Summary Plan Description

Summary Plan Description for UPS Retired Employees
<table>
<thead>
<tr>
<th>Event</th>
<th>Who to Call/What to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Emergency</td>
<td>Go to nearest emergency room. If you live in a network area, call your PCP within 48 hours.</td>
</tr>
<tr>
<td>Address Change</td>
<td>Call the Benefits Service Center at 1-800-UPS-1508 with your new address</td>
</tr>
<tr>
<td>Divorce/Legal Separation</td>
<td>Call the Benefits Service Center at 1-800-UPS-1508 to discontinue coverage for your spouse.</td>
</tr>
<tr>
<td>Traveling Overseas</td>
<td>Keep receipts of any medical care received. If you live in a network area, call your PCP within 48 hours of returning to the U.S. to receive in-network benefits.</td>
</tr>
<tr>
<td>Traveling Outside Network Area</td>
<td>Go to the nearest emergency room in an emergency. If you live in a network area, call your PCP within 48 hours to receive in-network benefits. If it is not an emergency, call your PCP to discuss treatment.</td>
</tr>
<tr>
<td>Death of a Covered Member</td>
<td>Call the Benefits Service Center at 1-800-UPS-1508 to change coverage.</td>
</tr>
<tr>
<td>Billing Inquiries</td>
<td>Call the Benefits Service Center at 1-800-UPS-1508.</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>Call Medicare at 1-800-MEDICARE (633-4227) or visit their website at <a href="http://www.medicare.gov">www.medicare.gov</a>.</td>
</tr>
</tbody>
</table>
Summary of Material Modifications
UPS Retired Employees' Health Care Plan
October 2016

This notice details plan improvements, changes, clarifications and required notifications effective January 1, 2017, unless otherwise noted below. You should keep this with your UPS Retired Employees' Health Care Plan Summary Plan Description ( SPD ) for reference. The terms of the plan are not changing and remain in full force and effect, except as specifically described in this summary.

Transgender Benefits
Effective January 1, 2017, services and treatments related to gender dysphoria and gender transition may be covered in accordance with the generally applicable terms of the plan (including but not limited to medical necessity and experimental and investigative).

HIPAA Privacy Notice
Your group health plan maintains a Notice of Privacy Practices that describes how the plan, and those that administer the plan, can and will use your protected health information ( PHI ). You receive a copy of the notice when you first enroll in the plan. You can request a copy of the notice by calling the UPS Benefits Service Center at 1-800-UPS-1508.
Summary of Material Modifications
UPS Retired Employees’ Health Care Plan
March 2016

Reasonable and Customary Charges
The following is a clarification of the definition of Reasonable and Customary Charges based on current Plan administration as of January 1, 2015.

When you use an out-of-network provider, the Plan pays its share of Reasonable and customary (R&C) charges. R&C charges are determined within the sole discretion of the Claims Administrator. R&C charges may, at the discretion of the Claims Administrator, be based on charges by healthcare providers with similar training and experience within the same geographical area where services are obtained; a percentage of Medicare reimbursement rates; a set fee schedule, or other methodology as determined to be applicable by the Claims Administrator consistent with the claims administrator’s standard practices with respect to such charges and/or providers. If a provider’s charges exceed R&C charges, you are responsible for that part of the charge that exceeds this limit. R&C charges apply to medical, behavioral health, dental and vision benefits. These charges do not count toward your deductible or out-of-pocket maximum.

If you take advantage of network benefits under a managed care component of the Plan, you will not be responsible for paying charges in excess of R&C amounts. That’s because network providers agree to charge a pre-determined fee for the services or care that they provide.

Prior to receiving services you should always confirm the network status of your providers, even if you are receiving services at an in-network facility.

Same-Sex Domestic Partner Coverage
Effective January 1, 2017 the Plan will no longer cover Same-Sex Domestic Partners and dependents who are eligible only as a condition of that relationship. Same-Sex Domestic Partners who were certified as eligible at the time of your retirement and who elect to marry before January 1, 2017 are eligible for plan coverage under the UPS Retired Employees’ Health Care Plan spouse eligibility rules. See the Summary Plan Description for more details on spouse eligibility.
Participants under Age 65

Traditional PPO Option
Effective January 1, 2016, the Traditional PPO option annual deductible for in-network and out-of-area services will increase to $300 individual and $600 family. The annual deductible for Out-of-Network services will increase to $600 individual and $1,200 family.

The Traditional PPO option annual Out-of-Pocket maximum for in-network and out-of-area services will increase to $2,500 individual and $5,000 family. The annual Out-of-Pocket maximum for Out-of-Network services will increase to $5,000 individual and $10,000 family.

Bariatric Surgery
Effective January 1, 2016, the Retired Employees’ Health Care Plan will only cover bariatric surgery on an in-network basis at a preferred facility designated by the claims administrator. Services are covered for in-network providers only. Services from out-of-network providers will not be covered.

Behavioral Health
ValueOptions, your mental health and substance use disorder administrator, has merged with Beacon Health Strategies to form Beacon Health Options. Only the name has changed. All benefits, provider networks, phone number and Web address remains the same.

Right of Recovery
For 2016, the Plan’s right of recovery and subrogation rights, as prescribed in the Right of Recovery section, will be modified as follows:

- The Plan’s reduction for attorney’s fees will continue as it is currently described in the SPD subject to the following revisions: (i) the reduction provided for in the plan is further limited to your attorney’s fees and (ii) the reduction set forth in the Plan will be conditioned on both your full cooperation with the Plan’s pursuit of reimbursement and not otherwise impeding or interfering with the Plan’s reimbursement right;
- The Plan has six (6) years from the date the Plan discovers that the covered individual has received a recovery or by the date otherwise set forth in applicable law, whichever is longer, to seek reimbursement in accordance with the terms of this Plan.

All Claims and Appeal Procedures
For clarification purposes, you must exhaust all internal claim and appeals described in the Plan before you can file suit in federal court. For example, if you fail to file a 2nd level appeal, the denial on the 1st level appeal will be final and binding and you will not be able to file suit in federal court.

Required Annual Notices

Minimum Essential Coverage
The medical plan coverage provided through the Plan constitutes minimum essential coverage for purposes of the individual mandate applicable to you beginning on January 1, 2016, as required by the Affordable Care Act (ACA).

Privacy Notice
Your group health plan maintains a Notice of Privacy Practices that describes how the plan, and those who administer the plan, can and will use your protected health information (PHI). You received a copy of the notice when you first enrolled in the plan. To obtain a copy of the notice, call the UPS Benefits Service Center at 1-800-UPS-1508.
Summary of Material Modifications
UPS Retired Employees’ Health Care Plan
September 2014

This notice details plan improvements, changes, clarifications and required notifications effective January 1, 2015, unless otherwise noted below. You should keep this with your UPS Retired Employees’ Health Care Plan Summary Plan Description (SPD) for reference. The terms of the plan are not changing and remain in full force and effect, except as specifically described in this summary.

Participants Under Age 65
Minimum Essential Coverage
The medical plan coverage provided through the Plan constitutes minimum essential coverage for purposes of the individual mandate applicable to you beginning on January 1, 2015, as required by the Affordable Care Act (ACA).

Privacy Notice
Your group health plan maintains a Notice of Privacy Practices that describes how the plan, and those who administer the plan, can and will use your protected health information (PHI). You received a copy of the notice when you first enrolled in the plan. To obtain a copy of the notice, call the UPS Benefits Service Center at 800-UPS-1508.

New Kaiser Georgia Healthy Savings Medical Option
For retirees and eligible dependents under age 65 who live in Georgia, the UPS Retired Employee’s Health Care Plan will provide a Kaiser Permanente Georgia Healthy Savings medical plan option, effective January 1, 2015. If you live in a Kaiser Georgia area, you will receive benefit information describing this option.

The Kaiser Georgia option provides coverage only within its own network. There is no out-of-network benefit. Note that medical, behavioral health and prescription drug benefits are provided by Kaiser Georgia, not by the other claims administrators described in the Summary Plan Description.

Except for an emergency, coverage is available only if you or your eligible dependents receive care through Kaiser Georgia network providers and facilities. This applies to eligible dependents who live outside the Kaiser Georgia network area (for example, those attending college outside of the network area). If emergency care is provided out of the network, Kaiser Georgia usually limits follow-up care benefits outside the network area.

Please refer to the Kaiser Georgia option materials furnished to you to learn about coverage.

If you have questions regarding the Kaiser Georgia option, call Kaiser member services at 404-261-2590.

