse and/or children. Different eligibility coverage may apply for same-sex domestic partners or civil union partners and/or their children.

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 with you 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 Incapacitated Children in this section).

*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 and evidence that you meet the state 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 National Health Plan for Part-Time 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 he or she meets the requirements of full-time status for the school he or she attends. You must certify your child’s student status each year during annual enrollment or he or she will lose coverage for the following year.

Your children’s (and eligible stepchildren’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). 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 the date he or she 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 covered child who becomes incapacitated before age 19 (or before age 25, if he or she is a full-time student) is eligible to continue certain types of coverage as long as the

Same-Sex Domestic Partners or Civil Union Partners

You may be eligible to elect certain benefits for your:

• Same-sex domestic partner and his or her dependent children; or
• Civil union partner and his or her dependent children.

Complete information about eligibility and what coverage is available for each is contained in separate documents. To request a copy, call 1-800-UPS-1508, listen for the “Health Care,” then “Coverage Changes and Dependents” prompts. Then ask for either the Same-Sex Domestic Partner Brochure or the Same-Sex Civil Union Brochure for your plan.
Eligibility (cont.)

incapacitation exists. This continuing coverage is available as long as the child:
- Becomes incapacitated while covered by the Plan
- Is verified by the claims administrator prior to losing coverage under 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 him- or herself, as determined by the 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. Contact your medical plan administrator for more information on certifying your child as incapacitated.

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 whom you could claim as a dependent on your tax return (as defined by Code Section 152) and anyone that you could otherwise claim as a dependent on your federal tax except when:
- The individual has income in excess of the income threshold established for “qualifying relatives” (as defined by Code Section 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. See the Spending Accounts section for more details about dependent eligibility.

Child/Elder Care Spending Account

Eligible dependents for the C/ECSA only include the following (if they reside with you):
- A qualifying child, according to Internal Revenue Code Section 152(a)(1), of the employee who is age 12 or younger
- 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/ECSA is anyone whom you could claim as a dependent on your tax return (as defined by Section 152) and anyone that you could otherwise claim as a dependent on your federal tax return except when:
- The individual has income in excess of the income threshold established for “qualifying relatives” defined under Code Section 152
- 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 is considered a “dependent” of both parents for purposes of the C/ECSA — 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. See the Spending Accounts section for more details about dependent eligibility.

**When Spouses or Children Are UPSers**

If you and your spouse or child both work for UPS and are both eligible for the UPS National Health Plan for Part-Time Employees, 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 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 National Health Plan for Part-Time Employees and your spouse or child is covered by another UPS-sponsored plan (for example, the Flexible Benefits Plan, UPS Health and Welfare Package 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 National Health Plan for Part-Time Employees.
- You may decide not to participate in the Plan, or “opt out.” 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 types of coverage in the UPS National Health Plan for Part-Time Employees: life insurance*, AD&D, legal, spending accounts, adoption assistance and personal lines insurance.

*If your spouse or child is eligible for supplemental life insurance through another UPS-administered Plan, you are not eligible to cover your spouse or child for supplemental life insurance through the UPS National Health Plan for Part-Time Employees. Your spouse or child must elect employee supplemental life insurance through her or his own employee plan.

**QMCOSO**

Medical (including the health care spending account), dental and vision coverage will comply with the terms of a Qualified Medical Child Support Order (QMCOSO) to the extent that a QMCOSO 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 that 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 care plans.

Federal law requires that a medical child support order must meet certain form and content requirements in order to be a QMCOSO. When an order is received, each affected participant and each child covered by the order will be notified of the implementation procedure to determine whether the order is valid.
Eligibility (cont.)

If you have any questions or would like to receive a copy of the UPS written procedure for determining whether an order is valid, or have a question about the procedure, submit the request to:

UPS Benefits Service Center
Attention: Qualified Order Team
P.O. Box 1433
Lincolnshire, IL 60069-1433

If you have questions about an order already filed, contact the UPS Benefits Service Center at 1-800-UPS-1508.

When Coverage Starts

All active part-time regular employees and their eligible dependents are eligible for comprehensive basic and supplemental benefits as defined below:

• Employee-only basic and supplemental coverage under the UPS National Health Plan for Part-Time Employees 12 months after your date of hire.

• Dependent basic and supplemental coverage under the UPS National Health Plan for Part-Time Employees 18 months after your date of hire.

In order for your dependents to be covered, you must also be eligible for coverage.

Certain populations are required to work a certain amount of hours in order for coverage to continue. Refer to your Summary Plan Description insert to determine whether these requirements apply to you.

Delayed Coverage

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 National Health Plan for Part-Time Employees 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, UPS National Health Plan for Part-Time Employees coverage for you and your eligible dependents continues as long as you meet the Plan’s eligibility requirements. Coverage typically ends on the date the applicable eligibility requirements are no longer satisfied, except as otherwise noted in this Summary Plan Description or insert. See the Life Events section for additional details.
Enrollment

There are different types of UPS National Health Plan for Part-Time Employee enrollments:

- 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
- Initial enrollment for eligible dependents when the employee becomes eligible for dependent coverage
- Annual enrollment, which happens every year, usually during the fall

In addition, once you are eligible for coverage under the Plan, you may enroll in or apply for coverage in certain supplemental benefits as well as the Quit For Life™ tobacco cessation program separately from initial or annual enrollment.

Once you are eligible for dependent coverage, your eligible dependent(s) will be covered by the same medical option you selected for your own coverage.

Initial Enrollment for the Employee

When you initially become eligible for benefits under the Plan, you’ll choose from the following medical coverage:

- Aetna Medical PPO Option (if available in your area)
- BlueCross BlueShield PPO Option (if available in your area)

Your enrollment worksheet will indicate whether you live inside the PPO network areas. If you live outside the network area, you are covered under the Traditional Program; or you may choose to “opt in” to a network. See “Opting In to a Network” later in this section.

In enrolling in a medical option under the Plan, you will automatically receive comprehensive basic coverage (see Basic Coverage in the Overview of the Plan section). At this time you will also have the opportunity to elect any supplemental coverage you choose (see Supplemental Coverage in the Overview of the Plan section).

After you enroll initially, you generally must wait until the next annual enrollment period to make changes to your elections.

Annual Enrollment

Each year you will receive an enrollment worksheet with instructions for keeping your present coverage or changing to any other available options. You will be advised of any changes in PPO network areas applicable to your ZIP Code.

During annual enrollment, you also have the opportunity to add eligible dependents to your basic and/or supplemental coverage.

At each annual enrollment, you may elect new benefit choices.

Initial Enrollment for the Employee’s Eligible Dependents

When you initially become eligible for dependent coverage under the Plan, your eligible dependents on file will be added to your medical coverage. Once your eligible dependents are enrolled in a medical option under the Plan, they will automatically receive comprehensive basic coverage (see Basic Coverage in the Overview of the Plan section). At this time you will also have the opportunity to elect any supplemental coverage you choose for your dependents (see Supplemental Coverage in the Overview of the Plan section).

After you enroll your dependents initially, generally you must wait until the next annual enrollment period to make changes to your elections.
Enrollment (cont.)

Enroll at Any Time

Employees who are eligible to participate in the Medical plan may also enroll in or apply for the following benefits at any time. Enrollment is separate from annual enrollment.

- Personal lines insurance
- Quit For Life tobacco cessation program

If You Do Not Enroll

Initial Enrollment

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:

- If only one network is available in your area, you will be enrolled in that network — either Aetna Medical PPO or BlueCross BlueShield PPO.
  - If both networks are available in your area, you will be enrolled in the Aetna Medical PPO option.
  - If no network is available in your area, you will be covered by the Traditional Program, administered by Aetna.

- Behavioral health coverage
- Prescription drug coverage
- Dental coverage
- Vision coverage
- Employee basic life insurance
- Employee basic AD&D
- Short-term disability
- Employee assistance program (EAP)
- Healthy Connections — Informed Choices wellness program

Annual Enrollment

If you do not make new benefit elections during future annual enrollment periods, you'll receive the same coverage for yourself 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.

“Opting In” to a Network

If you live outside a network area (referred to as “out of area”) but feel the network is convenient to you, you may elect to participate in the network by contacting the Benefits Service Center at 1-800-UPS-1508. Once you elect to “opt in” to the network, you cannot change your election to opt in to the network until the next annual enrollment period (unless as otherwise stated in the Life Events section).
Life Events

The UPS National Health Plan for Part-Time Employees 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 only to employee plus family, but you may not decrease your life insurance.

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.

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.

If the life event results in a loss of dependent eligibility for coverage under the Plan, you have 60 days to make the applicable changes to your coverage. However, if a family member becomes no longer eligible for coverage, you should notify the Benefits Service Center at 1-800-UPS-1508 immediately. Otherwise, you may be required to repay the Plan for any benefits the Plan provides for that family member between the date he or she is no longer eligible and the date you provide notice — even if you provided notice within the 60-day period. See Right of Recovery Provision in the Filing a Claim section for more information on the Plan’s right to reimbursement.

Spending Account Contributions and Coverage Changes

If you change your contribution amount (HCSA or C/ECSA) because of a status change, such as 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 example, 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 the contribution amount currently deducted per pay period. 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 contribution amount per pay period 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 contribution amount per pay period.

You may not decrease your account to an amount that is less than what you have already contributed or for which you have already been reimbursed. 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 National Health Plan for Part-Time Employees

#### Allowable Coverage Changes Matrix

(Only the changes listed below 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>Health Care Spending Account</th>
<th>Child/Elder Care Spending Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Start or stop coverage; change medical options</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>Start or increase contributions</td>
<td>Start, stop or change contributions</td>
</tr>
<tr>
<td>Divorce; Legal Separation; Annulment</td>
<td>Start or stop 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>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 or stop coverage; change medical options</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>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>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>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>Stop or decrease contributions</td>
<td>Stop or decrease contributions</td>
</tr>
</tbody>
</table>

*See the Life Insurance and AD&D section for details about coverage maximums and evidence of insurability requirements.
### UPS National Health Plan for Part-Time Employees

#### Allowable Coverage Changes Matrix (cont.)

(Only the changes listed below 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>Health Care Spending Account</th>
<th>Child/Elder Care Spending Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Outside Medical Coverage Eligibility with Other Employment</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>No changes</td>
<td>No changes</td>
<td>Add or increase coverage</td>
<td>No changes</td>
<td>No changes</td>
<td>Start or increase contributions (Spouse Gains Employment); No changes (Coverage, Open Enrollment)</td>
<td>Start, stop or change contributions</td>
<td></td>
</tr>
<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>Start, stop or change contributions (limited to 4 changes per 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>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>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>Start or increase contributions</td>
<td>Start or increase contributions</td>
</tr>
</tbody>
</table>

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

**Must comply with QMCSO. Dependent will be added only if dependent coverage is available. See the Eligibility section for more information.
Life Events (cont.)

What if...

If your employment status with UPS changes, that may affect UPS National Health Plan for Part-Time Employees 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 may be required to work a minimum amount of hours to continue coverage under the Plan. Refer to your Summary Plan Description insert to determine what the requirements are for your specific work group.

For information about Spending Accounts if you fail to maintain eligibility, see Spending Accounts and Leaves in this section.

If you terminate employment, you may convert life insurance coverage for yourself, your spouse and your children to an individual policy. You cannot convert AD&D coverage to an individual policy. See If You Leave UPS or Retire in the Life Insurance and AD&D section 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 National Health Plan for Part-Time Employees for a period of time after your termination date. (See the Continuation of Coverage under COBRA section for more information.) Also, you may convert life insurance for yourself and your dependents to individual policies. You cannot convert AD&D coverage to an individual policy. See If You Leave UPS or Retire in the Life Insurance and AD&D section for more details about continuing life insurance coverage.

...You Retire

You may be eligible for coverage under the part-time retiree health care plan offered to part-time employees in your area. Contact the UPS Benefits Service Center at 1-800-UPS-1508 for more information about eligibility.

See If You Leave UPS or Retire in the Life Insurance and AD&D section for more details about continuing life insurance coverage.

...You Die

If you die while you’re covered by the UPS National Health Plan for Part-Time Employees as an active employee, health care coverage (other than health care spending account coverage) for your eligible covered dependents will continue for up to six months following the date of your death (or the date that your covered dependents cease to be eligible, whichever
is earlier). Your dependents will continue to contribute their share, if any, of the cost of coverage. When the six-month period 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. See the Continuation of Coverage under COBRA section for more information.

Your surviving spouse and children may convert their basic life insurance to individual policies. See If You Leave UPS or Retire in the Life Insurance and AD&D section for more details about continuing life insurance coverage.

...You Are Laid Off
If you are laid off (and are recorded as such in the UPS eligibility system), your UPS National Health Plan for Part-Time Employees coverage will be continued until the last day of the month following the month in which your layoff begins. In addition, you can then continue your medical, dental, vision and health care spending account coverage through COBRA. See the Continuation of Coverage under COBRA section for more information.

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

...You Have Jury Duty
If you have jury duty, your UPS National Health Plan for Part-Time Employees participation continues.

...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 (FMLA) or company policy, full medical, prescription, dental, vision, life insurance and AD&D coverage for you and your dependents can be continued during your leave. You’ll need to continue to pay your share, if any, of the cost of supplemental coverage. If your leave is approved for extension beyond that provided by FMLA or company policy, your coverage from the UPS National Health Plan for Part-Time Employees will continue provided you pay the full cost of coverage (see Personal Leave in this section). 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.

Supplemental coverage (such as legal and supplemental life and AD&D insurance) may also be elected and continued during your leave. You may elect to continue any or all of your supplemental coverage. 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.

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

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.
Life Events (cont.)

- 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. See the Continuation of Coverage under COBRA section for more information.

Spending Accounts and Leaves

C/ECSA
Your child/elder care spending account contributions will stop during your leave until you return to work. Upon return to work, your contribution amount per pay period 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, you may choose to continue contributions to your health care spending account on an after-tax basis, or stop your contributions.

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 within 60 days of the start of your leave 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 FMLA in this section). Your annual contribution amount will be reduced by the amount not contributed during your leave.

For example, if your annual contribution amount is $1,200, 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 by $300 (the amount you didn’t pay while on leave) to $900.

Special Rules for FMLA Leaves

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 timely return to work following an FMLA leave, 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 participation in the UPS National Health Plan for Part-Time Employees 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 or off-the-job injury or illness, you and your covered dependents will continue to receive 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, if any, during these extension periods. When your health coverage extension ends, you and your dependents may elect COBRA continuation for up to an additional 18 months, for a total of up to 30 months of coverage.