Prescription Drug Benefits
The plan has adopted the CVS/Caremark (prescription claims administrator’s) standard formulary and compound exclusion list. Drugs determined as excluded and non-formulary, or compound ingredients excluded by CVS/Caremark, are not covered by the plan. Preferred and non-preferred drugs will continue to be paid accordingly. If you have questions about prescription drug coverage, call CVS/Caremark at 855-282-8412.

Participants Age 65 or Older
Retiree Reimbursement Account (RRA)
The maximum allocation of your Retiree Reimbursement Account (RRA) for 2015 is $2,157. If your defined dollar benefit (DDB) credits are less than $2,157, the amount in your RRA will equal the amount of DDB credits you earned.
Summary of Material Modifications
UPS Retired Employees’ Health Care Plan
October 2013

This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2014, unless otherwise noted below. You should keep this with your UPS Retired Employees’ Health Care Plan Summary Plan Description (SPD) 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.

Medical (Participants Under Age 65)
Effective January 1, 2014, the following changes will be made to the UPS Retired Employees’ Health Care Plan (REHCP):

Long-Term Disability (LTD) Participants
If you die while covered under the REHCP and you were eligible for the plan due solely to your receipt of LTD benefits under The Flexible Benefits Plan, coverage for your surviving, covered dependents will continue under the Plan on the same terms and conditions for 18 months following your date of death. At the end of the 18-month period, your surviving spouse or dependents will lose coverage; however, your surviving dependents will be able to elect COBRA continuation coverage for up to an additional 18 months.

However, if, at the time of your death, you also satisfied the requirements to participate in the Plan as a retiree, then your surviving, covered dependents will continue to be eligible for coverage under the REHCP as if you were participating in the Plan as a retiree and as long as they continue to meet the dependent eligibility requirements as described in the REHCP SPD.

Generally, you cannot add new dependents to coverage unless they were eligible at the time of your retirement, or you became eligible for LTD. In addition, you can defer your UPS coverage if you are eligible for the Plan as an LTD participant or as a retiree if you can show proof of other coverage. Contact the Benefits Service Center at 1-800-UPS-1508 for detailed information.

Filing a Claim
Claims filed under fraudulent pretenses (including any portion of the expense that is otherwise a covered expense) will not be covered under the Plan.

In addition, Plan coverage for you or your dependent may be terminated if you or your dependent submits, directly or through a provider, a fraudulent, misrepresented or altered claim. Plan coverage may also be terminated if:

- You or your dependent allows another party not covered under the Plan to use your coverage or your dependent’s coverage,
- You knowingly enroll an ineligible dependent in the Plan, or
- You do not remove an ineligible dependent from coverage.

Eligibility: Qualified Medical Child Support Order
If you wish to submit a medical child support order or to request a copy of the Plan’s policies and procedures for determining whether an order is “qualified” in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), please note the address has been changed to the following:

UPS Benefits Service Center
Attention: Qualified Order Team
PO Box 1542
Lincolnshire IL 60069-1542
Summary of Material Modifications
UPS Retired Employees’ Health Care Plan
October 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 Retired Employees’ Health Care Plan 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.

Pre-1993 Retirees
If you are a pre-1993 retiree, only the Prescription Drug Benefits (Under Age 65 Only) section below applies to you.

Preventive Medical Care Guidelines
The chart below replaces the current one in your Summary Plan Description. As an improvement to the guidelines, routine physicals are covered once every year for participants age 7 up to age 50, instead of every other year.

Guidelines for Children

<table>
<thead>
<tr>
<th>Age</th>
<th>Birth up to Age 1</th>
<th>Age 1 up to Age 3</th>
<th>Age 3 up to Age 7</th>
<th>Age 7 up to Age 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>7 well child</td>
<td>3 well child</td>
<td>1 well child</td>
<td>1 routine physical</td>
</tr>
<tr>
<td>Frequency</td>
<td>Every year</td>
<td>Every year</td>
<td>Every year</td>
<td>Every year</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Per current guidelines</td>
<td>Per current guidelines</td>
<td>Per current guidelines</td>
<td>Per current guidelines</td>
</tr>
</tbody>
</table>
| Tests          | • Hemoglobin and Hematocrit  
|                | • Tuberculin skin test  
|                | • PKU                 |
|                | • Hemoglobin and Hematocrit  
|                | • Tuberculin skin test  |
|                | • Hemoglobin and Hematocrit  
|                | • Tuberculin skin test  
|                | • Hearing screening     |

Females only

<table>
<thead>
<tr>
<th>Age</th>
<th>Birth up to Age 1</th>
<th>Age 1 up to Age 3</th>
<th>Age 3 up to Age 7</th>
<th>Age 7 up to Age 20</th>
</tr>
</thead>
</table>
|                | N/A               | N/A               | N/A               | • Gyn. exam every year 18 and older  
|                |                   |                   |                   | • Pap smear         
|                |                   |                   |                   | • Breast exam       |

Males only

<table>
<thead>
<tr>
<th>Age</th>
<th>Birth up to Age 1</th>
<th>Age 1 up to Age 3</th>
<th>Age 3 up to Age 7</th>
<th>Age 7 up to Age 20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>• Testicular exam</td>
</tr>
</tbody>
</table>

Guidelines for Adults

<table>
<thead>
<tr>
<th>Age</th>
<th>Age 20 up to Age 30</th>
<th>Age 30 up to Age 40</th>
<th>Age 40 up to Age 50</th>
<th>Age 50 to Age 64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>1 routine physical</td>
<td>1 routine physical</td>
<td>1 routine physical</td>
<td>1 routine physical</td>
</tr>
<tr>
<td>Frequency</td>
<td>Every year</td>
<td>Every year</td>
<td>Every year</td>
<td>Every year</td>
</tr>
<tr>
<td>Immunizations</td>
<td>• DPT</td>
<td>• DPT</td>
<td>• DPT</td>
<td>• DPT</td>
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<tr>
<td></td>
<td>• MMR</td>
<td>• MMR</td>
<td>• MMR</td>
<td>• MMR</td>
</tr>
<tr>
<td>Tests</td>
<td>• CBC</td>
<td>• CBC</td>
<td>• CBC</td>
<td>• CBC</td>
</tr>
<tr>
<td></td>
<td>• Occult blood</td>
<td></td>
<td></td>
<td>• Occult blood</td>
</tr>
</tbody>
</table>

Females only

<table>
<thead>
<tr>
<th>Age</th>
<th>Age 20 up to Age 30</th>
<th>Age 30 up to Age 40</th>
<th>Age 40 up to Age 50</th>
<th>Age 50 to Age 64</th>
</tr>
</thead>
</table>
|                | • Gyn. exam every year 18 and older  
|                | • Pap smear         
|                | • Breast exam       |
|                | • Gyn. exam every year 18 and older  
|                | • Pap smear         
|                | • Breast exam       |
|                | • Gyn. exam every year 18 and older  
|                | • Pap smear         
|                | • Breast exam       |

Males only

<table>
<thead>
<tr>
<th>Age</th>
<th>Age 20 up to Age 30</th>
<th>Age 30 up to Age 40</th>
<th>Age 40 up to Age 50</th>
<th>Age 50 to Age 64</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Testicular exam</td>
<td>• Testicular exam</td>
<td>• Testicular exam</td>
<td>• Testicular exam</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• PSA</td>
<td>• PSA</td>
</tr>
</tbody>
</table>
Medical Benefits
All services performed or directed by a licensed chiropractor are covered at the applicable deductible and/or coinsurance level. Chiropractor visits, including office visits, manipulation(s), physical therapy and/or other related services, are limited to 40 visits per calendar year. Medical necessity review is not required. Services are covered for in-network providers only. Services from out-of-network chiropractic providers will not be covered.

Health Maintenance Organization (HMO) Option for California and Hawaii Retirees
For retirees who live in certain areas of California or Hawaii only, The UPS Retired Employees’ Health Care Plan provides a Kaiser Permanente HMO option in addition to the other medical options, beginning in 2013.

If you live within one of these HMO service areas, you will receive benefit information describing this additional option.

Note that medical, behavioral health and prescription drug benefits are provided by the Kaiser HMO, not by the other claims administrators described in your Summary Plan Description. Refer to your HMO materials for complete details.

Prescription Drug Benefits (Under Age 65 Only)
CVS Caremark will replace Express Scripts/Medco as the new prescription drug benefits administrator for The UPS Retired Employees’ Health Care Plan. Your prescription drug benefits under the Plan are not changing.

If you have questions about your prescription drug benefits, you should call Express Scripts/Medco at 1-800-346-1327 through December 31, 2012.

Beginning January 1, 2013, contact CVS Caremark directly by phone at 1-855-282-8412, or online at www.caremark.com.