See the *Continuation of Coverage under COBRA* section for more information about continued 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 National Health Plan for Part-Time Employees pays benefits first, or whether Medicare is primary. See *Coordination with Medicare* in the *Filing a Claim* section.

**Life Insurance and AD&D**

Basic group life coverage for you and your dependents and your basic AD&D employee coverage continue for as long as your health care coverage continues. 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 the basic group life policy for yourself and your dependents to an individual policy without providing evidence of insurability. See *If You Leave UPS or Retire* in the *Life Insurance and AD&D* section for more details about continuing life insurance coverage.
Summary of Benefits

The tables on these pages represent a summary of the actual benefits available in the Plan document, except as noted. If, in the process of abbreviating the description, any coverage was summarized differently than detailed in the Plan, the Plan’s document will govern.

Medical Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Area — Aetna PPO or BCBS PPO</th>
<th>Outside Network Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Provider</td>
<td>Traditional Program*</td>
</tr>
<tr>
<td>Medical Basic Provisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual deductible (once you have met the annual deductible, your claims are paid at the benefit level indicated on this chart)</td>
<td>None</td>
<td>$50 per person</td>
</tr>
<tr>
<td></td>
<td>• $250 per person</td>
<td>$100 per family</td>
</tr>
<tr>
<td>Annual out-of-pocket maximum (copays and prescription coverage do not apply)</td>
<td>$1,000 per person</td>
<td>$3,000 per person</td>
</tr>
<tr>
<td>Lifetime maximum benefits</td>
<td></td>
<td>$1 million per person</td>
</tr>
<tr>
<td>Physician Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td>Paid at 100% after $10 copay</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Inpatient surgery</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Physician in-hospital services</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Allergy testing and treatment services</td>
<td>Paid at 90%</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Hospital Facility Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital admission fee</td>
<td>None</td>
<td>You pay $250</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(precertification required)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Emergency room care</td>
<td>Paid at 100% within 72 hours of accident or hospitalization; otherwise $25 copay</td>
<td>Paid at 100% within 72 hours of accident or hospitalization; otherwise $25 copay</td>
</tr>
<tr>
<td>Ambulance related to an emergency</td>
<td>Paid at 100%</td>
<td>Paid at 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 100%</td>
</tr>
<tr>
<td>Ambulance related to a non-emergency (if medically necessary)</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Maternity Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician charges</td>
<td>Paid at 100% after $10 copay initial visit</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Facility charges</td>
<td>Paid at 100% (no admission fee)</td>
<td>Paid at 80% after $250 admission fee</td>
</tr>
</tbody>
</table>

*All out-of-network provider and Traditional Plan medically necessary services are subject to reasonable and customary (R&C) limits and to the annual deductible.
### Medical Benefits (cont.)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Area — Aetna PPO or BCBS PPO</th>
<th>Outside Network Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Benefits</td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider*</td>
</tr>
<tr>
<td>Routine physicals (according to standard guidelines)</td>
<td>Paid at 100% after $10 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>OB-GYN exams</td>
<td>Paid at 100% after $10 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Well-child care (according to standard guidelines)</td>
<td>Paid at 100% after $10 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine mammograms (according to standard guidelines)</td>
<td>Paid at 100% after $10 copay</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Expenses</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care (up to $40 per visit; maximum of $1,000 per year)</td>
<td>Paid at 90%</td>
<td>Paid at 80%</td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Diagnostic x-ray and laboratory</td>
<td>Paid at 90%</td>
<td>Paid at 80%</td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Hospice care — inpatient</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Hospice care — outpatient (limited to 8 hours per day)</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>Paid at 100%</td>
<td>Paid at 80%; limited to 60 days per year</td>
<td>Paid at 90%; limited to 60 days per year</td>
</tr>
<tr>
<td>Outpatient private duty nursing (limited to 560 hours per year)</td>
<td>Paid at 100%</td>
<td>Paid at 80%</td>
<td>Paid at 90%</td>
</tr>
<tr>
<td>Home health care</td>
<td>Paid at 100%</td>
<td>Paid at 80%; limited to 120 four-hour visits per year</td>
<td>Paid at 90%; limited to 120 four-hour visits per year</td>
</tr>
<tr>
<td>Rehabilitation and speech therapy (combined inpatient and outpatient; combined physical, occupational and speech therapy)</td>
<td>Paid at 90%</td>
<td>Paid at 80%; limited to 60 visits per year</td>
<td>Paid at 90%; limited to 60 visits per year</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Paid at 90%</td>
<td>Paid at 80%</td>
<td>Paid at 90%</td>
</tr>
</tbody>
</table>

*All out-of-network medically necessary services are subject to reasonable and customary (R&C) limits and to the annual deductible.

### Behavioral Health Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>ValueOptions® Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Provider</td>
</tr>
<tr>
<td>Substance abuse treatment</td>
<td>Paid at 100%</td>
</tr>
<tr>
<td>Mental health — inpatient</td>
<td>Paid at 100%</td>
</tr>
<tr>
<td>Mental health — outpatient</td>
<td>Paid at 100% after $10 copay</td>
</tr>
</tbody>
</table>

*All out-of-network medically necessary services are subject to reasonable and customary (R&C) limits.
Summary of Benefits (cont.)

Prescription Drug Benefits
Prescription drug benefits are administered by Medco® Health Solutions. Benefit coverage levels are equivalent to prescription drug benefits available to full-time employees in your area. A prescription drug card and a mail-order program are available.

Refer to your Summary Plan Description insert for details about your prescription drug benefits.

Dental Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Aetna Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network and Out-of Area*</td>
</tr>
<tr>
<td>Annual deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>Dental care</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>Paid at 100%</td>
</tr>
<tr>
<td>Basic</td>
<td>Paid at 100%</td>
</tr>
<tr>
<td>Major</td>
<td>Paid at 80%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Paid at 50%</td>
</tr>
<tr>
<td><strong>Maximum benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Annual maximum per person (excluding orthodontia and TMJ)</td>
<td>None</td>
</tr>
<tr>
<td>Lifetime maximum for orthodontia and TMJ (each dependent child under age 19)</td>
<td></td>
</tr>
</tbody>
</table>

*Out-of-network and out-of-area dental provider charges are subject to reasonable and customary (R&C) limits.

Vision Benefits

<table>
<thead>
<tr>
<th>Benefit per Year</th>
<th>VSP Provider</th>
<th>Non-VSP Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>Paid at 100%</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Single-vision lenses</td>
<td>Paid at 100%</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Bifocal lenses</td>
<td>Paid at 100%</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocal lenses</td>
<td>Paid at 100%</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Frames*</td>
<td>Paid at 100%</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Standard daily-wear contact lenses in lieu of glasses</td>
<td>Paid at 100%</td>
<td>Up to $60</td>
</tr>
</tbody>
</table>

*More than 11,000 frames are covered in full by the current standard frame allowance. If you choose a more expensive frame, you’ll be responsible for additional charges, but at reduced VSP prices.
Additional Comprehensive Basic Benefits

UPS provides these types of coverage to employees eligible for the UPS National Health Plan for Part-Time Employees. Refer to the related section in this book for more information about each of these benefits.

<table>
<thead>
<tr>
<th>Managing Your Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPS Healthy Connections-Informed Choices</td>
</tr>
<tr>
<td>Provides a health coach advocacy program as well as tools and resources to help you and your family take charge of your health</td>
</tr>
<tr>
<td>Quit For Life tobacco cessation program</td>
</tr>
<tr>
<td>Provides assistance to help you stop using tobacco products (requires enrollment)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term disability</td>
</tr>
<tr>
<td>The Plan pays 60% of your average weekly base pay, up to a maximum of $500 per week, for up to 26 weeks</td>
</tr>
<tr>
<td>Basic employee life insurance</td>
</tr>
<tr>
<td>The Plan provides basic life insurance coverage equal to 1,040 times your hourly base pay, with a minimum benefit of $10,000 and a maximum benefit of $100,000. You can purchase additional coverage at a discounted group rate</td>
</tr>
<tr>
<td>Basic spouse’s life insurance</td>
</tr>
<tr>
<td>Once you are eligible for dependent coverage, the Plan provides basic life insurance coverage of $5,000. You can purchase additional coverage at a discounted group rate</td>
</tr>
<tr>
<td>Basic children’s life insurance</td>
</tr>
<tr>
<td>Once you are eligible for dependent coverage, the Plan provides basic life insurance coverage of $2,500. You can purchase additional coverage at a discounted group rate</td>
</tr>
<tr>
<td>Basic employee AD&amp;D insurance</td>
</tr>
<tr>
<td>The Plan provides basic life insurance coverage equal to 1,040 times your hourly base pay, with a minimum benefit of $10,000 and a maximum benefit of $100,000. You can purchase additional coverage at a discounted group rate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Valuable Extras</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Assistance Program and work/life benefit</td>
</tr>
<tr>
<td>Provides practical solutions, information, advice and support for a wide range of work-life issues</td>
</tr>
<tr>
<td>Adoption assistance</td>
</tr>
<tr>
<td>UPS pays $3,500 or $5,000 for adoption expenses</td>
</tr>
</tbody>
</table>
Summary of Benefits (cont.)

Supplemental Benefits

These types of optional coverage are available to employees eligible for the UPS National Health Plan for Part-Time Employees. Refer to the related section in this book for more information about each of these benefits.

<table>
<thead>
<tr>
<th>Your Security</th>
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<tbody>
<tr>
<td>Employee supplemental life insurance</td>
<td>Up to a maximum of $1,000,000 of coverage, in $1,000 increments</td>
</tr>
<tr>
<td>Employee supplemental AD&amp;D insurance</td>
<td>Up to a maximum of $1,000,000 of coverage, in $1,000 increments</td>
</tr>
<tr>
<td>Spouse’s life insurance (once you are eligible for dependent coverage)</td>
<td>$5,000 basic paid; you can elect $5,000, $20,000, or $45,000 additional coverage</td>
</tr>
<tr>
<td>Children’s life insurance (once you are eligible for dependent coverage)</td>
<td>$2,500 basic paid; you can elect $2,500 or $7,500 additional coverage</td>
</tr>
<tr>
<td>Personal lines insurance</td>
<td>Low group rates for auto and home insurance, and a choice of vendors</td>
</tr>
</tbody>
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<tr>
<th>Valuable Extras</th>
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<tr>
<td>Pre-tax spending accounts</td>
<td>Pre-tax spending accounts for health care and child/elder care</td>
</tr>
<tr>
<td>Legal plan</td>
<td>Assistance for a range of commonly needed legal services</td>
</tr>
</tbody>
</table>
Medical Benefits

Choice is a central part of the medical care provided through the UPS National Health Plan for Part-Time employees. For this reason, we offer you the option of up to two medical Preferred Provider Organization (PPO) network managers, where available:

- Aetna Medical PPO
- BlueCross BlueShield PPO

If you are a participant in a PPO and decide to seek “out-of-network” medical care (meaning the provider does not participate in your PPO network) — which you are always free to do — your benefits may be lower than if you used an in-network provider.

If you live in a location that falls outside both network areas and you do not opt in to a network, you’re considered “out of area” and will receive your coverage from the Traditional Program.

See the Overview of the Plan section for more information about your Medical plan options.

In describing the medical benefits provided by the Plan, this section first explains:

- How the network-based options work
- How the Traditional Program works
- Medical expenses you must pay
- Medical expenses covered by the Plan
- Medical expenses not covered by the Plan

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. UPS intends that all the network managers will consistently administer the coverage provided through the Plan. 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.

Preferred Provider Organization

If you participate in a PPO option, you and your family can enjoy the benefits of network-based care. You and your family may seek care from any physician or hospital in the network. You are not responsible for completing or filing claim forms when using network providers. Participants in a PPO 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.

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:

- Health care providers participating in the network have been carefully evaluated and monitored by the network manager for the services they provide.
- Preventive care and coordinated patient care are both emphasized.
- You do not have to complete or submit any claim forms.
- Network provider charges are always within reasonable and customary (R&C) limits.
- Network providers in most networks handle all hospital admission precertifications.
- You pay no annual deductible in-network.
- You are responsible only for modest office visit and emergency care copayments or coinsurance.
The Traditional Program
If you live outside both the PPO network areas — usually 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 benefits:
- 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. Contact the UPS Benefits Service Center at 1-800-UPS-1508 for more information.

Individuals entitled to Medicare will also receive Traditional Program coverage for themselves and their families in order to coordinate benefits with Medicare. (Medicare is primary.)

All Traditional Program benefits are subject to reasonable and customary (R&C) limits.

Choosing Your Health Care Provider
Preferred Provider Organization
If you participate in a PPO network, you and each covered family member can obtain health care from network providers (preferred providers) and receive the level of benefits indicated in the Summary of Benefits section.

Keep in mind that the behavioral health, dental, vision and prescription networks are available nationwide and are separate from medical networks. So you will still need to use network providers to receive the in-network benefit for those services — even if you don’t live within the Plan’s medical network.

Special Situations for Preferred Provider Organizations
If you participate in a PPO network, the special considerations described below apply. If you have any questions about these situations or other concerns not described here, please contact your medical claims administrator.
- 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 (if otherwise covered by the Plan) will be paid at the in-network level.
- If your eligible dependent child attends school away from home and needs non-preventive care away from your network, in-network benefits will apply. Preventive care is not covered if you seek services outside the network.
- 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, including covered preventive care services. To designate your dependent children or eligible spouse as nonresident dependents, call the Benefits Service Center at 1-800-UPS-1508.

Remember that these considerations apply only to coverage under a PPO network under the Medical plan. If you have any questions about these situations or others not described here, contact your medical claims administrator.

Traditional Program
If medical coverage 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. You can obtain claim forms online at your claims administrator’s Web site (a link is available at www.UPSers.com) or by calling the Member Services number on your medical ID card.

Even if you live outside a medical PPO network area, you may still want to use network health care providers — for example, if they are convenient to where you work. However, if you are covered by the Traditional Program, you do not receive PPO (in-network) benefits even if you see an in-network physician. To take advantage of in-network benefits, call the UPS Benefits Service Center at 1-800-UPS-1508 for further information about joining a network during your next annual enrollment period.

The behavioral health, vision, dental and prescription networks are available nationwide and are separate from the medical networks. So even if you receive medical coverage under the Traditional Program, you have access to network providers for these other types of coverage. In some cases, you may receive a higher level of coverage when you use network providers. Refer to the Summary of Benefits section for detailed information.