Filing a Claim with Caremark
Effective January 1, 2013, prescriptions for maintenance or long-term medications may be purchased either from a CVS/pharmacy retail store, or mailed to:

CVS Caremark
P.O. Box 94467
Palatine, IL 60094-4467

The mail order benefit levels apply regardless of whether the maintenance prescription is filled at a CVS/pharmacy or by mail from CVS Caremark.

First-level appeals for claims administered by CVS Caremark should be mailed to:
CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Plan Administration
Effective January 1, 2013, prescription drug benefits are administered by:
CVS Caremark
One CVS Drive
Woonsocket, RI 02895

Health Savings Account (HSA)
The maximum allowable annual contribution to the HSA in 2013 will be $3,250 for individual coverage or $6,450 for family coverage.

In 2013, the maximum allowable HSA catch-up contribution for individuals age 55 and older remains at an additional $1,000 per year.

Filing a Medical Claim
The following language is a clarification of current Plan administration.

Any reimbursement checks that are not cashed within 12 months from the date of the check are void, and you lose any rights to such reimbursement.

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)
This notice is intended to fulfill UPS’s legal obligation to notify employees of material changes to The UPS Retired Employees’ Health Care Plan. This notice formally amends the coverage available under the Plan.

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1. Healthcare Facilities Accreditation Program (HFAP)
2. Accreditation for Ambulatory Health Care (AAHC)
3. Det Norske Veritas (DNV)
4. 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.

**Split-Family Coverage**

A covered individual who is under age 65 is still eligible for the benefits provided to those under age 65 even though a covered family member (in other words, the retiree or spouse) has turned age 65 and is no longer eligible for benefits provided to those under age 65. The participant(s) under age 65 will receive new health care ID cards upon eligibility for split-family coverage.

The retiree’s eligible credits (if any) will be applied to a retiree reimbursement account (RRA) for the individual who is age 65 or older and will be used to offset premiums for the coverage under the UPS Plan for the individual who is under age 65. In addition to the premium, the RRA can be used for eligible out-of-pocket expenses, such as deductibles, coinsurance and copays. For more information about your credits, contact the Benefits Service Center at 1-800-UPS-1508.

**Long-Term Care**

In November 2010, MetLife made the decision to discontinue offering the long-term care insurance (LTC) product to new entrants after December 31, 2012.

If you would like to enroll in the MetLife LTC program before the deadline, you must contact MetLife at 1-888-526-8495 to request an enrollment application no later than December 3, 2012. Your application must be received—not postmarked—by MetLife no later than January 2, 2013. This will allow ample time for you to complete and return your application.

If you currently have LTC, or choose to purchase it by the deadlines above, your coverage is guaranteed renewable by MetLife as long as you continue making premium payments. MetLife will ensure that you continue to receive the same high level of service that you have come to expect.

LTC is subject to rate increases as determined by MetLife. It is not a UPS-administered health care plan and is only available as a voluntary benefit offering. You must contact MetLife with questions about rate increases or wait for additional information from MetLife during the first quarter of 2013.

The LTC benefits are offered pursuant to insurance certificates/documents issued by MetLife. If there is any conflict between the insurance certificates/documents and the information contained in the UPS Retired Employees’ Health Care Plan Summary Plan Description (including this SMM), the certificates/insurance documents control.

For more information on LTC, contact MetLife at 1-800-GET-MET8, or visit MetLife’s website at www.metlife.com/mybenefits.

**Retiree Reimbursement Account (Age 65 and Older Only)**

The amount contributed to your RRA each year is determined by UPS, which reserves the right to change the details of your RRA at any time. The amount in your RRA is the lesser of your Defined Dollar Benefit (DDB) credit earned in the UPS Retirement Plan or the maximum subsidy set by UPS each year.

You will receive an annual RRA notification of the amount credited to your RRA account.
Participants Under Age 65

Medical

Effective January 1, 2012, the following changes will be made to the UPS Retired Employees’ Health Care Plan (REHCP) for participants under age 65.

Two medical options will now be offered under the UPS REHCP: the Traditional PPO option (previously known as Network Plus) and the Healthy Savings PPO option.

The provisions of the Traditional PPO option have not changed; they are highlighted in this SMM to show how the Traditional PPO option differs from the new Healthy Savings PPO option.

Medical Coverage Levels

The benefits under each option will be paid according to the chart shown below. Although not included on this chart, both options provide out-of-network benefits. A complete list of benefits can be found in the UPS Retired Employees’ Health Care Plan Summary Plan Description (SPD). The 2012 revision of the SPD will be available during the first quarter of 2012.

<table>
<thead>
<tr>
<th></th>
<th>Traditional PPO</th>
<th>Health Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network†</td>
<td>Out-of-Network††</td>
</tr>
<tr>
<td>(Single/Family)</td>
<td>(Single/Family)</td>
<td>(Single/Family)</td>
</tr>
<tr>
<td>Annual deductible</td>
<td>$250/$500</td>
<td>$500/$1,000</td>
</tr>
<tr>
<td>Annual out-of-pocket maximum</td>
<td>$2,000/$4,000</td>
<td>$4,000/$8,000</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>$1 Million</td>
<td>$1 Million</td>
</tr>
<tr>
<td>Preventive care</td>
<td>100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office visit</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Emergency room</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Hospital inpatient</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Surgery</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Urgent care clinic visit</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Mental health &amp; substance abuse – Inpatient or outpatient</td>
<td>85%</td>
<td>65%</td>
</tr>
</tbody>
</table>

† If you live outside the network area, you will receive the in-network level of benefit—even if the provider you receive services from is not in the Plan’s network.

†† Under both the Traditional and the Healthy Savings options, all out-of-network and out-of-area medically necessary services are subject to reasonable and customary (R&C) limits.
**Traditional PPO**  
In the Traditional PPO option:

- In-network preventive care, which includes physicals and screenings, is covered at 100 percent—even before you’ve met your deductible. Examples include routine physicals, routine OB/GYN exams, routine mammograms, and well-child care, based on the plan’s guidelines for your age and gender. However, preventive care received from out-of-network providers is not covered.

- If you have coverage for:
  - yourself only, the single deductible and out-of-pocket maximum apply to you.
  - yourself and at least one other family member, both single and family deductibles and out-of-pocket maximums apply to your coverage. That means that, when you or anyone you cover meets the single deductible, he or she receives benefits for eligible expenses at the applicable coinsurance level for the rest of the plan year. And if the family deductible is met by two or more covered members of your family, all covered family members receive benefits at the applicable coinsurance level.

- You are not required to meet the medical deductible before prescription drug benefits are paid at the applicable coinsurance level.

- The in-network deductibles and out-of-pocket maximums do not apply to the out-of-network deductible and out-of-pocket maximums, and vice-versa.

- Once the out-of-pocket maximum is met, covered medical services are paid at 100 percent (subject to any additional limitations imposed by the Plan, such as reasonable and customary charges).

**Healthy Savings PPO**  
In the Healthy Savings PPO option:

- In-network preventive care, which includes physicals and screenings, is covered at 100 percent—even before you’ve met your deductible. Examples include routine physicals, routine OB/GYN exams, routine mammograms, and well-child care, based on the plan’s guidelines for your age and gender. However, preventive care received from out-of-network providers is not covered. “Preventive care” expenses that are eligible for benefits prior to satisfaction of the deductible will be determined in accordance with IRS guidelines and principles.

- If you have coverage for:
  - yourself only, the single deductible and out-of-pocket maximum apply to you.
  - yourself and at least one other family member, the single deductible and out-of-pocket maximum do not apply to your coverage. Instead, the family deductible must be met before any benefits are paid for any covered member of the family, at the applicable coinsurance level for that service.

- You are required to meet the medical deductible before prescription drug benefits are paid at the coinsurance level.

- The in-network deductibles and out-of-pocket maximums do not apply to the out-of-network deductible and out-of-pocket maximums, and vice-versa.

- If you have coverage for only yourself, once the single out-of-pocket maximum is met, covered medical services are paid at 100 percent (subject to any additional limitations imposed by the Plan, such as reasonable and customary charges).

- If you have coverage for yourself and at least one other dependent, once the family out-of-pocket maximum is met, covered medical services are paid at 100 percent (subject to any additional limitations imposed by the Plan, such as reasonable and customary charges).

A unique feature of the Healthy Savings PPO option is the opportunity to contribute to a health savings account (HSA) that helps you save and pay for out-of-pocket medical, dental, and vision expenses such as deductibles and coinsurance. The money you contribute to your account will carry over from year to year, allowing you to save for future health care expenses. This account belongs to you – not UPS. For more
information, contact UPS’s preferred vendor, OptumHealth Bank, at 1-866-234-8913, or visit their Web site at www.optumhealthbank.com.