**Toll-Free Information Service**

You can call your claims administrator’s Member Services representative to:

- Ask questions about a network physician’s credentials
- Ask questions about claims
- Ask questions about your benefits
- Get a new ID card
- Obtain information about a network provider or service
- Precertify a hospital stay

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:

- For most PPOs, if you participate in the PPO network and your care is provided or coordinated by a network physician, he or she will start the precertification process. You don’t need to do anything.
- If your provider does not precertify your hospital stay, you are responsible for contacting Member Services to start the precertification process.
- If you participate in the Traditional Program, you are responsible for starting the precertification process yourself.

**If You Don’t Call to Precertify**

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 a hospital stay, 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
Medical Benefits (cont.)

hospital confinement begins on a Friday or Saturday, the call must be made within 72 hours of admission.

According to federal law, precertification is not required for hospital stays in connection with childbirth for the mother or newborn child when the hospital stay is less than 48 hours after a normal vaginal delivery, or less than 96 hours after a cesarean section.

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 of the certification decision. This notification includes 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 a PPO network, check with your network for precertification requirements. Most network providers will initiate precertification for you.

Precertification is not a guarantee of coverage. Whether an expense is payable by the Plan depends on the facts and circumstances surrounding the provision of care. This is determined at the time the claim is submitted for payment.

What Medical Expenses You Have to Pay

Your medical option 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 if you participate in either a PPO network or the Traditional Program. For information about the amount of these charges, see the Summary of Benefits section.

Annual Deductible

The deductible is the amount you must pay out of pocket each year before the Plan begins to pay Traditional Program or out-of-network benefits as described in this Summary Plan Description.

The individual deductible must be paid each year before certain benefits are paid. In addition to an individual deductible, the Traditional Program and out-of-network benefits have 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 according to the terms of the Plan. 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>
<td>$ 20</td>
</tr>
<tr>
<td>Your Spouse</td>
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<td>Son</td>
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<td>Total</td>
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**Copayment**

For some services, such as doctor’s office visits, you pay a low flat fee, called a copayment, for each network provider office visit. Then the Plan covers the remaining expense at 100 percent (subject to other limitations in the Plan). A copayment also applies to network care for behavioral health treatment through Solutions, and to certain emergency room services.

**Coinsurance**

Once you have satisfied any applicable deductible, you pay only a portion of any covered expenses. For example, if the Plan covers an expense at 90 percent, you pay the remaining 10 percent, which is called your coinsurance.

**Hospital Admission Fee**

In some cases you are responsible for paying a hospital admission fee each time you are admitted to a hospital as an inpatient. However, 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.

**Annual 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 most health care expenses in a calendar year. Once your eligible 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 (if applicable), coinsurance amount, and the hospital admission fee.

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

If you are confined in the hospital from one calendar year to the next, your hospital charges for that entire 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 National Health Plan for Part-Time Employees. 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 drug 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. Each January 1,
Medical Benefits (cont.)

up to $1,000 in individual benefits paid during the preceding year or years will automatically be restored. Also, amounts UPS recovers in accordance with the Plan’s right of recovery provisions (except amounts recovered as a result of erroneous payments) are credited toward your lifetime maximum, reduced by the Plan’s expenses incurred to recover the amount.

Covered Expenses

Regardless of whether you participate in a PPO network or the Traditional Program, in order to be covered by the Plan, the medical services and supplies provided must be:

- Medically necessary, as determined by the claims administrator
- Neither investigational nor experimental, as determined by the claims administrator
- Within the reasonable and customary limits (R&C), as determined by the claims administrator

Medically Necessary Services and Supplies

Except as specifically noted under Preventive Care in this section, only medically necessary services are covered by the UPS National Health Plan for Part-Time Employees. A service or supply is medically necessary if it is determined by the claims administrator to be 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 to both 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, as determined by the claims administrator. 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. An R&C 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 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.
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, including routine physicals performed by a general practitioner. 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, call the toll-free number that appears on your medical ID card, or call 1-800-UPS-1508 to be connected to your medical provider’s Member Services.

For more information on covered preventive care services, see the Summary of Benefits section.

In an Emergency

In case of an emergency, seek medical care as quickly as possible. Then, within 48 hours after receiving treatment, call the number on the back of your medical ID card 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.

For more information on coverage for emergency care, see the Summary of Benefits section.

Ambulance Coverage (Ground or Air)

Emergency use of an ambulance is covered as an emergency benefit in all options.

Non-emergency

If you receive medically necessary care for a non-emergency at an emergency facility, your out-of-pocket costs may be higher. See the Summary of Benefits section for detailed information.

Hospital Services

Inpatient

The Medical plan covers 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

Claims administrator refers to the company that administers the health care plan and is responsible for processing claims for that option.
Medical Benefits (cont.)

Outpatient
The PPO networks and the Traditional Program cover the following 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 under the Plan 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

Professional Services
The PPO networks 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 Services
Maternity services are covered, like any other condition requiring medical treatment.

Physician charges are paid at the coinsurance level indicated in the Summary of Benefits section. At delivery, a coinsurance applies to your hospital charges. You do not pay a hospital admission fee unless you participate in a PPO network and use an out-of-network facility.

Covered maternity 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 care 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).

**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
• Prostheses; and
• Physical complications of all stages of mastectomy, including lymph edemas, in a manner determined in consultation with the attending physician and the patient.

**Transplants**

Transplants are covered like any other medical procedure in the PPO networks and the Traditional Program.

Network managers 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 (meaning 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 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 Benefits (cont.)

Medical Supplies
The PPO networks 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 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

- PKU supplements

Call your 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 functional gastrointestinal tract who:

- Experiences dysfunction of surrounding structures that are necessary to permit food to reach the gastrointestinal tract, and

- 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

Allergy testing and treatments (including injections) by a network provider are covered in full after the appropriate copayment or coinsurance, based on your option. Injections received without an office visit charge are covered at 90 percent in-network or 80 percent after the deductible out-of-network. Tests and injections are both covered at 90 percent after the deductible 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. Drugs for sexual dysfunction 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 your Summary Plan Description insert to determine whether infertility medications are covered.

The following procedures are not covered by the PPO networks 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 coinsurance, up to a maximum of $40 per visit (including diagnostic testing). There is an annual $1,000 benefit maximum per individual for chiropractic care.

Special Types of Therapy

The PPO networks 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 a PPO network, rehabilitation and speech therapy benefits are covered in-network at the coinsurance level indicated in the Summary of Benefits section. There is no limit for medically necessary visits in the PPO networks or the Traditional Program. If you participate in a PPO network and choose to see an out-of-network provider, you are limited to 60 visits (combined rehabilitation and speech therapy) per Plan year.

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.
Medical Benefits (cont.)

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 National Health Plan for Part-Time Employees, 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 (except as otherwise stated below). For example, children who have not fully developed their speech skills (in other words, as a result of developmental delays) 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 claims administrator.

Besides the exclusions noted in What’s Not Covered by Your Medical Benefits in this section and situations covered by Public Law 94-142, there are other speech-related conditions not covered by the Medical plan. 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

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 the PPO networks and the Traditional Program.

There are no limits to the number of days of skilled facility care from a network provider. Up to 60 days per calendar year are covered for an out-of-network provider or through the Traditional Program.

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. Benefits are limited 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 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.
Medical Benefits (cont.)

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 from a network provider. Up to 120 home health care visits per calendar year are covered when provided by an out-of-network provider 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, housecleaning 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 National Health Plan for Part-Time 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 the Plan, call 1-800-UPS-1508 to be connected to Member Services.

• Charges that exceed the R&C limit (see Reasonable and Customary Charges in this section)

• Services and supplies that are not medically necessary (see Medically Necessary Services and Supplies in this section), even if prescribed, recommended or approved by the attending physician or dentist

• Services and supplies that are unnecessary for the diagnosis, care or treatment of the condition involved; as determined by the claims administrator

• Care, treatment, services or supplies not prescribed, recommended and approved by the attending physician

• Services or supplies not specifically identified as a covered expense in this Summary Plan Description or insert

• 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 Investigational or Experimental in this section)

• Occupational 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 in this section and PKU supplements
Medical Benefits (cont.)

- Services or supplies related to any eye surgery performed mainly to correct refractive errors (for example, 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 pre-approved by the 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;
  — Correct a severe birth defect, including harelip 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 National Health Plan for Part-Time 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
• Expenses listed as not covered in the following subheadings in this section:
  — Enteral Nutrition and Total Parenteral Nutrition
  — Infertility Treatment
  — Special Types of Therapy
  — Home Health Care
  — Hospice Care

How to File a Medical Claim
See the Filing a Claim section.

Maintenance of Benefits and Coordination with Medicare
If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the Plan pays benefits first, or whether the other payer is primary. See Maintenance of Benefits and Coordination with Medicare in the Filing a Claim section for more information.

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 Right of Recovery Provision in the Filing a Claim section for details.
Behavioral Health Benefits

When you or covered family members need help with a mental health or substance abuse problem, you can turn to a special UPS behavioral health program administered by ValueOptions that provides confidential behavioral health counseling, treatment and referrals through a network of trained professionals. This coverage is included in your Medical benefits.

To view a summary of behavioral health benefits, see the Summary of Benefits section.

Your behavioral health coverage is administered by ValueOptions. You don’t need a referral from your doctor to take advantage of the program’s services. Furthermore, the ValueOptions network is nationwide, so you can get the advice and care you need no matter where you live.

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

The Plan provides benefits for behavioral health 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 ValueOptions Network

Through your behavioral health benefit, you and your family have access to a nationwide network of behavioral health treatment professionals, programs and facilities, including the following:

Professional
• Psychiatrists (MD and DO)
• Licensed clinical psychologists (doctoral level)
• Licensed masters-level clinical social workers (for example, licensed MSW)
• Masters-prepared psychiatric registered nurses (for example, MA, MS, MSN)
• Masters-level psychologists
• Licensed Professional Counselors
• Licensed Marriage and Family Therapists

Facilities
• Treatment clinics
• Hospitals

All professionals in the network must be licensed at the highest level for their discipline in the state in which they are practicing and have at least three years of clinical experience in providing direct patient care. There are both male and female therapists, some of whom are multilingual. The providers in the network must meet strict membership requirements and have up-to-date credentials. They are regularly reviewed by ValueOptions to make sure they continually meet network membership standards.

You will receive maximum benefits if you call ValueOptions for a referral. You and your covered dependents can contact ValueOptions 24 hours a day, 365 days a year by calling 1-800-336-9117. If you seek emergency treatment, you must contact ValueOptions within 48 hours. You can receive treatment through ValueOptions by getting a referral from the EAP or calling directly for emergency or non-emergency care.
When you first call ValueOptions, you’ll talk with a masters-level clinician 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, ValueOptions will monitor the care to ensure the treatment you receive is appropriate and medically necessary.

**Mental health** treatment is covered as follows:
- All inpatient mental health treatment must be provided through the ValueOptions network.
- Outpatient mental health treatment may be provided by a network provider or an out-of-network provider.
- If you choose to seek treatment outside the ValueOptions network, the provider must hold the highest level of licensure 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.
- ValueOptions must always precertify the following services, regardless of whether an in- or out-of-network provider or facility is used:
  - All inpatient treatment (including partial hospitalization, intensive outpatient treatment and residential treatment)
  - Psychological testing
  - Electroconvulsive therapy (ECT)
  - Biofeedback
  - Hypnotherapy
  - Aversion therapy
  - Individual therapy for chemical dependency (only available through the ValueOptions network)

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

**Substance abuse** treatment is covered only through the ValueOptions network. Substance abuse treatment not approved by ValueOptions before the treatment is provided is not covered.

**Confidentiality**
Information regarding your or an eligible dependent’s mental health/substance abuse benefits will be kept confidential, except with your written consent or where disclosure is required by law or as otherwise set forth in the health plan privacy policies.

**What’s Not Covered**
The following behavioral health services and treatments are not covered by the Plan:
- 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 that 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

**Precertification Required**
ValueOptions must always precertify the following services, regardless of whether or not you use a Solutions network provider:
- All inpatient treatment (including partial hospitalization, intensive outpatient treatment and residential treatment)
- Psychological testing
- Electroconvulsive therapy (ECT)
- Biofeedback
- Hypnotherapy
- Aversion therapy
- Individual therapy for chemical dependency (only available through the ValueOptions network)

If you or your provider don’t precertify these procedures, no benefits are payable.
Behavioral Health Benefits (cont.)

- 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 and 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
- Expenses listed as not covered in this section

In addition to this list, certain medical services or supplies are not covered (for a general list of what’s not covered, see What’s Not Covered by Your Medical Plan in the Medical section). To determine if specific mental health or substance abuse treatment will be covered, call ValueOptions at 1-800-336-9117.

Maintenance of Benefits and Coordination with Medicare

If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the Plan pays benefits first, or whether the other payer is primary. See Maintenance of Benefits and Coordination with Medicare in the Filing a Claim section for more information.

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 Right of Recovery Provision in the Filing a Claim section for details on the Plan’s right of recovery provisions.

How to File a Behavioral Health Claim

See the Filing a Claim section.
Prescription Drug Benefits

Prescription drug benefits for participants in the PPO networks and the Traditional Program are administered by Medco Health Solutions. The program gives you and your family two ways to save money on prescription medications:

• You may have your prescriptions filled at pharmacies that participate in the Medco retail pharmacy program. There are no medical claim forms to worry about.
• You order maintenance medications through the Medco By Mail program.

Prescription drug coverage levels vary based on the prescription drug program available in your area. Refer to your Summary Plan Description insert for detailed information about your prescription drug coverage.

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 the Plan, you’ll receive a prescription ID card. To find a participating pharmacy near you, find a link to Medco Health from www.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. Refer to your Summary Plan Description insert for details on your benefits.

Medco By Mail

The Medco By Mail program allows you and your family to save time and money when purchasing 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 Medco By Mail program:

• You can order up to a 90-day supply of medication.
• You won’t need to file a claim or wait for reimbursement.
• 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 Medco information kit. You can call Medco at 1-800-346-1327, or go to www.medco.com for a questionnaire.
  — Mail the questionnaire in the special mail service order envelope (included with the questionnaire), along with your original prescription.
• Your 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 compare your prescription to your personal medical profile to safeguard you against adverse reactions.

Refill Prescriptions Online

You may also order Medco By Mail 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 www.UPSers.com.
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.

Prescription Drug Benefits (cont.)

Specialty Drugs
Certain specialty drugs must be obtained through your prescription drug benefit and not your medical benefit. Prior to obtaining these prescriptions, your medical provider must contact Medco at 1-800-803-2523 for precertification.