Except as described above, the Healthy Savings PPO is subject to the same terms and conditions (for example, “medically necessary”, “reasonable and customary”, exclusions, etc.) as the Traditional PPO.

**Retiree Health Access (RHA) for Retirees Under Age 65**
The Retiree Health Access program will no longer be available effective January 1, 2012. If you or your spouse elected medical coverage under a RHA plan, your RHA coverage will end on December 31, 2011. If you do not elect one of the other options available under the UPS REHCP during your annual enrollment period, you will be enrolled by default in the Healthy Savings PPO.

Any claims for RHA premium reimbursement from your Retiree Reimbursement Account for the 2011 calendar must be received by the Aetna Retiree Reimbursement Account (RRA) before March 31, 2012. Any claims received after this date will be denied by the Plan.

**Participants Age 65 and Over**

**UPS REHCP Coverage is Changing for Retirees Age 65 and Over**
Effective January 1, 2012, UPS will no longer offer medical coverage to retirees and/or dependents who are age 65 and over and Medicare-eligible other than through the RRA (see below for a description of the RRA). If you and/or your spouse elected medical coverage under the UPS REHCP, your coverage under that plan will end on December 31, 2011. Under the REHCP, you will have an RRA into which you will be credited an amount that you may use for reimbursement of certain insurance premiums and other expenses. See “New Medicare Coordinator Model” for details regarding individually owned policies.

Note: Special rules apply if you become entitled to Medicare prior to turning age 65 due to end stage renal disease; in that case, you will continue to receive the same coverage available to retirees under age 65 through the end of the applicable Medicare coordination period.

**RHA No Longer Available to Retirees Age 65 and Over**
The Retiree Health Access (RHA) program will no longer be available for retirees age 65 and over and Medicare-eligible as of December 31, 2011. If you or and/or your spouse elected medical and/or Medicare Part D prescription drug coverage under a RHA plan, your coverage under that plan will end on December 31, 2011.

**New Medicare Coordinator Model**
Effective January 1, 2012, for UPS retirees and their dependents who are age 65 and over and Medicare-eligible, UPS is moving from providing a group medical plan to providing access to individual Medicare supplemental medical plans through Aon Hewitt Navigators Insurance Services, Inc. Under the new program, you may choose to select individually-owned coverage through a Medicare Supplement, Medicare Advantage, and/or a Medicare Prescription Drug plan (known as “eligible Medicare policies”). For more information, contact Aon Hewitt Navigators at 1-800-505-8515 or visit their Web site at www.aonhewittnavigators.com/ups.

Enrolling in a plan through Aon Hewitt Navigators is optional. You may purchase an individual plan directly from an insurance carrier and still receive reimbursement from your RRA. However, the advisor and advocacy services provided by Aon Hewitt Navigators will not be available to you. To receive reimbursement from your RRA, you will have to file your own claims to the RRA. You will receive detailed instructions about the reimbursement process through Aon Hewitt in your enrollment material. If you have immediate questions about the reimbursement process, please contact Aon Hewitt at 1-800-505-8515.

Whichever policy you choose, it is owned by you. UPS does not sponsor or maintain policies on the individual Medicare market.
Retiree Reimbursement Account (RRA)
Regardless of whether you select individual coverage through Aon Hewitt Navigators or a plan outside of Aon Hewitt Navigators, you are eligible to receive funds allocated to your Retiree Reimbursement Account (RRA). Your RRA can be used for reimbursement of eligible premiums for Medicare Supplement, Medicare Advantage, and/or Medicare Part D prescription drug plan coverage. In addition, your RRA can be used to reimburse you for eligible out-of-pocket medical care expenses, as defined by Internal Code Section 213(d), such as deductibles, coinsurance and copayments.

Note: Certain insurance premium expenses that otherwise qualify as “medical care” are not eligible for reimbursement, such as dental and/or vision insurance premiums, and premiums for health insurance policies (other than the premium for an eligible Medicare Policy). Also, qualified long-term care expenses are not eligible for reimbursement.

The maximum allocation to your Retiree Reimbursement Account (RRA) for 2012 will be $1,974. If your Defined Dollar Benefit (DDB) credits are less than $1,974, the amount allocated to your RRA will equal your DDB credits. Your eligible spouse (in other words, a spouse age 65 or older and Medicare-eligible) will receive an amount equal to yours, allocated to your RRA. The amounts allocated on your behalf and your eligible spouse’s behalf will be available to for use by both the retiree and the spouse. See the UPS Retirement Plan Summary Plan Description for an explanation of your DDB credits.

If you do not enroll in a plan through Aon Hewitt, you must file claims directly with the RRA claims administrator to receive reimbursement for your premiums.

The claims administrator for the RRA will change from Aetna to Aon Hewitt, effective January 1, 2012. Any claims for premium reimbursement for the 2011 calendar year must be received by the Aetna Retiree Reimbursement Account (RRA) before March 31, 2012. Any claims for 2011 expenses that are received after this date will be denied by the Plan. You will receive detailed instructions about the reimbursement process through Aon Hewitt in your enrollment material. For immediate questions about the reimbursement process, please contact Aon Hewitt at 1-800-505-8515.

All Participants

Plan Amendment or Termination
UPS has established this Plan with the expectation that it will continue indefinitely. Nevertheless, UPS reserves the right to amend or terminate the Plan at any time by written resolution of the Board of Directors (or their authorized designee) which is duly accepted. No amendment or termination of this Plan will reduce or eliminate benefits for claims incurred prior to the effective date of the amendment or termination.

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

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

Coverage is subject to the same deductible and coinsurance provisions, as well as other limitations and exclusions, that are 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.
Summary of Material Modifications  
UPS Retired Employees’ Health Care Plan  
October 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 Retired Employees’ Health Care Plan Summary Plan Description for future reference. Items marked with an asterisk (*) do not apply to COBRA participants.

**Medicare Part D Premium Reimbursement**  
If you or your spouse is eligible for reimbursement of your Medicare Part D prescription drug plan (PDP) premium through a Retiree Reimbursement Account (RRA), the 2011 maximum reimbursement for Medicare Part D is $529.

**Retiree Health Access (RHA)**  
RHA is a program that offers additional options alongside Network Plus coverage. There are changes to the options available effective January 1, 2011. Be sure to review the information you will receive from RHA if you are currently enrolled in an RHA option.

**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.

**Precertification Requirements**  
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 inpatient or 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.

**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.

**Long-Term Care Insurance**  
Long-term care insurance rates increased effective August 1, 2010. This rate increase applies only to new applicants. If you enrolled in the long-term care insurance under the Plan prior to August 1, 2010, your rates will remain the same. Refer to your rate sheet from MetLife for more information.

**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.
Summary of Material Modifications
UPS Retired Employees' Health Care Plan
December 2009

Each year, we announce material changes to the Retired Employees’ Health Care Plan. This notice details improvements, changes, clarifications, and required notifications effective January 1, 2010. You should keep this with your UPS Retired Employees’ Health Care Plan Summary Plan Description for future reference.

**Long-Term Disability**

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

**LTD Claims On or Before December 18, 2009**

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

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

**LTD Claims Incurred in 2009 and Reported On or After December 19, 2009**

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

**LTD Appeals Rights and Procedures**

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

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

The appeal process will continue to be a two-level process, but will be handled by MetLife instead of UPS. The first level of appeal must be filed within 180 days from the receipt of the denial. If the first-level appeal is denied, you have a right to a second-level appeal. The second-level appeal must be filed within 60 days of receipt of the first-level denial.

Please include in your appeal letter the reason(s) you believe the claim was improperly denied and submit any additional comments, documents, records or other information (including medical documentation, test results, x-rays, etc.) relating to your claim that you deem appropriate. You have the right, upon request, to receive a copy of the documents, records, or other information MetLife has that are relevant to your claim. These documents may include any provided by medical or vocational expert(s) whose advice was obtained in connection with your claim.

**LTD Claims Incurred On or After January 1, 2010**

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

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with respect to long-term disability benefit claims. If your claim for an insured benefit is denied under the Plan, you should refer to the applicable policy or Certificate of Coverage which will be provided by MetLife, or contact MetLife at 1-877-638-4877 for more information on the applicable claims and appeals procedures.

If you choose to appeal an insured claim, you must do so by sending a written request for appeal directly to MetLife at:

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

Plan Administration
Effective January 1, 2010, the long-term disability benefits claims administrator for the claims identified above is:

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
Summary of Material Modifications
UPS Retired Employees’ Health Care Plan
October 2009

Each year, we announce material changes to the Retired Employees’ Health Care Plan. This notice details improvements, changes, clarifications, and required notifications effective January 1, 2010. You should keep this with your UPS Retired Employees’ Health Care Plan Summary Plan Description for future reference. Items marked with an asterisk (*) do not apply to COBRA participants.

Network Plus Medical and Mental Health Benefits
Medical and mental health coverage levels are changing if you are under age 65 and enrolled in the Network Plus option. A deductible will be applied to all benefits not related to preventive medical care. Once the annual deductible has been met, benefits are paid at the coinsurance level indicated below. This chart is a summary of coverage and not an all-inclusive list of covered benefits.

<table>
<thead>
<tr>
<th>2010 Network Plus</th>
<th>In-Network (Single/Family)</th>
<th>Out-of-Network† (Single/Family)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
<td>$250 / $500</td>
<td>$500 / $1,000</td>
</tr>
<tr>
<td>Annual out-of-pocket maximum</td>
<td>$2,000 / $4,000</td>
<td>$4,000 / $8,000</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>$1 Million</td>
<td></td>
</tr>
<tr>
<td>Preventive medical care</td>
<td>100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office visit (PCP or specialist)</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Emergency room</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Hospital inpatient</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Surgery</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Mental health &amp; substance abuse – inpatient or outpatient</td>
<td>85%</td>
<td>65%</td>
</tr>
</tbody>
</table>

† All medically necessary covered services from out-of-network providers are subject to reasonable and customary (R&C) limits.

Lifetime Maximum
The lifetime maximum benefit accumulation will be reset to $0 on January 1, 2010, for all participants in the Retired Employees’ Health Care Plan.

In addition, your prescription drug benefits, along with medical and mental health benefits, will be included in the lifetime maximum if you are under age 65.

Prescription Drug Benefits
Your prescription drug coverage levels are changing only if:
• You are enrolled in the Network Plus option and are under age 65, or
• You are enrolled in the Traditional (indemnity) option, you are under age 65 and the employee’s retirement date was 1993 to 1995.

Your plan will have three levels of benefits, as shown in the table below.

<table>
<thead>
<tr>
<th>Benefit Level</th>
<th>Plan Pays</th>
<th>Retail Per-Script Min/Max</th>
<th>Mail Per-Script Min/Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generics</td>
<td>80%</td>
<td>$5 / $100</td>
<td>$10 / $200</td>
</tr>
<tr>
<td>Preferred brands</td>
<td>80%</td>
<td>$25 / $150</td>
<td>$50 / $300</td>
</tr>
<tr>
<td>Non-preferred brands and non-sedating antihistamines</td>
<td>50%</td>
<td>$50 / $300</td>
<td>$100 / $600</td>
</tr>
</tbody>
</table>

Meeting your medical deductible is not required for prescription drug benefits to be paid at the coinsurance level indicated. A minimum and maximum out-of-pocket expense applies to each prescription.

If you choose to purchase a brand-name drug when a generic is available, you will continue to be responsible for paying the difference between the brand and generic drug costs. This difference is not included in the per-script or out-of-pocket maximum.

The highest benefit is paid for generic drugs, followed by brand-name drugs included on the preferred brand drug list, called a “formulary”. The lowest level of benefits is paid for brand-name drugs that are not included on the preferred brand drug list.

Most non-preferred drugs require prior authorization. If required, no benefit is paid when prior authorization is not received for non-preferred brand name drugs.

UPS has designated Medco’s specialty care pharmacy, Accredo Health Group, as their preferred provider for specialty medications. Specialty medications not purchased from Accredo Health Group will not be covered under this plan. Specialty medications are typically injectable medications administered either by you or a health care professional, and they often require special handling. If your physician prescribes an injectable drug, a drug that requires infusion or a drug that
requires special handling, contact Accredo Health Group at 1-800-803-2523 for more specific information.

**Medicare Part D Premium Reimbursement**

If you or your spouse is eligible for reimbursement of your Medicare Part D prescription drug plan (PDP) premium through a Retiree Reimbursement Account (RRA), the 2010 maximum reimbursement for Medicare Part D is $515.

**Mental Health and Substance Abuse 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 before you seek any mental health or substance abuse treatment. In addition, you should periodically check the Summary Plan Description (SPD) for any specific changes made pursuant to the new law.

If you participate in the Network Plus option (and are under age 65 and not covered by Medicare), ValueOptions must always preauthorize 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)
- All outpatient treatment after the initial 10 visits. This requirement 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

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.

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

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

In compliance with the Parity legislation, eligible mental health and substance abuse benefits will be covered at the same level as any other covered medical expense. Participants in the Network Plus medical option who are under age 65 should see the Network Plus Medical and Mental Health Benefits section of this Summary of Material Modifications for details. All others should refer to the Hospital Services section of your Retired Employees’ Health Care Plan SPD for medical coverage levels.

**Over-the-Counter Drugs Not Covered**

As a clarification of current Plan administration, the Retired Employees Health Care Plan does not provide coverage for non-prescription, over-the-counter medications, with the exception of diabetic supplies with a prescription.

**Eligibility: Long-Term Disability Benefits Recipients**

As clarification of current Plan administration, you are eligible to participate in the Plan if you are receiving long-term disability (LTD) benefits provided under the Flexible Benefits Plan and your employment with UPS has been administratively terminated.

**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 cover under the Plan. This condition allows UPS to comply with a new 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. Refer to the Right of Recovery
section of your 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 your family status and/or medical option. If you opted out of coverage, you may start coverage.

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

You must call the UPS Benefits Service Center at 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 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.

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

- **Legal**
  Hyatt Legal Plans
  1111 Superior Avenue
  Cleveland, OH 44114

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

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

- **Prescription Drug**
  Medco Health Solutions
  100 Parsons Pond Drive
  Fairlawn, NJ 07410
This notice is intended to fulfill UPS’s legal obligation to notify employees of material changes to the UPS Retired Employees’ Health Care Plan. This notice formally amends the coverage available under the Plan.

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Summary of Material Modifications
UPS Retired Employees’ Health Care Plan
October 2008

This notice details UPS Retired Employees’ Health Care Plan improvements, changes, clarifications, and required notifications effective January 1, 2009, unless otherwise noted. Items marked with an asterisk (*) do not apply to COBRA participants. You should keep this with your UPS Retired Employees’ Health Care Plan Summary Plan Description for future reference.

Medical Networks
The point of service options under the Plan are being replaced by preferred provider organization (PPO) networks. If you participate in a PPO network, you and your family may seek care from any physician, hospital, or other medical provider—regardless of whether that provider participates in the network. However, your benefit is greater when using in-network providers. In a PPO network, it is not necessary to obtain a referral from your primary care physician (PCP) to visit a specialist. In addition, participants in a PPO network are not required to select a PCP.

Medical Vendors
The medical networks for the UPS Retired Employees’ Health Care Plan are being changed to Aetna and UnitedHealthcare. Refer to your 2009 annual enrollment information for details of this change and the medical vendor who will administer your benefits.

If you were previously enrolled in the Traditional Plan or the Network Plus Indemnity option now administered by Aetna, your benefits will be administered by either UnitedHealthcare or Aetna effective January 1, 2009, depending on which of these carriers UPS has selected for the state in which you live. Please note: Because of the change in medical networks, you may live in a network area starting in 2009.

Medicare Part D Premium Reimbursement*
If you or your spouse is eligible for reimbursement of your Medicare Part D prescription drug plan (PDP) premium through a Retiree Reimbursement Account (RRA), the 2009 maximum reimbursement for Medicare Part D is $473.

Routine Physical Evaluations
The Plan guidelines have changed to allow one physical evaluation every 24 months for adults age 20 through age 49.

Streamlined claims submission for RRA*
If you receive medical and/or prescription drug benefits through an RHA health plan, you are no longer required to submit claim forms to your Retiree Reimbursement Account (RRA), administered by Aetna, to be reimbursed for your paid RHA premiums. RHA will notify Aetna monthly of paid RHA premiums, and Aetna will automatically reimburse you from funds in your RRA account, up to the amount available in your account.

If you elect a Medicare Part D prescription drug plan from the individual market, you are still eligible for reimbursement from your RRA; however, you must continue to submit a claim form for reimbursement.

Same-Sex Partner Eligibility*
As a clarification of current Plan administration, in order for your same-sex partner and his or her eligible dependents to be eligible for coverage under the UPS Retired Employees’ Health Care Plan, 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.