Specialty drugs are those high-cost medications that:
• May require specialized patient training and coordination of care prior to therapy initiation and during therapy;
• May require unique patient compliance and safety monitoring requirements;
• Have unique requirements for handling, shipping and storage; or
• Have a potential for significant waste.

Examples of these types of drugs are:
• IVIG
• Procrit
• Remicade

For more information about specialty drugs, please go online at www.medco.com.

Prior Authorization Program
Medco retail pharmacies and the Medco By Mail program 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 Medco to request authorization for coverage of these drugs. The list of drugs requiring prior authorization may change from time to time; contact Medco at 1-800-UPS-1508 for more information.

Refer to your Summary Plan Description insert for further information, if applicable.

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 Right of Recovery Provision in the Filing a Claim section for details on the Plan’s right of recovery provisions.

How to File a Claim
See the Filing a Claim section.
Dental Benefits

The UPS National Health Plan for Part-Time Employees Dental PPO network is administered by Aetna, regardless of the medical option you participate in. The Plan’s dental coverage offers four categories of necessary dental care:

- Preventive services
- Basic services
- Major restorative services
- Orthodontia for children

The Dental plan allows you to see the dental provider of your choice. You can choose to use a dentist who participates in the Dental PPO, a network of dentists who have agreed to negotiated rates, to receive the greatest amount of coverage. Or you can see a provider who doesn’t participate in the network; however, you will pay more to see an out-of-network provider. The choice is yours each time you seek care.

The Aetna Dental PPO

A central feature of the Dental plan is access to the Aetna Dental PPO, a national network of preferred dental care providers who have agreed to a discounted fee schedule. This means your out-of-pocket costs will generally be less when you see a participating dentist, rather than a dentist who does not participate in the Dental PPO.

You can obtain a list of local participating dentists from a link to Aetna’s Website at www.UPSers.com or by calling 1-800-UPS-1508 to reach Aetna’s Dental Member Services. Every dentist selected to participate in the Dental PPO must meet Aetna’s selection criteria, which includes an appropriate professional degree; a current, unrestricted state license; adequate malpractice insurance; and sufficient office hours to meet patient demand.

Schedule your appointment as you would with any dentist, but be sure to identify yourself as an Aetna Dental PPO participant, and show your ID card when you visit the dentist’s office.

If you need specialty care, the Dental PPO includes a national listing of specialty dentists. You may also select a non-participating specialist, although your out-of-pocket expenses may be greater.

If you choose a dentist who does not participate in the Aetna Dental PPO network, reasonable and customary (R&C) limits will apply. See Reasonable and Customary in this section for more information.

No deductible applies to in- or out-of-network dental benefits. See the Summary of Benefits section to see a summary of dental benefits.

Annual Maximum Benefits

If you choose to use a non-participating dentist, an annual maximum applies to benefits paid. The portion of your claim paid by the Plan counts toward the individual annual dental maximum. The Plan’s cost of preventive services also counts toward your annual maximum. See the Summary of Benefits section for the maximum annual benefit for out-of-network dental services.

Reasonable and Customary

All eligible dental expenses from a non-participating dentist are subject to reasonable and customary (R&C) 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 R&C limit, you’re required to pay any amounts considered above the R&C. R&C limits do not apply to services provided through a participating Aetna Dental PPO dentist.
Dental Benefits (cont.)

Predetermination of Benefits
The Aetna Dental PPO has a provision that lets you know — in advance — what benefits will be paid. If 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) to Aetna 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. This way, you’ll understand the benefits that will be paid and have the opportunity to discuss possible treatment options with your dentist before treatment begins. 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 option will pay.

Preauthorization of Benefits
You will not need to seek preauthorization from Aetna for covered services except dental implants. However, it may be required to provide all necessary or requested documents for review of a claim.

Aetna Member Services
Member Services is your link to the Aetna Dental PPO. You can reach Member Services by calling 1-800-UPS-1508 to:
• Ask questions about your benefits
• Obtain information about a network provider or service
• Obtain help in filing claims

Covered Expenses
This section describes the types of services and supplies covered by the Dental PPO options. 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, as determined by Aetna. See the Summary of Benefits section to view the benefit payable for covered expenses, both in- and out-of-network.

Preventive Services
Covered preventive services are:
• Oral exams (twice a year*)
• Prophylaxis — any type (twice a year*)
• Topical fluoride applications for children (twice a year), until the end of the year in which the child turns 15
• X-rays:
  — Full-mouth or panoramic (once every three years)
  — Bitewing (one set per year)
  — Vertical bitewing (one set every three years)
• 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
Covered basic services are:
• Visits and exams
  — Problem-focused exams (twice a year*)
  — Professional visit after hours
  — Special consultation by a specialist
  — Emergency palliative treatment
• X-ray and pathology
  — Single films (up to 13)
  — Intra-oral, occlusal view, maxillary or mandibular
  — Upper or lower jaw, extra-oral
  — Biopsy and examination of oral tissue
  — Study models
  — Microscopic examination
• Oral surgery — includes local anesthetics and routine postoperative care
  — Extractions
    ■ Uncomplicated
    ■ Surgical removal of erupted tooth
    ■ Postoperative visit (sutures and complications) after multiple extractions and impaction
— Impacted teeth
  ■ Removal of tooth
— Alveolar or gingival reconstructions
  ■ Alveolectomy (edentulous) per quadrant
  ■ Alveolectomy (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
  ■ Dilation of salivary duct
  ■ 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
  ■ Menisectomy 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
  ■ Injection of sclerosing agent into temporomandibular joint
  ■ Treatment of trigeminal neuralgia by injection into second and third divisions

• Anesthetics
  — General, only when provided in conjunction with an eligible surgical procedure

• Periodontics
  — Emergency treatment (periodontal abscess, acute periodontitis, etc.)
  — Subgingival curettage or root planing and scaling, per quadrant (not prophylaxis), limited to four quadrants every two years*
  — Correction of occlusion related to periodontal surgery, per quadrant
  — Gingivectomy (including post-surgical visits) per quadrant/site every three years
  — Gingivectomy, treatment per tooth (fewer than five teeth)
  — Osseous or muco-gingival surgery (including post-surgical visits) — one surgery per quadrant/site every three years
  — Crown lengthening — reviewed on a per-claim basis. Predeterminations are suggested.

• 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
Dental Benefits (cont.)

- Bi-rooted
- Tri-rooted
- Apicoectomy (separate procedure)

- Basic restorative — excludes inlays, crowns (other than stainless steel and bridges). Multiple restorations in one surface will be considered as a single restoration.
  - 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
  - Pins
    - Pin (retention) when part of the restoration used instead of gold or crown restoration
  - Crowns
    - Stainless steel (when tooth cannot be restored with a filling material)
    - Crown build-up — will be reviewed by a dental consultant for necessity
  - Full and partial denture repairs
    - Broken dentures, no teeth involved
    - Partial denture repairs (metal)
    - Replacing missing or broken teeth
    - Adding teeth to partial denture to replace extracted natural teeth
  - Teeth and clasps
  - Recementation
    - Inlay
    - Crown
    - Bridge
  - Repairs — crowns and bridges

- Space maintainers — includes all adjustments within six months after installation
  - Fixed or cemented inhibiting appliance to correct thumb sucking

*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.

Major Services

Covered major services are:

- 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
    - 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
— 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
  ■ Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two clasps
  ■ Additional clasps
  ■ Stress breakers
  ■ Stayplate, base — additional clasps
  ■ Office reline, cold cure, acrylic
  ■ Laboratory reline
  ■ Special tissue conditioning, per denture
  ■ Denture duplication (jump case), per denture
  ■ Adjustment to denture more than six months after installation
• Other services
  — Precision attachments (eligible with dentures if they are functionally necessary)
  — Implants (if specifically approved in advance)

Alternate Benefit Provision
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. In this case, the Plan will pay only for the alternate service or supply. 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 Plan will pay only for the amalgam filling. If you wish to have the composite filling, you will pay the difference between the composite and the amalgam filling.

While predetermination is not required, you may wish to submit your course of treatment in advance so you know what amount your dental option will pay. See Predetermination of Benefits in this section for more information.

Orthodontia
The Aetna Dental PPO allows benefits for teeth straightening for your covered 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 the treatment began before the child’s 19th birthday. The Plan pays 50 percent of the R&C charges for orthodontia in the Dental PPO, 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 child’s mouth. Covered orthodontic services are:
• Initial consultation
• Moldings and impressions
• Installation of braces
• Regular visits

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.
Dental Benefits (cont.)

Temporomandibular Joint (TMJ) Therapy

Temporomandibular joint dysfunction is covered for adults and dependent children. This coverage is for TMJ appliance therapy (bite splints), adjustments and diagnostic materials (including impressions) only.

The Aetna Dental PPO 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.

Accidental Injury Coverage

Under the Dental PPO, coverage for treatment and repair of sound teeth and gums damaged by an accidental injury will be covered as a regular dental expense (see the Summary of Benefits section). For this treatment and repair of accidental injuries only, the annual maximum will be waived for 36 months from the date of the injury. (Under certain circumstances this waiver could be extended for dependent children.)

Additionally, orthodontic treatment required for repair will be covered at 50 percent (of reasonable and customary limits if received out-of-network) for up to 36 months from the date of the injury with the lifetime orthodontic maximum waived during this treatment period. This benefit includes all eligible participants of the Plan regardless of age. The treatment must be medically necessary to restore the teeth to their condition prior to the accident. Cosmetic treatment beyond restoration is not covered under this benefit.

All other out-of-network dental care will continue to be subject to the annual maximum during these treatment periods.

What’s Not Covered by Your Dental Benefits

In addition to services not specifically listed in Covered Expenses in this 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, as determined by Aetna
- Services not reasonably necessary or customarily performed
- 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
- Services covered by the medical options
- Treatment of a work-related injury
- Services furnished by or for the United States government or for any other 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
- Claims received more than 12 months past the date of service
- IV sedation, except in certain circumstances; call Aetna at 1-800-UPS-1508
- Appliances, restoration or procedures needed to alter vertical dimensions or restore occlusion or for the purpose of splinting or correcting non-severe attrition or abrasion
• 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 installed or delivered more than 30 days after the patient’s coverage ends
• Replacement of lost, stolen or broken appliances
• Dental implants (unless specifically approved in advance)
• Education 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 Services in this section
• Infection control
• Behavior management
• Canal preparation, if submitted as a separate charge
• Rubber dam

Coordinating with Medical Coverage
If you’re enrolled in a Medical PPO network and need dental surgery that requires hospitalization, you should follow the required steps to precertify your hospital admission. See Precertification in the Medical Benefits section.

In all cases, if you’re hospitalized for dental care, the dentist’s charges are covered by dental benefits. Other eligible charges are covered by your medical benefits.

How to File a Claim
See the Filing a Claim section.

Maintenance of Benefits and Coordination with Medicare
If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the Plan pays benefits first, or whether the other payer is primary. See Maintenance of Benefits and Coordination with Medicare in the Filing a Claim section for more information.

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 Right of Recovery Provision in the Filing a Claim section for details.
Vision Benefits

All participants in the Plan are eligible for 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 option. If you experience a medical problem with your eyes, you should consult your physician (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 plan pays higher benefit levels when you use a VSP provider.

The Plan provides annual benefits as indicated in the Summary of Benefits section.

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 www.UPSers.com, or call VSP at 1-800-877-7195.

When calling the doctor’s office to make an appointment for yourself 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 the Summary of Benefits section). 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.

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 VisionCareSM network of doctors.

Visit VSP’s Web site from a link at www.UPSers.com to learn more about laser vision correction and participating doctors. Or, call VSP at 1-800-877-7195 for more information.

What’s Not Covered by Your 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 Plan; for example, vision therapy after cataract surgery is covered by the medical benefits

How to File a Claim
See the Filing a Claim section.

Maintenance of Benefits and Coordination with Medicare
If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the Plan pays benefits first, or whether the other payer is primary. See Maintenance of Benefits and Coordination with Medicare in the Filing a Claim section for more information.
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 National Health Plan for Part-Time Employees 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-UPS-1508.

When Is Coverage Effective?

As a bargaining unit employee of UPS, your eligibility for basic and supplemental life insurance and AD&D coverage under the UPS National Health Plan for Part-Time Employees is as follows:
- You become eligible when you become eligible for medical benefits
- Your dependents become eligible when you become eligible for dependent coverage

In all cases, exceptions apply (see Exceptions to Coverage Effective Date in this section.) See the Eligibility section of this book for complete information about eligibility for benefits under the Plan for yourself and your eligible dependents.

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

For change in status elections related to a life event, 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. See the Life Events section for more information.

Exceptions to Coverage Effective Date

In all cases, the following exceptions apply to the effective date of coverage:
- 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 (Good Health) in this section.
• If your dependent has had treatment for disease or injury within the 90-day period preceding the date coverage should start, coverage will not be effective until the dependent has been free from treatment for 90 days or evidence of good health has been approved by Prudential, if earlier. This does not apply to newborns. However, stillborn deliveries are not covered.

• If your dependent is ill or injured and confined at home, in a hospital or other facility providing healthcare on the day coverage should start, his or her UPS National Health Plan for Part-Time Employees 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.

**Basic Life Insurance**

UPS pays the full cost of basic life insurance, up to a maximum of $100,000. The benefit amount of basic life insurance is:

- For employees — 1,040 hours times the hourly rate of your base pay
- 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 at 1-800-UPS-1508.

**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.

**Supplemental Life Insurance**

If you want more insurance for yourself 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, refer to the Prudential Supplemental Term Life Insurance 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 or your spouse 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.
Life Insurance and AD&D (cont.)

Portability
If you leave UPS for any reason, the portability option lets you continue your supplemental term 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 retain 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.

Dependent Life Insurance
At your option, once you become eligible for dependent coverage, you may purchase dependent life insurance for your eligible spouse and/or eligible children, as described below. Refer to the Prudential Supplemental Term Life Insurance brochure for premium rates and complete details about coverage.

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

Spouse’s Life Insurance
You may purchase dependent coverage for your spouse 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</td>
</tr>
<tr>
<td></td>
<td>(basic + $5,000 supplemental)</td>
</tr>
<tr>
<td>2</td>
<td>$25,000 of coverage</td>
</tr>
<tr>
<td></td>
<td>(basic + $20,000 supplemental)</td>
</tr>
<tr>
<td>3</td>
<td>$50,000 of coverage</td>
</tr>
<tr>
<td></td>
<td>(basic + $45,000 supplemental)</td>
</tr>
</tbody>
</table>

You are always the beneficiary of this insurance. This coverage ends when coverage under the UPS National Health Plan for Part-Time Employees 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
Once you are eligible for dependent coverage, coverage for newborns is effective on the date of birth, except as stated in When Is Coverage Effective? in this section. However, stillborn deliveries are not covered.