Please note: This opportunity does not remove the eligibility requirement in the UPS Retired Employees’ Health Care Plan that your eligible dependents must be eligible at the time of your retirement.
Summary of Material Modifications
Retired Employees’ Health Care Plan
October 2007

Each year we announce material changes to the Retired Employees’ Health Care Plan. This notice details Plan improvements, changes, clarifications, and required notifications effective January 1, 2008. Keep this with your Retired Employees’ Health Care Plan (REHCP) Summary Plan Description (SPD) for future reference. Items noted with an asterisk (*) do not apply to COBRA participants.

Group Legal Plan*
The Signature LegalCare legal assistance plan will be replaced by the Hyatt Legal Plan, available from MetLife®. If you are currently participating in Signature LegalCare and want to have coverage in the new legal plan for 2008, you do not need to enroll in the Hyatt Legal Plan during annual enrollment—your coverage for legal assistance benefits in 2008 will be through the Hyatt Legal Plan. If you’re currently using a legal professional under the current plan, you should check to see if he or she is a participating provider through the new Hyatt Legal Plan for services provided in 2008. If you do not currently have legal assistance coverage through the Plan, and would like to begin receiving legal benefits in the Hyatt Legal Plan for 2008, call MetLife during annual enrollment at 1-800-GET-MET-8.

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

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

Out-of-Network Providers
You no longer have to seek a core specific certification provider if you seek care outside the ValueOptions network; however, the provider must hold the highest level of 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.

High-Performance Physicians
Additional networks are designating high-performance physicians based on quality of care and cost efficiency.

The following network areas are adding high-performance physician designations:
• Aetna: Tampa, Northern California, San Diego, and Central Valley, CA
• CIGNA: Arizona, Orlando, and South Florida
• UHC: Nashville

Revised Eligibility Rule
If you pass away while covered under the Flexible Benefits Plan as an active employee, your surviving spouse and/or dependent children may still be eligible for coverage under the Retired Employees’ Health Care Plan as if you retired (after a temporary continuation of coverage under the Flexible Benefits Plan). For your surviving spouse and dependents to be eligible for this Plan at the time of your death:
• You must have been otherwise eligible for coverage (age 55 with 10 or more years of vesting service of age 65 with five years of vesting service); or
• You must have at least one year of vesting service as a participant in the UPS Retirement Plan and worked for UPS at least 25 years.

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

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

Civil union partners are not considered spouses under the Internal Revenue Code. Accordingly, they may not receive tax-free benefits from employer benefit plans. Any benefits received by a civil union partner and/or children of a civil union partner must be taxed. The exception would be if the civil union partner and/or his or her children are the employee’s tax dependents for health care coverage purposes under the Internal Revenue Code.

As a result, the full cost of medical, dental and vision coverage for your civil union partner and his or her eligible dependent children will be subject to federal, state and local income taxes. This cost—known as imputed income—is based on the price of the coverage you select.

The full value (the price tag) of civil union partner benefits will be shown as imputed income on a W-2 statement you will receive at year end.

To find out further details about this benefit, you can contact the Benefits Service Center at 1-800-UPS-1508 to request a copy of the UPS Retired Employees’ Health Care Plan Civil Union brochure.

Please note: This opportunity does not remove the eligibility requirement in the UPS Retired Employees’ Health Care Plan that your eligible dependents must be eligible at the time of your retirement.

**Retiree Health Access (RHA)**

RHA is a program that offers additional options along side network plus coverage. The options available and the administrator of the program are changing effective January 1, 2008. Be sure to review the information packet you will receive from RHA if you are currently enrolled in an RHA option or may be interested in electing RHA this annual enrollment.

**Medicare Part D Premium Reimbursement**

If you or your spouse are eligible for reimbursement of your Medicare Part D prescription drug plan (PDP) premium through a Retiree Reimbursement Account (RRA), the 2008 maximum reimbursement for Medicare Part D is $415.

**Retiree Reimbursement Account Clarification**

Claims for reimbursement must be received by Aetna within 90 days from the end of the plan year, which is December 31 of each year vs. submitted to Aetna by that date.

**Paying for Coverage Clarification**

The amount of credits that you may be eligible to receive to apply toward the cost of retiree health care is set forth in the Retirement Plan Summary Plan Description.

**Clarification of Separate Elections for Medical/Prescription Drug, Dental and Vision Benefits**

If you are enrolled in the Retired Employees’ Health Care Plan medical plan, you may choose whether to elect dental and/or vision coverage separately. You are no longer required to enroll in all three coverages. However, if you opt out of medical coverage under the Retired Employees’ Health Care Plan, you may not choose to elect dental and/or vision coverage only.

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This notice is intended to fulfill UPS’s legal obligation to notify employees of significant changes to the UPS Retired Employees’ Health Care Plan. This notice formally amends the coverage available under the UPS Retired Employees’ Health Care Plan. Keep this notification with your Summary Plan Description (SPD) for future reference.

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700-0015
Summary of Material Modifications
UPS Retired Employees’ Health Care Plan
February 2007

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

Quit For Life™ Tobacco Cessation Program

Effective February 1, 2007, UPS is offering a new tobacco cessation program benefit as a component of the UPS Retired Employees’ Health Care Plan to help participants quit tobacco use. All tobacco types are included (cigarettes, cigars, and smokeless tobacco).

What the Program Includes

• Up to five outbound counseling and intervention calls to you.
• In-depth assessment to evaluate readiness to quit tobacco use.
• Assistance and support with over-the-counter Nicotine Replacement Therapy (NRT) in the form of patch or gum only. If you decide that NRT is right for you, this program provides direct mail order of NRT. There is no cost to the participant for the NRT. This program provides assistance and support with NRT throughout the program cycle.
• Assistance and support regarding prescription medications such as bupropion and Chantix.

Note: Prescription medication is not covered under this program. If you are a participant in the Medical Plan, you should check your Medical Plan’s Summary Plan Description (SPD) for prescription drug coverage information. Assistance and support provided by Free & Clear®, the program’s administrator, should not be a substitute for your doctor’s advice.

• Quit Guide sent to your home following program registration.
• Unlimited and easy access to quit coaches through a toll-free number for twelve months from the time of enrollment.
• Access to Web Coach™, an interactive Web site that helps you stay on track between calls.

Eligibility

Quit For Life is available to all retirees who are covered under the Medical Plan that is a component of the UPS Retired Employees’ Health Care Plan and who are under age 65. Quit For Life is also available to all dependents of such retirees who are age 18 years and older and are covered under the Medical Plan. If you enroll, the benefits are provided to you and your eligible dependents at no additional cost. Benefits under this program do not begin until the date that coverage under the Medical Plan begins, or the date you enroll in Quit For Life (if later). Please refer to your SPD booklet for details regarding eligible dependents and when coverage begins. Details on enrolling in this Program are provided at the Free & Clear Web site at www.freeclear.com/ups.

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.

Enrolling/Registering In Quit For Life

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

Quit coaches are available Monday through Sunday from 8:00 a.m. to 12:00 a.m. Eastern Time. After-hours voicemail is available. All messages are returned within 24 hours.

English- and Spanish-speaking tobacco treatment staff and supervisors are available, as well as translation services for many other languages.

You and/or your dependent must provide your employee ID number to prove eligibility when contacting Quit For Life.

Plan Administration

Quit For Life is administered by:
Free & Clear, Inc.
999 Third Avenue, Suite 2100
Seattle, WA 98104
Women’s Health and Cancer Rights Act Notice

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

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

Coverage is subject to the same deductible, coinsurance provisions and other limitations and exclusions applicable under the Plan.
Prescription Drug Benefits (under age 65 only)

If you are in Network Plus, regardless of retirement date, or you retired on or after January 1, 1993 and are in Traditional Care, your prescription drug coverage is changing as follows:

You will pay a 20 percent coinsurance with per-prescription minimums and maximums. In turn, the $1,500 annual prescription maximum has been removed.

For Retail prescriptions:

− **Generic prescriptions** - participants now will pay 20 percent of the prescription drug cost, with a $5 per prescription minimum and $100 per prescription maximum, or the cost of the drug; whichever is less.

− **Brand prescriptions without a generic equivalent** - participants now will pay 20 percent of the prescription drug cost, with a $25 per prescription minimum and $100 per prescription maximum, or the cost of the drug; whichever is less.

− **Brand prescriptions that have a generic equivalent** - participants now will pay 20 percent of the generic prescription drug cost, with a $5 per prescription minimum and $100 per prescription maximum, or the cost of the drug (whichever is less) in addition to the cost difference between the generic and brand drug.

For Mail Order prescriptions (three-month supply):

− **Generic prescriptions** - participants now will pay 20 percent of the prescription drug cost, with a $10 per prescription minimum and $200 per prescription maximum, or the cost of the drug; whichever is less.

− **Brand prescriptions without a generic equivalent** - participants now will pay 20 percent of the generic prescription drug cost, with a $50 per prescription minimum and $200 per prescription maximum, or the cost of the drug; whichever is less.

− **Brand prescriptions that have a generic equivalent** - participants now will pay 20 percent of the generic prescription drug cost, with a $10 per prescription minimum and $200 per prescription maximum, or the cost of the drug (whichever is less) in addition to the cost difference between the generic and the brand drug.

Maintenance prescription drug requirement

Maintenance medications are those intended for long-term use (over three months). When filling maintenance medication prescriptions, you should use the Medco By Mail mail-order benefit. The following applies to maintenance medications intended for long-term use:

− Retail pharmacy coinsurance rates only apply to each long-term medication for the first three times they are filled at a network pharmacy beginning January 1, 2007. The fourth time and any additional time thereafter you refill a long-term use medication at a retail pharmacy and not through the Medco By Mail mail-order benefit, you pay the entire cost of each long-term drug.

− The mail-order coinsurance rate applies to long-term medications for up to a 90-day supply.

For a complete list of medications affected by this change, go to www.medco.com or contact Medco directly at 1-800-346-1327.

Dental (under age 65 only)

The American Dental Association (ADA) has made changes to standard protocols and procedures. UPS has adjusted the plan with the following new standards:

− Bitewing X-rays - one set per year

− Vertical bitewings - one set every three years

− Scaling and root planning - four separate quadrants every two years

− Gingivectomy - one per quadrant/site every three years

− Osseous surgery - one per quadrant/site every three years

− Occlusal guards - one every three years

− Problem-focused exams - two per year

Medical

New networks (Network Plus only)

Point-of-service (POS) network coverage through UnitedHealthcare will be added in Central and Southern Alabama. POS network coverage through Aetna will be added in Northern Michigan.

Administrative change (Network Plus only)

The Blue Cross Blue Shield (BCBS) POS plans in Indiana, Kentucky, South Carolina and Wisconsin, and the exclusive provider organization (EPO) in Ohio will have claims administration processed in a different location. The Member Services phone numbers also will change.

− The new Indiana, Kentucky, Ohio, and Wisconsin BCBS Member Services phone number is 1-800-514-4541.

− The South Carolina BCBS Member Services phone number is 1-800-821-3023.

Claims should be submitted by network to:

**Indiana**
P.O. Box 37010
Louisville, KY 40233-7010
Kentucky
P.O. Box 37690
Louisville, KY 40233-7690

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

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

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

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

Preventive care
The Plan now will provide preventive care coverage for Gardasil, a new vaccine intended to help prevent cervical cancer. Females between ages 9-26 are currently eligible to receive this vaccine which is given in a series of three parts over a 180-day period. Coverage of the Gardasil vaccine will be the same as other preventive care vaccinations under the Plan.

What’s not covered by Medical Benefits
In addition to the list in the SPD, expenses related to the purchase of orthopedic shoes or related corrective devices and appliances are not covered except where the shoes or devices are permanently fastened to an orthopedic brace and are medically necessary or used in the place of surgery.

Correction to Summary of Network Plus Benefits chart
Chiropractors, podiatrists, OB/GYNs, and rehabilitation are all specialists or specialty care. Therefore, the applicable copay for an in-network provider is $30, not $15.

Health Risk Assessment (under age 65 only)
If you and/or your spouse are under the age of 65 and covered under the REHCP medical benefit, you are eligible to take the UPS-sponsored online health risk assessment.

The health risk assessment (administered by HealthMedia and referred to as “Succeed”) takes inventory of overall health and helps participants learn to make healthy lifestyle choices.

Go to www.my.healthmedia.com to access the assessment. Use the access code “upsretiree” and your UPS employee ID (found on your personalized Enrollment Worksheet at the top of page one) to create a personal report. Eligible spouses should sign up as a new HealthMedia member using the same employee ID and access code and by choosing the “spouse” option to ensure a new account is created.

Retiree Health Access (RHA) Enhancements
If you are in Network Plus and under age 65, you now have the opportunity to elect an RHA medical option and continue dental and/or vision coverage under the REHCP. This is a change from last year whereby enrolling in RHA meant you had to forego dental and vision coverage under the REHCP. (RHA does not offer dental and vision coverage.) If you select RHA medical and REHCP dental and vision, any credits you have first will be applied to coverage selected under the REHCP. Any eligible remaining credit according to the Plan will be applied to a Retire Reimbursement Account and is available to reimburse any RHA premiums.

Split-family coverage
You now may choose split-family coverage between the REHCP and RHA. For example, if an over-age-65 retiree wants to enroll in a Medicare Advantage plan through RHA, he or she may do so and his or her covered dependents may continue coverage under the REHCP as a separate election. In this example, the retiree’s eligible credits (if any) will be applied to an RRA and the spouse’s eligible credits (if any) will be used to pay for the coverage under REHCP. Split family coverage between REHCP and RHA is not allowed if the retiree and spouse are either both over age 65 or both under age 65. This differs from last year when those interested in RHA had to move the whole family as no other separate elections were allowed.

Medicare Part D Premium Reimbursement
If you or your spouse are eligible for reimbursement of your Medicare Part D prescription drug plan (PDP) premium through a Retiree Reimbursement Account (RRA), the 2007 maximum reimbursement for Medicare Part D is $384.

Women’s Health and Cancer Rights Act
The Women’s Health and Cancer Rights Act requires that we notify you annually that the Plan provides coverage for the following after a covered mastectomy:
− Reconstruction of the breast on which the mastectomy was performed;
− Surgery and reconstruction of the other breast to produce a symmetrical appearance;
− Prostheses, and
− Treatment of physical complications of all stages of a mastectomy, including lymphedemas.
Coverage will be subject to the same annual deductible and coinsurance provisions and other limitations and exclusions applicable under the Plan.

Coinsurance, Deductibles, and Other Costs
As a clarification of current Plan administration, your coinsurance, copayments, and/or deductible amounts under the Plan may be determined before application of any allowances, incentives, and/or other adjustments to which the Plan may be entitled. All allowances, incentives and/or other adjustments are retained by the Plan to be used as permitted under applicable law.
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Overview of the Plan

Concern for the security and well-being of UPS employees is the cornerstone of the UPS Retired Employees’ Health Care Plan described in this book. The Plan demonstrates the value UPS places on you — not just while you are an active UPSer, but during your retirement years.

UPS continues managed care into retirement by offering you Network Plus. Network Plus provides enhanced health care coverage, including preventive medical care as well as prescription drug, dental, and vision benefits for you and your eligible dependents until you or your spouse reaches age 65. Once you reach age 65 and/or become eligible for Medicare, your coverage changes to a traditional indemnity plan to better coordinate with Medicare.

If you are under age 65 and Medicare eligible due to a disability, your coverage will continue to include preventive medical care, prescription drug, dental, and vision coverage and your benefits are the same as those who are in the Network Plus Indemnity Plan for Non-Network Areas as outlined in the Summary of Network Plus Benefits.

If you are eligible for Medicare due to attaining age 65, your indemnity plan coverage does not include preventive medical care, prescription drug, dental, or vision coverage.

When it comes to health care, one size does not fit all. And because of that, UPS has made it possible for you to choose what is best for your personal needs. In addition to Network Plus, other plans are offered by Retiree Health Access (RHA). You also may be eligible for a Retiree Reimbursement Account (RRA). (See the RHA and RRA sections.) Each year during the annual enrollment period, you will have an opportunity to choose coverage under the UPS Retired Employees’ Health Care Plan or coverage through Retiree Health Access.

UPS contributes toward the cost of your health care coverage. You, your spouse and/or dependents also may contribute toward the cost of your health care.

Your contributions help ensure Plan benefits continue for you and your family, as well as for your fellow retired UPSers and their families.

The Basic Care Plan, which has historically provided medical-only coverage, is no longer an option effective January 1, 2006.

How to Use This Book

Read this book to learn important information about:
- Paying for coverage
- Network Plus
- Other important details about the Plan

Refer to the Key Terms section in the back of this booklet to educate yourself on terminology used within this booklet.

It is important that you and your family review this book carefully. Keep it as a handy reference guide.

Who Is Eligible

UPS and its affiliated corporations established the UPS Retired Employees’ Health Care Plan (REHCP) for the benefit of their eligible employees, in order to provide benefits to those employees upon their retirement, disability or death.