The cost per $1,000 of coverage is the same regardless of how many children are covered. Refer to the Prudential Supplemental Term Life Insurance 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 National Health Plan for Part-Time Employees 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 National Health Plan for Part-Time Employees 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 1,040 hours times the hourly rate of your base pay.

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 at 1-800-UPS-1508.

**Supplemental AD&D Insurance**

You may purchase supplemental AD&D coverage in $1,000 increments up to a maximum of $1,000,000.

**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 (in the case of paralysis, within 365 days of the accident).

Standard benefits apply to basic and supplemental coverage. For more information and the Schedule of Losses, refer to the Prudential Supplemental Term Life Insurance 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. Refer to the Prudential Supplemental Term Life Insurance 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
Life Insurance and AD&D (cont.)

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 for Life and AD&D Coverage

Your Beneficiary
You may name anyone you choose as beneficiary for your own 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-UPS-1508 for instructions.

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

If you name more than one beneficiary, and do not indicate the percentage of your benefits you want paid to 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 order shown below:
• Your spouse
• Your child(ren)
• Your parent(s)
• Your sibling(s)
• The executor(s) or administrator(s) of your estate

Refer to the Prudential Supplemental Term Life Insurance brochure for more details about life and AD&D insurance.
For example, if you didn’t designate a beneficiary, your spouse would receive 100 percent of the benefit if he or she was living at your death; and if your spouse was not living at your death, your child(ren) would receive 100 percent of the benefit.

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 basic term life insurance coverage for you and, if you have become eligible for dependent coverage, your spouse and your children 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 1-877-889-2070. 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 supplemental coverage through the portability option. If you choose to continue your coverage under the portability option, your spouse, if you have become eligible for dependent coverage, may also continue her or 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 the *Filing a Claim* section.
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 Aetna Disability and Absence Management (ADAM). An absence for maternity is treated like an absence for illness.

Eligibility

STD is available to active employees when eligibility begins under the UPS National Health Plan for Part-Time Employees.

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

- Your employment with UPS terminates
- Your eligibility for coverage under the UPS National Health Plan for Part-Time Employees ends
- You retire, or
- You enter full-time military service

STD 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. Once approved, your 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. ADAM 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 pay.

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, ADAM, determines that you are unable to perform 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 clinical medical information to ADAM supporting your disability. You may also need medical approval prior to returning to work.

If you are unable to return to work when your benefits end, call ADAM to discuss the situation with your case manager. ADAM will contact your physician for an update on your condition. You should also contact your supervisor to keep him or her informed of your progress.

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 the absence is due to 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.
Health Care Coverage

You and your covered dependents will continue to receive medical coverage for up to 12 months following the date of your disability. You continue to be responsible for your share, if any, of the cost of supplemental coverage.

Remember that you cannot change your elections for life or AD&D insurance while you are absent due to disability.

See the What If...You Become Disabled in the Life Events section for complete information about continuation of your health care coverage while absent due to disability.

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 and New York have state-mandated benefits. In these states, the amount paid to you will be the greater of either the state-mandated benefit or your approved 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, ADAM, 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 (for example, 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 ADAM 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.
Short-Term Disability (cont.)

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 indeterminate 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” that qualifies you for benefits under the Plan
• Fail to provide clinical medical documentation requested by the claims administrator. ADAM 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, including, but not limited to, receiving treatment from a health care or mental health professional who does not have appropriate training and experience in the field of medicine related to your particular disability
• 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

How to File a Claim
See the Filing a Claim section.

Taxes and Your STD Benefit
STD benefits are taxed when paid to you. The claims administrator, ADAM, will create all W-2 forms for any benefits received under the STD plan.
Solutions — Your EAP and Work/Life Benefit

To help you balance your responsibilities at work and in your personal life, Solutions offers free, confidential assistance with many of the work-life challenges you face each day. The Employee Assistance Program, 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.

Eligibility

You do not have to enroll for this program; it is provided at no cost to you and your dependents on the date each of you becomes eligible for the medical benefits under the Plan. All regular part-time active union employees, employees on a company-approved leave of absence, and their eligible dependents are covered under Solutions — Your EAP and Work/Life Benefit. Coverage begins when you and your dependents become eligible for coverage under the Medical plan. Refer to the Eligibility section of this book for details regarding eligible dependents and when coverage begins.

How the EAP Works

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 will discuss your question, problem or concern. Depending on your situation, the Solutions counselor may refer you to a licensed network EAP provider in your community for up to six in-person visits, link you to available resources in your community or offer you support over the telephone. Additionally, if the counselor determines the situation seems to require it, the participant may be referred for additional assistance to the group behavioral health plan they are covered under. Any information about your call or treatment is kept confidential, except with your written consent or where disclosure is required by law or as otherwise set forth in the health plan privacy policies.

Legal and Financial Assistance

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.
Solutions — Your EAP and Work/Life Benefit (cont.)

• 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 investment 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.

Additional Work/Life Services

Work-life services include consultations with work/life specialists who research and provide referrals and educational materials that may include articles, checklists, booklets, and pamphlets, written by specialists and renowned experts and organizations. Work/Life specialists can provide assistance with child and adult care providers, schools, colleges, adoption services, community resources and other daily living resources.

Contacting the Employee Assistance Program

You can contact Solutions by phone at 1-800-336-9117 or on their Web site at the following URL: www.achievesolutions.net/ups. Please have the employee’s name, phone number and birthdate available when contacting Solutions — Your EAP and Work/Life Benefit.
Healthy Connections — Informed Choices

If you or a family member is coping with a chronic or complex health issue, a supportive partnership with a health care professional can help you navigate the health care system, improve your health, and reduce your confusion and stress regarding the benefits, resources and choices available to you.

UPS Healthy Connections — Informed Choices is a unique program that offers support to those who need it. The program provides:

- In-depth medical and lifestyle information
- Regular interaction with a health coach partner
- Tools and resources to help you and your family take charge of your health

Eligibility

You do not have to enroll for this program; it is provided at no cost to you and your dependents on the date each of you becomes eligible for the medical benefits under the Plan. All regular part-time active union employees, employees on a company-approved leave of absence, and their eligible dependents are covered under Healthy Connections — Informed Choices. Coverage begins when you and your dependents become eligible for coverage under the Medical plan. Refer to the Eligibility section of this book for details regarding eligible dependents and when coverage begins.

Program Resources

Proactive Outreach

Based on your recent prescriptions, doctor visits or hospital stays, a health coach may contact you and offer his or her professional support. He or she can discuss your overall health and tell you more about the programs and resources that would most benefit you or a family member. At that time, you can choose to enroll in a program.

Condition Management

The Condition Management program is an invitation to work one-to-one with a health coach who can answer questions about your condition and give you information about treatment options. Focused, individualized programs will be offered to those with the following conditions:

- Asthma
- Diabetes
- Coronary artery disease
- Congestive heart failure

Proactive In-reach

The Condition Management program also offers an in-reach feature that enables you to ask for a health coach to contact you by visiting the UPS Healthy Connections — Informed Choices Web site. Once at the site, you can complete an online form and receive a message that tells you when you can expect to hear from the health coach.

Lifestyle Coaching

UPS Healthy Connections — Informed Choices health coaches can also refer participants to additional resources, such as dieticians, counselors and other professionals to help you improve your overall wellness. These programs may help you quit smoking, manage stress or lose weight.

Not all eligible Plan participants will be identified to participate in the proactive outreach, condition management or lifestyle coaching resources. If you are already demonstrating effective management of your condition, you may not be placed in a Condition Management program, even if you use the program’s in-reach feature. If you receive a call from a health coach, you have been identified as someone who could best benefit from a health coach resource.
Healthy Connections — Informed Choices (cont.)

Enhanced Case Management
There may be times when you or your dependents need extra support and attention for health care needs, such as before, during or after a hospitalization, or perhaps during an acute illness or recovery period. Your health care plan has registered nurses who can assist through the Enhanced Case Management (ECM) program, an integrated component of your health care plan.

Licensed, professional nurses serving as Enhanced Case Managers can help you navigate the health care system and reduce stress and confusion regarding your upcoming hospitalization or illness. They can also help identify the benefits, resources and choices available to you. If you are scheduled for a hospital admission and/or if you have been diagnosed with a specific condition, you may be proactively contacted by a nurse, or you may wish to contact a nurse at your health care plan directly for any of the following:

Pre-Admission Counseling
Once you and your doctor have determined that you will be admitted to the hospital for surgery or a specialized procedure, the Enhanced Case Manager can:

• Answer questions or provide additional health care information and resources related to your condition
• Help you think through additional questions or concerns that you may want to talk to your doctor about
• Discuss what will occur during your hospitalization
• Start planning for a successful recovery period after discharge from the hospital

Post-Discharge Counseling
Whether your hospitalization was planned ahead of time or was the result of an emergency situation, your Enhanced Case Manager is there to help you plan for appropriate, timely care once you are discharged from the hospital. The nurse can:

• Assist you and your family caregiver in understanding and complying with your discharge instructions
• Facilitate necessary home care, medical equipment or outpatient follow-up services such as physical therapy or cardiac rehab
• Provide health care educational resources that will help you recover well and stay as healthy as possible

Support for Other Health Concerns
There are many other health care situations where the personal assistance of your Enhanced Case Management registered nurse can be valuable. Partnering with you and your physician, providing educational support and resources, and coordinating health care services are all part of what’s available to you. Among a wide array of general knowledge, the nurses have special expertise in:

• Care after acute trauma or accidents
• Diseases of the heart and circulatory system
• Infectious diseases
• Pregnancy, maternity care and newborns
• Debilitating musculoskeletal conditions
• Neurology
• Cancer diagnoses
• Kidney diseases
• Respiratory diseases
• Specialized surgical procedures
When to Seek ECM Help

It’s a good idea to always seek help from an Enhanced Case Management registered nurse before any scheduled inpatient hospitalization and for some outpatient surgeries. Call the number on your medical ID card to discuss whether Enhanced Case Management is appropriate for your situation.

In an emergency, be sure to first get the medical care you need to bring the situation under control, then contact your health care plan’s case management unit and speak with a registered nurse who can offer support and direction.

Information Kept Confidential

Services provided by these programs are entirely confidential. UPS Healthy Connections — Informed Choices and the Enhanced Case Management program are managed on behalf of your health care plan by a group of highly qualified health care professionals with years of clinical experience. You can be confident that all personal health information is kept confidential, except with your written consent or where disclosure is required by law or as otherwise set forth in the health plan privacy policies.

Contacting the Healthy Connections — Informed Choices Program

You can contact the program via a link on www.UPSers.com or directly at www.upshealthyconnections-informedchoices.com.
**Quit For Life Tobacco Cessation Program**

UPS provides a tobacco cessation program benefit as a component of the UPS National Health Plan for Part-Time Employees to help participants quit tobacco use. All tobacco types are included (cigarettes, cigars and smokeless tobacco).

**Eligibility**

Quit For Life is available to all active employees who otherwise satisfy the eligibility requirements for the UPS National Health Plan for Part-Time Employees, including such employees on an approved leave of absence. Individuals who otherwise satisfy the requirements to be a “dependent” age 18 and older are also eligible for this program. See the Eligibility section for more information about your eligibility for the UPS National Health Plan for Part-Time Employees.

**Enrollment**

You must enroll in the Quit For Life program in order to participate and receive the tobacco cessation benefits of the program. To enroll, access the Web site at the following URL: [www.freeclear.com/ups](http://www.freeclear.com/ups) or call 1-866-QUIT-4-LIFE.

**Program Benefits**

Program benefits are provided at no additional cost to participants who enroll in Quit For Life, and include:

- 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 you for the NRT
- Assistance and support with NRT throughout the program cycle
- Assistance and support regarding prescription medications such as bupropion and Chantix®
- A Quit Guide sent to your home following program registration
- Unlimited, easy, toll-free access to Quit Coaches for 12 months from the time of enrollment
- Access to Web Coach, an interactive Web site that helps you stay on track between calls

*Prescription medication is not covered under this program. See the Prescription Drug Program section for information about prescription drug coverage under the Medical plan. Assistance and support provided by Free & Clear, the program’s administrator, should not be a substitute for your doctor’s advice.

**Two Lifetime Quit Cycles**

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.

**When Benefits Begin**

If you or your eligible dependents are already covered by the Medical plan, your benefits in Quit For Life begin the date you or your dependent enrolls in the program. If your Medical plan coverage has not begun, your benefits under the Quit For Life program begin the date coverage under the Medical plan begins.
Spending Accounts

Spending accounts let you set aside a portion of your annual earnings on a pre-tax basis to pay for many of your out-of-pocket health, child and elder care expenses.

You can use the health care spending account (HCSA) 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 the Plan — such as adult orthodontia — as long as these expenses meet the IRS guidelines
- Over-the-counter medications used for medical care (but not if used for general well-being)

The child/elder care spending account (C/ECSA) lets you save on the cost of care for your dependents so you — and your spouse, if you’re married — can work or attend school.

How the Spending Accounts Work

First, you estimate the amount of eligible expenses you will incur in the coming year. Based on your estimate, you decide how much to contribute to each account. Then you enroll in each account independently of the other. Your elections will be in effect during the entire calendar year. The amount you choose to contribute to your account will be deducted, before taxes, from your regular pay in equal amounts throughout the year. Finally, once you have incurred eligible expenses, you submit a claim form for reimbursement from your account. (See Streamlined Claims Submission and Direct Deposit in this section for a more convenient way to be reimbursed for your expenses.)

All eligible health, child or elder care expenses must be incurred during the year for which you make your account contributions. An expense is considered incurred when the service is provided, not when you are billed or when you pay for it.

“Use It or Lose It” Rule

It’s important that you carefully estimate your expenses before you enroll in either the HCSA or C/ECSA 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 HCSA — during the grace period. This is often called the “use it or lose it” rule. 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 (see Grace Period in this section)
- Stop making contributions until the following January 1 unless an eligible change in status occurs

Any forfeited amounts in the spending accounts are used by the Plan to offset administrative costs of the Plan or as otherwise permitted under applicable law.

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.

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 deposit into a spending account.

Certain states and localities include spending account deposits as taxable income. Please contact your local Human Resources representative to find out whether spending accounts are taxed in your area.
Spending Accounts (cont.)

If you’re a highly compensated employee (as that term is defined by the IRS), the maximum amount you can contribute to the HCSA and/or the C/ECSA may be limited. You’ll be notified if these limits apply to you and your maximum contribution may be reduced.

Health Care Spending Account (HCSA)

The HCSA lets you pay for eligible expenses with pre-tax dollars, thereby reducing your taxable income. All eligible health care expenses must be incurred during the year for which you make your HCSA contributions or during the grace period. (See Grace Period in this section for more information on the terms and conditions). An expense is considered incurred when the service is provided, not when you are billed or when you pay for it.

How Much Can You Contribute?

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

Eligible Dependents

For the HCSA 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). Refer to the Eligibility section of this book for complete information about dependents.

How the HCSA Is Used

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 an HCSA. 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.

Only those expenses that are considered “medical care” as defined in Internal Revenue Code Section 213(d) (except for long-term or health insurance premiums) are reimbursable through your HCSA.

Eligible Health Care Expenses

Here are some examples of eligible health care expenses, based on applicable guidance relating to Internal Revenue Code Section 213(d):

- Your deductibles and copayments (including those from other employers’ plans)
  — All receipts 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.
- Fees for doctors, dentists and hospital services not covered by a medical, dental or vision option (for example, adult orthodontia)
- Charges that exceed reasonable and customary amounts (see the medical or dental section for an explanation of the term reasonable and customary)
- Equipment and materials required for using contact lenses, such as saline solution and enzyme cleaners
- Over-the-counter medications, equipment and supplies when used for “medical care” and not for general well being
- 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)
• Birth control pills or other birth control items prescribed by your doctor
• Infertility treatment

Ineligible Health Care Expenses
You may not receive reimbursement from your HCSA for expenses that are not considered “medical care.” Following are some examples of ineligible expenses, based on applicable guidance relating to Internal Revenue Code Section 213(d):
• Health insurance premiums
• Athletic club expenses to keep physically fit (even if suggested by doctor)
• Cosmetic surgery of a non-reconstructive nature (in other words, 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
• Qualified long-term care services

HCSA Reimbursements
Reimbursements from the HCSA will equal the lesser of:
• The actual amount of your claim
• The total amount you’ve elected to contribute to 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 (C/ECSA)
The 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?
The annual reimbursement amount you elect cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. The maximum amount is currently $5,000* per Plan year if:
• You are married and file a joint return
• You are married but:
  — Your spouse maintains a separate residence for the last six months of the calendar year
  — You file a separate tax return, and
  — You furnish more than one-half the cost of maintaining those eligible dependents; or
• You are single

If you are married and reside together, but file a separate federal income tax return, the maximum annual dependent care reimbursement amount that you may elect is $2,500. In addition, the amount you set aside during the year for C/ECSA expenses will not be on a tax-free basis to the extent it exceeds the lesser of:
• Your earned income (as defined in Code Section 32) or
• Your spouse’s earned income.

If you choose to participate, your minimum contribution amount is $50 annually.

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 earned income amount of $250 if you have one dependent, or $500 if you have two or more dependents (as defined for purposes of the child/elder care account). 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 in commuting to and from work.

*Combined total for all dependent care flexible spending account plans to which you and/or your spouse contribute.
**Spending Accounts** (cont.)

**Eligible Dependents**
Refer to the *Eligibility* section of this book for complete information about dependents.

**How the Child/Elder Care Spending Account Is Used**
You can use the C/ECSA to pay for eligible dependent care expenses that are expenses incurred:
- For the custodial care of an eligible dependent (as described in *Eligible Dependents* in this section) or for related household services, and
- To enable you (and your spouse, if applicable) to be gainfully employed or look for work.

Whether an expense enables you (and your spouse, if applicable) to work or look for work should be determined on a daily basis. Normally, you should not include expenses incurred on days when you (and your spouse, if applicable) are not working or looking for work. However, you are not required to exclude expenses for a “temporary absence.” A temporary absence of two weeks or less is considered a temporary absence.

Expenses for overnight camp are not eligible day-care expenses.

Expenses that are primarily for education, food and/or clothing are not considered to be for custodial care. Therefore, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, day camps are considered to be for custodial care even if they also provide educational activities such as soccer and computer.

Summer school and summer tutoring programs are considered to be “education” and therefore do not qualify as custodial care.

**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 expenses for using the tax credit</td>
</tr>
<tr>
<td>Maximum annual contribution is $5,000 ($2,500 each if married filing separately)</td>
<td>Maximum annual expense applicable toward tax credit is $3,000 for one child; $6,000 for two or more children</td>
</tr>
<tr>
<td>Contributions are excluded from taxable income</td>
<td>A percentage of expense 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>
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</table>
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
- 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, day camps and day care and elder care centers that meet state or local regulations, provide care for more than six non-residents and receive fees for services provided (per IRS rulings, pre-kindergarten is an eligible expense)

You will not 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.

Ineligible Child/Elder Care Expenses

Services that do not qualify for reimbursement through your C/ECSA include:
- Dependent care provided by a spouse, parent of the child, child under age 19, or by anyone you claim as a dependent on your federal income tax return
- Dependent care that isn’t necessary to enable you (and your spouse, if applicable) to be gainfully employed
- Dependent care provided if your spouse does not work (unless the spouse is a student or incapacitated)
- Any expense you take as a credit on your income tax return
- Transportation to and from a dependent care location, except those charged by the day-care provider to pick up and/or take the child to and from the day-care center
- Care provided in a full-time residential institution
- Expenses that are primarily educational (such as kindergarten)
- Overnight care expenses (unless the parents work nights)
- Late payment fees
- Expenses for a provider’s food, clothing and entertainment
- Expenses to care for dependents that do not live with you at least eight hours per day

To receive reimbursements from the C/ECSA, you must provide written receipts showing the caregiver’s name and taxpayer ID 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 ID number.)

C/ECSA Reimbursements

Reimbursements from the C/ECSA 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.

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

Refer to IRS Publication 503 for a complete discussion of the tax credit. To order a copy, visit the IRS Web site at www.irs.gov, or call 1-800-829-3676.
Spending Accounts (cont.)

Streamlined Claims Submission and Direct Deposit

Streamlined claims submission allows any unpaid amounts to be automatically forwarded to your spending account once your Aetna medical or dental claim under the UPS National Health Plan for Part-Time Employees has been processed. In addition, any unpaid amounts from prescription drug expenses filed with Medco are automatically forwarded every two weeks to Aetna for processing under your HCSA. Unpaid amounts are reviewed and reimbursed until you reach your annual election. This eliminates the need to keep receipts or complete spending account claim forms. Depending on the date of your claim, data transfer dates, and HCSA reimbursement schedules, this process can take up to 35 days.

Direct deposit allows your spending account reimbursements to be directly deposited into your bank account — saving days in transit. Direct deposit applies to both your HCSA and C/ECSA reimbursements. HCSA reimbursements are paid on days 15 and 30 of each month (or the first business day thereafter). C/ECSA reimbursements are paid weekly on Fridays. Reimbursements are usually available in your account within three to five business days.

Claims for any expenses other than those described above, including claims from claims administrators other than Aetna, cannot be streamlined and still must be submitted.

How to Enroll in Streamlined Claims Submission and Direct Deposit

By enrolling in direct deposit or streamlined claims submission, you automatically are signed up for both. To participate in direct deposit, your bank must be part of the Automated Clearing House (ACH) System. Call your bank to verify participation. Setting up direct deposit can take up to 35 days.

Complete an enrollment form available by calling the Benefits Service Center at 1-800-UPS-1508. Do not send this form to Aetna. Return the form to the Benefits Service Center at the following address:

Benefits Service Center
100 Half Day Road
Lincolnshire, IL 60069

You do not need to sign up for this feature each year. Once enrolled, streamlined claim submission and direct deposit continues each year.

To update your bank information in the future, call the Benefits Service Center at 1-800-UPS-1508 to request a new enrollment form.

Impact on Other Benefits

While your spending account contributions reduce your taxable income, Company-sponsored benefit amounts, like life insurance and disability, are based on your earnings before spending account contributions have been withheld.

Grace Period

You now have the advantage of a “grace period” that follows the end of the Plan year in which you allocated 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 C/ECSA.

The grace period will begin on the first day of the next Plan year and will end two months and 15 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. For example, $200 remains in your HCSA at the end of the 2008 Plan year and you elected to allocate $2,400 to your HCSA for the 2009 Plan year. If you submit for reimbursement an eligible medical expense of $500 that was incurred on January 15, 2009, $200 of your claim will be paid out of the unused amounts remaining in your HCSA from the 2008 Plan year and the remaining $300 will be paid out of amounts allocated to your HCSA for 2009.

Run-Out Period

Expenses incurred during a grace period must be submitted before the end of the run-out period described below. 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 or have a status change, refer to the Life Events section for information about the impact to your spending accounts.

End-of-Year Claims

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.

Termination of Employment

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

How to File a Claim

See the Filing a Claim section.
Legal Plan

The Hyatt legal plan helps protect you from the financial expenses that may arise if you need legal services. This supplemental plan offers a range of commonly needed legal services as well as access to a legal hotline and individual consultation administered by Hyatt Legal Plans, a MetLife® company.

You and your covered family members will have access to more than 10,000 plan attorneys participating in the Hyatt Legal Plans network. You will receive full coverage for covered services from a Hyatt network attorney. You may also use any attorney of your choice. Upon request, Hyatt will provide a fee reimbursement schedule that shows the maximum amount payable for specific services under the plan.

As a participant in the Hyatt legal plan, there’s no limit on how often you can use the plan. No matter how many times you utilize the plan, if you use a Hyatt network attorney, your payroll deduction stays the same.

Eligibility

The supplemental Hyatt legal plan is available to individuals and their eligible dependents who are eligible for the UPS National Health Plan for Part-Time Employees.

Enrollment

You may enroll or discontinue your coverage in the supplemental Hyatt legal plan benefit at initial enrollment, during annual enrollment periods, or following a recognized life status change.

How the Legal Benefits Work

If you enroll for legal coverage, you have access to legal services from three sources:

- **Telephone service.** You have 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.
- **Hyatt Legal Plans attorneys.** If you need an attorney, you can choose one from Hyatt’s national network of attorneys throughout the United States who have agreed to provide covered services to Hyatt legal plan participants. If you use a Hyatt Legal Plans network attorney, all attorney fees for covered services are paid in full.
- **Non-participating attorneys.** You can also receive legal counsel from an attorney who does not participate in the Hyatt Legal Plans 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 to pay the difference, if any, between the plan’s payment and the non-network attorney’s charge for services.

Legal Services Covered and Excluded

Legal benefits are provided according to the contract with Hyatt Legal Plans. Covered and non-covered services are subject to change at Hyatt’s discretion. To obtain a complete list of covered and excluded services, contact the Hyatt Legal Plans Client Service center at 1-800-821-6400, or visit their Web site at [www.legalplans.com](http://www.legalplans.com). If there is any conflict between the summary of benefits provided in this Summary Plan Description and the benefits described in the contract or on the Hyatt Legal Plans Web site, the description in the contract and/or on the Web site controls.

Covered Legal Services

Examples of covered services include:

- Wills and estate planning
- Consumer protection matters, including small claims assistance
- Real estate matters, including sale or purchase of your home and property tax assessment
- Debt matters, including personal bankruptcy, tax audits and identity theft defense
- Defense of civil lawsuits
- Document preparation, including deeds, mortgages and notes
• Family law, including premarital agreements, protection from domestic violence, and uncontested adoption
• Traffic matters/criminal, including juvenile court defense, restoration of driving privileges, and traffic ticket defense (does not include DUI)
• Immigration assistance

Excluded Legal Services
Examples of excluded services include services related to:
• Employment-related matters, including Company or statutory benefits
• Matters involving the employer, MetLife and affiliates, and plan attorneys
• Matters in which there is a conflict of interest between the employee and spouse or dependents, in which case services are excluded for the spouse and dependents
• Appeals and class actions
• Farm and business matters, including rental issues when the participant is the landlord
• Patent, trademark and copyright matters
• Costs or fines
• Frivolous or unethical matters
• Matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits

How to Use the Plan
Once you are enrolled, go to www.legalplans.com or call the Hyatt Legal Plans Client Services center at 1-800-821-6400 Monday through Thursday from 8 a.m. to 7 p.m. (Eastern Time). A Client Services Representative will confirm that you are eligible to use the plan, and will give you the address and telephone number of the attorney(s) located most conveniently to you, as well as a case number. Once you have this information, you may contact the attorney yourself to schedule an appointment.

How to File a Claim
If you choose to receive services from one of Hyatt’s national network of attorneys, all covered services are paid in full — there is no need to submit a claim form.

If you use a non-network attorney, you will be reimbursed for covered services according to a set fee schedule. You are responsible to pay the difference, if any, between the plan’s payment and the non-network attorney’s charge for services. To request a claim form, contact the Hyatt Legal Plans Client Services center at 1-800-821-6400 or go online at www.legalplans.com.

The Client Services Representative can also help you:
• Understand coverage
• Offer information about using an out-of-network attorney
• Answer any other questions

Cost of Coverage
To determine how much the coverage will cost, visit www.metlife.com/mybenefits. Rates are subject to change.

Paying for Coverage
Payment for legal plan coverage is made through payroll deductions.

Benefit Termination
Generally, your coverage under this benefit ends when you retire or leave the Company for any other reason. However, you have the option to continue coverage through an individual policy. See Portability below.

Portability
You are eligible to convert your Hyatt legal plan coverage to an individual policy upon leaving the Company. If you choose to continue legal coverage, you will be billed directly for the cost. Contact the Hyatt Legal Plans Client Services center at 1-800-821-6400 for more information.
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 coverage under the UPS National Health Plan for Part-Time Employees.

Eligibility

Employees are eligible for this benefit as part of the comprehensive basic coverage under the UPS National Health Plan for Part-Time Employees. You do not need to enroll separately in the Adoption Assistance Program benefit. There is no cost to you to take advantage of this program.

Benefit Amount

UPS will reimburse 100 percent of eligible costs, up to $3,500 per child, associated with the adoption of a child less than age 18, as long as the child is not related by marriage or blood. 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 UPS 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 UPS Benefits Service Center at 1-800-UPS-1508 to request a UPS Adoption Assistance Program claim form.

What’s Not Covered by the Program

The following expenses are not covered by the UPS 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 the Filing a Claim section.
Personal Lines Insurance (Auto and Home)

Personal lines insurance is a supplemental group auto and home benefit program that provides you with access to insurance coverage for your personal insurance needs. Policies available include:

- Auto
- Landlord’s rental dwelling
- Condo
- Mobile home
- Renter’s
- Recreational vehicle
- Boat
- Personal excess liability (“umbrella”)

The program gives you access to special group rates and policy discounts. Additional program benefits include 24-hour claim reporting and coverage that you can take with you if you retire or leave the Company for any other reason.

You have a choice of insurance carriers for your personal lines insurance. You may choose to purchase one or more policies from either of these carriers:

- Liberty Mutual® Personal Lines
- MetLife Auto & Home®

Enrollment

You may enroll in the supplemental personal lines insurance benefit at any time of the year by calling 1-800-UPS-1508 to connect to either MetLife Auto & Home or Liberty Mutual.

Cost of Coverage

To obtain a quote for coverage, call 1-800-UPS-1508 to be connected to Liberty Mutual or MetLife Auto & Home. Rates are subject to change.

Keep in mind that the rates quoted by MetLife Auto & Home or 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.

Paying for Coverage

Payment for auto and/or homeowners insurance can be made via direct billing or through payroll deductions. Both Liberty Mutual and MetLife Auto & Home offer an additional discount when payment is made via payroll deductions.

To Purchase Insurance

Call 1-800-UPS-1508 to be connected to Liberty Mutual or MetLife Auto & Home.

If you elect to purchase a policy, the paperwork is handled by the insurance carrier, including notification of the appropriate payroll deductions. All personal lines insurance deductions are taken on an after-tax basis.

Benefit Termination

Your coverage under the auto and/or homeowners insurance benefit continues until you notify the insurance carrier to discontinue coverage.

Portability

If you retire or leave UPS for any other reason, the portability option lets you continue your auto and/or homeowners insurance through an individual policy, unless you notify your carrier to discontinue coverage. You will be billed directly by the carrier for the cost of your coverage.

How to File a Claim

To file a claim on your personal lines insurance policy, contact the insurance carrier directly at the number provided on your policy, or call 1-800-UPS-1508 to be connected to Liberty Mutual or MetLife Auto & Home.
Filing a Claim

This section reviews what you need to do to file claims for the different benefit options in the UPS National Health Plan for Part-Time Employees. If you have any questions about filing claims, please call the appropriate claims administrator.

Medical

When to File a Claim

If you participate in a PPO 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 network provider will take care of claims for you.

You will be responsible for filing your own claims if:

- You participate in the Traditional Program (even if you see a network provider)
- You have a covered dependent living permanently outside the network area, and he or she receives services from an out-of-area provider

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 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.

Maintenance of Benefits

The UPS National Health Plan for Part-Time Employees has a maintenance of benefits (MOB) provision. Under this provision, benefits from the Plan 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 applies to medical, dental and vision benefits; it 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 part-time employee is also covered as a result of full-time employment, the plan offering coverage as a result of full-time employment is primary.

Filing a Claim (cont.)

- If a person is covered as an employee by two plans, the plan covering the person the longest is the primary plan.
- If a part-time employee is also covered as a result of full-time employment, the plan offering coverage as a result of full-time employment is primary.
- 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.

Any other situation will be handled in accordance with guidelines established for coordination of benefits by the National Association of Insurance Commissioners.

Maintenance of Benefits 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 medical 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.

Remember when calculating what you have to pay, that a health care provider may be a participant in one plan’s network but not the other. This affects the amount of benefits payable from the plan in which an out-of-network benefit is paid. For example, assume your spouse has an office visit to a doctor who participates in your spouse’s medical plan network, but not in your Plan’s network. For purposes of the maintenance of benefits provision, that visit will be considered an out-of-network expense.

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 Plan pays benefits first, or whether Medicare is primary.
**Coordination of UPS National Health Plan for Part-Time Employees**

Covered individuals who are covered under the UPS National Health Plan for Part-Time Employees based on criteria other than current employment status — for example, COBRA continuers and 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 National Health Plan for Part-Time Employees, this Plan 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 National Health Plan for Part-Time Employees would be primary for you and any covered dependents who may be eligible for Medicare for the first six calendar months of your disability period. After the six-month period, if you are not actively working at the Company, Medicare pays benefits first for you and any covered dependents (if they are also eligible for Medicare).

**Coordination of End Stage Renal Disease (ESRD) Coverage**

In the event an individual is eligible for Medicare due to end stage renal disease (ESRD) and is covered by the Plan, the Plan will be primary during the coordination period (currently the first 30 months of ESRD). Thereafter, Medicare will be primary.

Notwithstanding the foregoing, the Plan will coordinate with Medicare to the extent permitted under applicable law.

During the time the Plan pays benefits first, you should submit a claim for any remaining expenses not covered by the Plan to Medicare. (Incidentally, you should apply for Social Security disability income benefits during the fifth month of disability to make sure you have no gaps in income protection.) During the time Medicare pays benefits first, you should first submit claims to Medicare for payment.

**Behavioral Health/Substance Abuse**

If your provider does not file a claim for you, send your invoice to:

- **ValueOptions**
  - P. O. Box 1347
  - Latham, NY 12110-8847

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.

If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the UPS National Health Plan for Part-Time Employees pays benefits first, or whether the other payer is primary. See **Maintenance of Benefits and Coordination with Medicare** in this section for more information.

**Prescriptions**

The procedure for filing prescription drug claims depends on whether you fill your prescription at a Medco retail pharmacy or through the Medco By Mail program.

**At a Participating Pharmacy**

If you fill your prescription at a participating Medco retail pharmacy, you do not have
Filing a Claim (cont.)

to file a claim form. You simply present your Medco ID card and pay any member responsibility amount at the pharmacy.

At a Non-Participating Pharmacy

When using a non-participating pharmacy, you'll have to pay the full amount of each prescription and submit a completed 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 member responsibility amount. Call Medco at 1-800-UPS-1508 for a claim form.

Medco By Mail Program

You don't file claim forms if you fill your maintenance drug prescriptions through the Medco by Mail program. To order drugs through the program, send your prescription with your member responsibility amount (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.medco.com or through a link available under the My Life and Career tab at www.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.

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 nonparticipating 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.

If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the UPS National Health Plan for Part-Time Employees pays benefits first, or whether the other payer is primary. See Maintenance of Benefits and Coordination with Medicare in this section for more information.

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 www.UPSers.com.

When calling the doctor's office to make an appointment for yourself 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.
If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the UPS National Health Plan for Part-Time Employees pays benefits first, or whether the other payer is primary. See Maintenance of Benefits and Coordination with Medicare in this section for more information.

**Spending Accounts**
Streamlined Claims Submission and Direct Deposit are available for convenient reimbursement of your eligible health care and child/elder care expenses. See the Spending Accounts section of this book for complete information, including how to enroll.

If you choose not to participate in Streamlined Claims Submission and Direct Deposit, or have expenses that cannot be streamlined, claim forms for the Health Care Spending Account and Child/Elder Care Spending Account are available at [www.aetna.com](http://www.aetna.com) or by calling Aetna Member Services. Complete and return the form together with written proof of payment of the expenses to:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000

Or fax to 1-888-238-3539
(1-800-AET-FLEX)

**Life Insurance and AD&D**
Contact your district Human Resources Office or Prudential Life Insurance Company at 1-877-877-2955 for information about filing life insurance and AD&D claims. 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 [www.UPSers.com](http://www.UPSers.com), or go directly to [www.wkabsystem.com](http://www.wkabsystem.com). Enter **UPS** as the Company Identifier and your employee ID as the User ID. When you first access this site, you’ll need to click New User Registration and choose a password that you will enter each time you visit the site. Or call 1-800-UPS-1508 to reach an ADAM representative who 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 ADAM 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 ADAM that supports your disability.

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

For STD purposes, you are considered disabled if the claims administrator, ADAM, determines that you are unable to perform 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 clinical medical information to ADAM supporting your disability. You may also need medical approval prior to returning to work.

If your claim is approved, you will receive an approval letter providing you a number to call if you have questions about your coverage. ADAM 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 your claim is approved.

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. ADAM will notify UPS that your claim has been denied. You should contact your manager to schedule your return to work.

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 an international adoption)
- Send the form and documentation to:
  Adoption Assistance Program
  United Parcel Service
  55 Glenlake Parkway, N.E.
  Atlanta, GA 30328

Once reimbursement is approved, you will receive a check from your local Human Resources representative 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.

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 (in other words, 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 (for example, 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.

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>BlueCross BlueShield</td>
<td>✓</td>
<td>Prudential life insurance</td>
<td></td>
</tr>
<tr>
<td>Aetna medical</td>
<td>✓</td>
<td>Prudential AD&amp;D</td>
<td>✓</td>
</tr>
<tr>
<td>Aetna dental</td>
<td>✓</td>
<td>Liberty Mutual</td>
<td>✓</td>
</tr>
<tr>
<td>Aetna spending accounts</td>
<td>✓</td>
<td>MetLife Auto &amp; Home</td>
<td></td>
</tr>
<tr>
<td>ValueOptions behavioral health</td>
<td>✓</td>
<td>Hyatt legal plan</td>
<td></td>
</tr>
<tr>
<td>Medco prescription drugs</td>
<td>✓</td>
<td>Quit For Life tobacco cessation</td>
<td></td>
</tr>
<tr>
<td>Short-term disability</td>
<td>✓</td>
<td>Vision Service Plan (VSP)</td>
<td></td>
</tr>
<tr>
<td>Adoption assistance</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Denial of Other Claims

If the denied claim is one for which the UPS Claims Review Committee (“the Committee”) makes the final decision (see the Fiduciary Chart in this section), 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 Claim Type Definitions in this section for a detailed description of the types of claims.

Appeals Procedures

Generally, the following steps describe your appeal procedures (regardless of the type of claim — pre-service, concurrent care or other).

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 Claims and Appeals Procedures Chart 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:

- a. The reason(s) for the denial and the Plan provisions on which the denial is based;
- b. 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;
- c. 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;
- d. 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;
- e. 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
- f. If the claim was an Urgent Care Claim, a description of the expedited appeals 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 Claims and Appeals Procedures Chart, 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 a Claim Is Denied (cont.)

If the Committee denies your 2nd Level Appeal, you will receive notice within the time period described in the Claims and Appeals Procedures chart, 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 Filing a Claim 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 (in other words, 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-Term Disability

The same steps described above for group health claims apply to short-term disability claims; however, the time periods for making a decision for disability claims are different. See Claim Type Definitions in this section for more 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 Claims and Appeals Procedures chart in this section. 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**

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>Group Health Benefit Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Service</strong></td>
<td>15 days from receipt of claim</td>
<td>45 days of date extension notice</td>
<td>180 days of claim denial</td>
</tr>
<tr>
<td><strong>Pre-Service: Involving Urgent Care</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 info)</td>
</tr>
<tr>
<td><strong>Concurrent: To end or reduce treatment prematurely</strong></td>
<td>The notification to end or reduce treatment, to allow time to finalize appeal before end of treatment</td>
<td>N/A</td>
<td>(Denial letter will specify filing limit)</td>
</tr>
<tr>
<td><strong>Concurrent: To deny your request to extend treatment</strong></td>
<td>Treated as any other pre-service or post-service claim</td>
<td>Treated as any other pre-service or post-service claim</td>
<td>Treated as any other pre-service or post-service claim</td>
</tr>
<tr>
<td><strong>Concurrent: Involving Urgent Care</strong></td>
<td>24 hours if claim submitted at least 24 hours before the scheduled end of treatment. Otherwise, treated as Pre-Service Urgent Care: 30 days from receipt of appeal</td>
<td>None</td>
<td>(Denial letter will specify filing limit)</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>180 days of claim denial</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C/ECSA and Adoption Assistance</strong></td>
<td>30 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>180 days of claim denial</td>
</tr>
<tr>
<td><strong>Short-term Disability</strong></td>
<td>45 days from receipt of claim</td>
<td>Two extensions of 30 days each</td>
<td>45 days of date extension notice</td>
</tr>
</tbody>
</table>

*The extension period is measured from the end of the original determination due date.*
If a Claim Is Denied (cont.)

Claim Type Definitions

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).
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 Qualifying Events table in this section 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 2 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. (There is 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 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 care plan after electing COBRA coverage (except where the person is subject to a pre-existing condition)
- UPS terminates all group health care plans, or
- Your coverage would be terminated as an active employee for any other reason

Continued coverage under the HCSA is only available through the end of the plan year in which the qualifying event occurs (in some cases, it may not be available to those who overspent their account at the time of the qualifying event).

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 of the determination (and provide any requested supporting documentation, such as the Social Security Determination) before the

The 60-Day Notice

If you do not notify the Benefits Service Center at 1-800-UPS-1508 within 60 days of a divorce, legal separation or loss of dependent status (not due to age), you forfeit your right to COBRA coverage.
Continuation of Coverage under COBRA (cont.)

end of the 60-day notice period.* The 60-day notice period ends 60 days after the latest of the following:
— The qualifying event,
— The date coverage is lost as a result of the qualifying event, or
— The date of the determination by the Social Security Administration.

*In addition, the notice must be provided before the end of the 18-month COBRA period without regard to the 60-day notice period. If you receive the Social Security Administration determination with only two weeks left in your 18-month COBRA period, you have only two weeks to provide the notice.

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-UPS-1508 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 or 29-month continuation period up to 36 months (measured from the date of the original qualifying event) 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>
</table>
| • Termination  
• Retirement  
• Layoff  
• Death of employee  
• Transfer to ineligible position  
• Reaching 12 months on an FMLA Leave of Absence  
• Loss of dependent status due to age | Benefits Service Center will automatically send your COBRA enrollment materials to the employee’s address on file. |
| • Divorce  
• Legal Separation  
• Loss of dependent status not due to age | You or the qualified beneficiary should call the Benefits Service Center at 1-800-UPS-1508 immediately. If you do not notify the Service Center within 60 days, you forfeit any right to COBRA coverage. |

Enrollment in COBRA
There are two types of COBRA 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 the Life Events section 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 Benefits Service Center can be reached at 1-800-UPS-1508.

**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 pre-existing condition exclusion. To take advantage of this HIPAA right, you must complete your 18-, 29- or 36-month COBRA coverage period under the UPS National Health Plan for Part-Time 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 Event</th>
<th>Continuation of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You terminate UPS employment before retiring</td>
<td>18 months</td>
</tr>
<tr>
<td>Your work hours are reduced*</td>
<td>18 months</td>
</tr>
<tr>
<td>You retire</td>
<td>18 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
<tr>
<td>You become divorced or legally separated</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child ceases to be a qualified dependent</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*And, as a result, you’re ineligible for health care coverage.

**Includes six-month extension period paid by UPS (see What If... You Die in the Life Events section).**

For further information, contact the UPS Benefits Service Center at 1-800-UPS-1508.
Continuation of Coverage under COBRA (cont.)

Special Rule for Military Leaves of Absence
If a covered employee takes a leave of absence to perform services in the Uniformed Services (as addressed in the Uniformed Services Employment and Reemployment Act, or USERRA) that is expected to last 31 days or more, the covered employee may be able to continue health coverage for the employee and any covered dependents until the earliest of the following:

- 24 months from the date the leave began
- The date that the employee fails to return to work as required under USERRA, or
- The date a premium is not timely paid.

The cost to continue this coverage during the 24-month period is 102 percent of the applicable premium.

The USERRA continuation period will run concurrently with the COBRA period described herein; however, the rights described above apply only to the COBRA continuation coverage periods. Notwithstanding anything to the contrary in this Notice, continuation of coverage during a military leave of absence covered under USERRA will be administered in accordance with requirements of USERRA. UPS has no obligation to provide continuation coverage on and after the date it ceases to offer any group health plans.
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 National Health Plan for Part-Time 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 Plan. 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 Plan’s 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 National Health Plan for Part-Time Employees 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 — both for you and your family — described in this booklet 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 life insurance, accidental death and dismemberment, personal lines insurance and legal assistance are provided to UPS National Health Plan for Part-Time Employees 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 the Plan 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 shown in the table that follows.
## ERISA and Other Important Information (cont.)

### Administrative Services Provided for the Plan

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Provided By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>BlueCross BlueShield of Illinois</td>
</tr>
<tr>
<td></td>
<td>300 East Randolph Street</td>
</tr>
<tr>
<td></td>
<td>Chicago, IL 60601</td>
</tr>
<tr>
<td></td>
<td>Aetna</td>
</tr>
<tr>
<td></td>
<td>151 Farmington Road</td>
</tr>
<tr>
<td></td>
<td>Hartford, CT 06156</td>
</tr>
<tr>
<td>Prescription drug</td>
<td>Medco Health Solutions</td>
</tr>
<tr>
<td></td>
<td>100 Parsons Pond Drive</td>
</tr>
<tr>
<td></td>
<td>Fair Lawn, NJ 07410</td>
</tr>
<tr>
<td>Behavioral health benefits</td>
<td>ValueOptions</td>
</tr>
<tr>
<td></td>
<td>1199 S. Beltline Road, Suite 100</td>
</tr>
<tr>
<td></td>
<td>Coppell, TX 75019</td>
</tr>
<tr>
<td>Dental</td>
<td>Aetna</td>
</tr>
<tr>
<td></td>
<td>151 Farmington Road</td>
</tr>
<tr>
<td></td>
<td>Hartford, CT 06156</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision Service Plan</td>
</tr>
<tr>
<td></td>
<td>3333 Quality Drive</td>
</tr>
<tr>
<td></td>
<td>Rancho Cordova, CA 95670</td>
</tr>
<tr>
<td>Quit For Life tobacco cessation program</td>
<td>Free &amp; Clear, Inc.</td>
</tr>
<tr>
<td></td>
<td>999 Third Avenue, Suite 2100</td>
</tr>
<tr>
<td></td>
<td>Seattle, WA 98104</td>
</tr>
<tr>
<td>Healthy Connections — Informed Choices</td>
<td>Aetna</td>
</tr>
<tr>
<td>health and wellness program</td>
<td>151 Farmington Avenue</td>
</tr>
<tr>
<td></td>
<td>Hartford, CT 06156</td>
</tr>
<tr>
<td></td>
<td>Optum</td>
</tr>
<tr>
<td></td>
<td>6300 Olson Memorial Highway</td>
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<tr>
<td></td>
<td>Golden Valley, MN 55427</td>
</tr>
<tr>
<td>Life and AD&amp;D Insurance</td>
<td>Prudential Life Insurance Company</td>
</tr>
<tr>
<td></td>
<td>751 Broad Street</td>
</tr>
<tr>
<td></td>
<td>Newark, NJ 07102</td>
</tr>
<tr>
<td>Short-Term Disability</td>
<td>Aetna Disability and Absence Management (ADAM)</td>
</tr>
<tr>
<td></td>
<td>1601 SW 80th Terrace</td>
</tr>
<tr>
<td></td>
<td>Plantation, FL 33324</td>
</tr>
<tr>
<td>Solutions EAP and Work/Life Benefits</td>
<td>ValueOptions</td>
</tr>
<tr>
<td></td>
<td>1199 S. Beltline Road, Suite 100</td>
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<td>Coppell, TX 75019</td>
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<tr>
<td>Health Care and Child/Elder Care Spending Accounts</td>
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<tr>
<td></td>
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**Administrative Services Provided for the Plan (cont.)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider Information</th>
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<tbody>
<tr>
<td>Adoption assistance</td>
<td>UPS Adoption Assistance Program</td>
</tr>
<tr>
<td></td>
<td>United Parcel Service of America, Inc.</td>
</tr>
<tr>
<td></td>
<td>55 Glenlake Parkway, NE</td>
</tr>
<tr>
<td></td>
<td>Atlanta, GA 30328</td>
</tr>
<tr>
<td>Legal assistance</td>
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<td></td>
<td>1111 Superior Avenue</td>
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<tr>
<td></td>
<td>Cleveland, OH 44114</td>
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<tr>
<td>Personal lines insurance</td>
<td>Liberty Mutual Auto and Home</td>
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<tr>
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<td>175 Berkeley Street</td>
</tr>
<tr>
<td></td>
<td>Boston, MA 02117</td>
</tr>
<tr>
<td></td>
<td>Metropolitan Property and Casualty Insurance Company</td>
</tr>
<tr>
<td></td>
<td>c/o MetLife Voluntary Benefits Group Sales</td>
</tr>
<tr>
<td></td>
<td>10 South LaSalle Street, Suite 3350</td>
</tr>
<tr>
<td></td>
<td>Chicago, IL 60603</td>
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</table>

**General Information**

**UPS National Health Plan for Part-Time Employees**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
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<tbody>
<tr>
<td>Name of Plan</td>
<td>The UPS National Health Plan for Part-Time Employees</td>
</tr>
<tr>
<td>Plan Number</td>
<td>537</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 through December 31</td>
</tr>
<tr>
<td>Employer and Plan Sponsor</td>
<td>United Parcel Service of America, Inc.</td>
</tr>
<tr>
<td></td>
<td>55 Glenlake Parkway, N.E.</td>
</tr>
<tr>
<td></td>
<td>Atlanta, GA 30328</td>
</tr>
<tr>
<td></td>
<td>(404) 828-6044</td>
</tr>
<tr>
<td>Employer Identification Number (EIN)</td>
<td>95-1732075</td>
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<tr>
<td>Plan Administrator</td>
<td>UPS National Health Plan for Part-Time Employees</td>
</tr>
<tr>
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<td>United Parcel Service of America, Inc.</td>
</tr>
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<td></td>
<td>55 Glenlake Parkway, N.E.</td>
</tr>
<tr>
<td></td>
<td>Atlanta, GA 30328</td>
</tr>
</tbody>
</table>
ERISA and Other Important Information (cont.)

Your ERISA Rights

The UPS National Health Plan for Part-Time Employees is an employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA). As a participant in the 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 care 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 National Health Plan for Part-Time Employees does 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 Qualified Medical Child Support Order (QMCSO), 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 this Plan with the expectation that it will be continued indefinitely.

Nevertheless, UPS reserves the right to amend or terminate the 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 the Plan will reduce or eliminate benefits for claims incurred prior to the effective date of the amendment or termination.

**About This Book**

This book, as updated by any future summary of material modification, constitutes your Summary Plan Description (SPD) for the UPS National Health Plan for Part-Time Employees. In addition, this SPD, as the official Plan document, governs the Plan. UPS reserves the right to amend or terminate the Plan or any portion of the Plan at any time.
UPS National Health Plan for Part-Time Employees

Member Services

UPSers.com
www.UPSers.com
• The online link to all your benefits and more
My Life and Career tab

eHR
1-800-UPS-1508
• Toll-free phone access to all your benefits and vendors

Benefits Service Center
1-800-UPS-1508
• Enrollment
• Verify eligibility
• Add or remove dependents
• Request benefits material
• COBRA administration

Aetna
www.aetna.com
• Medical PPO 1-800-237-0575
• Medical Traditional Plan 1-800-237-0575
• Dental 1-877-263-0659
• Short-term disability 1-866-825-0186
• Spending Accounts 1-888-238-6226

BlueCross BlueShield
www.bcbsil.com/ups
• Medical PPO 1-800-516-1270

ValueOptions
www.achievesolutions.net/ups
• Behavioral health 1-800-336-9117
• Employee Assistance Program (EAP) 1-800-336-9117

Medco Health Solutions
www.medco.com
• Prescription drugs 1-800-346-1327

Vision Service Plan (VSP)
www.vsp.com
• Vision 1-800-877-7195

Prudential Insurance Company
• Life insurance and AD&D 1-877-877-2955
1-877-889-2070 (conversions only)

Healthy Connections — Informed Choices
www.upshealthyconnections-informedchoices.com
• Health coaches and condition management

Quit For Life
• Tobacco cessation program
1-866-QUIT-A-LIFE

Summary Plan Description

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ENROLLMENT KIT
You Have a Lot to Protect

UPS National Health Plan
for Part-Time Employees

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

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**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 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.

“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.*

<table>
<thead>
<tr>
<th>Years</th>
<th>Factor</th>
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<tbody>
<tr>
<td>10 yrs</td>
<td>8.1</td>
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<tr>
<td>15 yrs</td>
<td>11.1</td>
</tr>
<tr>
<td>20 yrs</td>
<td>13.6</td>
</tr>
<tr>
<td>25 yrs</td>
<td>15.6</td>
</tr>
<tr>
<td>30 yrs</td>
<td>17.3</td>
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<tr>
<td>35 yrs</td>
<td>18.7</td>
</tr>
<tr>
<td>40 yrs</td>
<td>20.0</td>
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</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Years</th>
<th>Factor</th>
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</thead>
<tbody>
<tr>
<td>5 yrs</td>
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<tr>
<td>10 yrs</td>
<td>.68</td>
</tr>
<tr>
<td>15 yrs</td>
<td>.56</td>
</tr>
<tr>
<td>20 yrs</td>
<td>.46</td>
</tr>
</tbody>
</table>

Child 1: $________________________ Child 2: $________________________
Child 3: $________________________ 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.

---

*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 National Health Plan
for Part-Time Employees

Supplemental Term Life Insurance

Supplemental Dependent Term Life Insurance

Supplemental Accidental Death & Dismemberment (AD&D) Insurance

Issued by The Prudential Insurance Company of America
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 National Health Plan for Part-Time Employees 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. Part-time employees: If you enroll within 45 days of your date of eligibility, your guaranteed coverage amount is up to $50,000.</td>
</tr>
<tr>
<td>Medical Evidence Requirements</td>
<td>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. <strong>You will be moved to the Prudential standard portability rate structure after one year and your rates will increase.</strong> 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 the UPS National Health Plan for Part-Time Employees 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: 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.
## 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 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 National Health Plan for Part-Time Employees or another UPS-sponsored plan that offers supplemental life insurance (for example, the Flexible Benefits Plan or UPS Health and Welfare Package), 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 National Health Plan for Part-Time Employees. 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 National Health Plan for Part-Time Employees 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 your 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 National Health Plan for Part-Time Employees coverage ends. You will 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 | Please refer to the UPS National Health Plan for Part-Time Employees Summary Plan Description for specific requirements regarding eligibility and when coverage begins. 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.*
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.

Eligibility to Participate
Please refer to the UPS National Health Plan for Part-Time Employees Summary Plan Description for specific eligibility requirements.

Coverage Amounts
You may enroll in increments of $1,000, up to a maximum of $1,000,000.

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.

*Minnesota Residents: Please see the Minnesota Insert for information on continuation and conversion.
Employee—Supplemental AD&D (continued)

## 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>Seat Belt Benefit</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>Air Bag Benefit</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>Rehabilitation Benefit</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>Brain Damage Benefit</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>Continuation of Medical Funding Benefit</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 National Health Plan for Part-Time Employees. 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>Emergency Medical Evacuation or Return of Remains Benefit</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>Termination of Coverage</td>
<td>Your Supplemental AD&amp;D coverage will end when your UPS National Health Plan for Part-Time Employees 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 National Health Plan for Part-Time Employees**

*Effective Date: January 1, 2013*

## Supplemental Term Life—Employee

<table>
<thead>
<tr>
<th>Age (As of January 1 of coverage year)</th>
<th>Annual Cost of Insurance (rates per $1,000 of coverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual Non-Smoker Rates</td>
</tr>
<tr>
<td>Under 30</td>
<td>$0.44</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.44</td>
</tr>
<tr>
<td>35–39</td>
<td>$0.56</td>
</tr>
<tr>
<td>40–44</td>
<td>$0.90</td>
</tr>
<tr>
<td>45–49</td>
<td>$1.58</td>
</tr>
<tr>
<td>50–54</td>
<td>$2.60</td>
</tr>
<tr>
<td>55–59</td>
<td>$4.52</td>
</tr>
<tr>
<td>60–64</td>
<td>$7.45</td>
</tr>
<tr>
<td>65–69</td>
<td>$12.88</td>
</tr>
<tr>
<td>70–74</td>
<td>$23.28</td>
</tr>
<tr>
<td>75–79</td>
<td>$38.42</td>
</tr>
<tr>
<td>80–84</td>
<td>$54.01</td>
</tr>
<tr>
<td>85–89</td>
<td>$77.75</td>
</tr>
<tr>
<td>90–94</td>
<td>$112.66</td>
</tr>
<tr>
<td>95+</td>
<td>$229.84</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

<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.
Rate Sheet
UPS National Health Plan for Part-Time Employees
Effective Date: January 1, 2013

Supplemental Dependent Term Life—
Spouse, Same-Sex Domestic Partner, or Civil Union Partner*

<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 is 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 National Health Plan for Part-Time Employees
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 National Health Plan for Part-Time Employees 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 the Supplemental Dependent Term Life coverage of your spouse, same-sex domestic partner, or civil union partner under the Group Contract at your expense if your UPS National Health Plan for Part-Time Employees 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 the Supplemental Dependent Term Life coverage of your spouse, same-sex domestic partner, or civil union partner by converting his/her 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 National Health Plan for Part-Time Employees 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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