You are eligible to participate in the Plan if you are a full- or part-time union-free employee when you retire from UPS. In addition, you must:
- Select early (beginning as early as age 55) or normal retirement (age 65),
  - If at least age 55, have 10 or more years of vesting service (at least one of which was as a participant in the UPS Retirement Plan), or
  - If age 65, have five or more years of vesting service (at least one of which was as a participant in the UPS Retirement Plan) and
- Retire on or after June 15, 1995
Unless you choose otherwise, your spouse (as of the date your UPS Retired Employees’ Health Care Plan coverage begins) and any eligible dependent children are also covered.

If you pass away while you are covered by the Flexible Benefits Plan as an active employee, your surviving spouse and/or dependent children may still be eligible for coverage under the Retired Employees’ Health Care Plan as if you retired (after a temporary continuation of coverage under the Flexible Benefits Plan). For your surviving spouse and dependents to be eligible for this Plan at the time of your death:

- You must have been otherwise eligible for coverage (age 55 with 10 or more years of vesting service or age 65 with five years of vesting service); or
- You must have at least one year of vesting service as a participant in the UPS Retirement Plan and worked for UPS at least 30 years.

If you meet either of the above requirements at the time of your death, your eligible surviving spouse and dependents receive a Company-paid 13-month extension of Flexible Benefits Plan coverage, as explained in the Life Events section of the Flexible Benefits Plan SPD. At the end of the 13-month extension, your surviving spouse and/or eligible dependents become eligible for coverage under the Retired Employees Health Care Plan.

If you should pass away while covered under the UPS Retired Employees’ Health Care Plan, your covered spouse and dependents continue to receive coverage for as long as they remain eligible. (Please refer to the When Coverage Ends section for more detailed information.)

Employees that terminate employment prior to meeting the eligibility requirements set forth above are not eligible to receive medical benefits under the UPS Retired Employees’ Health Care Plan (REHCP) even when they begin to receive a retirement benefit.

- Your legal spouse/domestic partner* at the time of your retirement
- A child who at the time of your retirement is a natural child, an adopted child (or a child placed for adoption), a child for whom you are a court-appointed guardian or custodian, or a stepchild, provided that the stepchild lives with you at least one half of the year who is:
  — Unmarried, under age 19 and financially dependent on you; or up to age 25 if a full-time student and still unmarried and financially dependent on you
  — Incapacitated and meets the requirements set forth on page 4 of this Summary Plan Description.

If you have children age 19 or older, each year during annual enrollment you must certify their full-time student status to continue their coverage for the following year. You may be asked to provide proof of eligibility. If you fail to certify and/or provide proof of eligibility, your child’s coverage will end on December 31 of that Plan year. If your child’s coverage ends on December 31 as a result of your failure to certify his or her student status, coverage can be reinstated effective the date your child returns to school full-time. You must call the Benefits Service Center within 60 days of the child’s return-to-school date to reinstate your child to coverage.

As of January 1, 2006, you cannot add dependents to coverage unless they were eligible dependents at the time of retirement. New dependents due to — but not limited to — marriage, birth, or adoption cannot be added for coverage under the Retired Employees’ Health Care Plan after a retiree’s initial retirement date.

You may be periodically required to provide proof of dependent status. Failure to provide proof may result in termination of coverage (including retroactive termination) and repayment of any erroneously paid claims (in accordance with the Plan’s right of recovery provisions).

*Domestic Partner Coverage — Same-sex domestic partners may be eligible as dependents under the Plan. Their children, if otherwise eligible for coverage, also may be covered. There are specific rules regarding qualifications for same-sex domestic partner coverage and tax consequences of such coverage. Details are available in a separate document that can be ordered by calling 1-800-UPS-1508.
Incapacitated Children

A child who becomes incapacitated while covered under the Plan is eligible to continue certain coverage beyond the age limits identified above as long as the incapacity exists. This continuing coverage is available as long as the child becomes incapacitated while covered by the Plan, is unmarried, and primarily depends on you for support and maintenance. The child must have a mental or physical incapacity that renders the child unable to care for her or himself as determined by the network manager or claims administrator. For this purpose, the incapacity needs to be verified before coverage can be continued. In addition, periodic medical documentation of the continuing incapacity is required as determined by the network manager or claims administrator.

When Coverage Starts

The REHCP coverage effective date will begin the first day of the month following your Retirement Date plus 30 days.

Example

Retirement Date = October 15, 2006
Retirement Date + 30 days = November 14, 2006
Flexible Benefits Plan coverage ends = November 30, 2006
Retired Employees’ Health Care Plan begins = December 1, 2006.

Coverage under the Plan for your spouse and/or eligible children begins at the same time (except as otherwise set forth on page 3 of this Summary Plan Description for survivors of active employees who meet certain requirements at their death).

Waiving Coverage

In certain circumstances, you may wish to waive coverage for yourself or your dependents — for instance if you have coverage at another employer. You may not waive coverage for yourself and continue coverage for your spouse and dependents. To waive coverage, you must provide written proof of other coverage or you will not be allowed to reinstate coverage in the future. To reinstate coverage in the future, you must provide written proof of loss of other coverage to the Benefits Service Center within 60 days from the date of the loss of coverage. Remember, you cannot add dependents to coverage unless they were eligible dependents at the time of retirement. For more information about waiving and reinstating coverage, call the Benefits Service Center at 1-800-UPS-1508.

Address Changes

It is important to keep the Benefits Service Center informed about your current address. To change your address, call the Benefits Service Center at 1-800-UPS-1508. It is not necessary to contact your insurance carrier. The Benefits Service Center will forward your new address to the appropriate insurance companies. (Address changes may affect which network is available to you based on ZIP Code).

If you maintain two residences, you must change your address each time you move. Call the Benefits Service Center at 1-800-UPS-1508. If you live in a network area and do not change your address when you move, all care received without your PCP’s approval is paid at out-of-network levels.

Paying for Your Coverage

UPS may pay a portion of the cost of Plan coverage. Depending on the average annual cost of providing Plan benefits, you or your dependents may be required to contribute to the cost of coverage. Your Retired Employees’ Health Care Plan Enrollment Worksheet from the Benefits Service Center displays the amount of credits you will receive, if any, towards the cost of the Plan.

If You Are Required to Pay for Coverage

The Plan through your Retired Employees’ Health Care Plan Enrollment Worksheet from the Benefits Service Center will notify you each year of the premium cost of your coverage for the following year, and your share of that premium, if any. You are billed directly in quarterly installments by the Plan’s administrative services provider, the Benefits Service Center. You can elect to have your premiums deducted from your bank account. If so, your share of the premium will be deducted from your bank account on a monthly basis. Contact the Benefits Service Center for a direct debit enrollment form.

If you fail to make timely payments, your coverage will terminate.
Network Plus

Introduction

Network Plus provides you and your covered dependents with managed care coverage until you reach age 65 and/or become eligible for Medicare. Your coverage then changes to a traditional indemnity plan to better coordinate with Medicare.

Managed care offers many advantages, such as cost savings to you and your dependents, preventive care, no annual deductibles, coordination of your medical care by a primary care physician, and no claim forms to file. Because of the efficiency of managed care, UPS also offers dental and vision coverage while you are participating in managed care.

If you live outside of the managed care network area (a non-network area) or if you are under age 65 and eligible for Medicare, an indemnity plan is available. You are still eligible for dental and vision coverage — as well as preventive care — until you or your spouse reach age 65.

Once you reach age 65 and become eligible for Medicare, your preventive care, prescription drug, dental, and vision coverage ends.

If you reach age 65 before your spouse, or if your spouse reaches age 65 before you, it is possible that you and your eligible spouse could have different benefit coverage. For example, if you reach age 65 before your spouse, your coverage would change to the indemnity plan while your spouse would remain covered by the managed care, dental, and vision plans.

Your coverage before age 65 includes:
- Medical
- Dental
- Vision

Your coverage with Medicare includes:
- Medical only

If you have dependent children, their coverage is the same as the youngest covered parent. This allows you to keep your dependent children in the managed care, dental, and vision plans for a longer period of time. In the event of the death of the youngest parent, the children’s coverage changes to the surviving parent’s coverage.

What You Will Find in This Section

Everything you need to know about your Network Plus coverage — both under age 65 and after you become eligible for Medicare — is explained in this section.

First, the section explains how your plan works before age 65. After describing what expenses you have to pay and the different types of expenses covered, this section describes several special benefit categories:
- Prescription drug benefits — Medco Health for short-term and immediate prescription needs and the Medco Mail Order Program for long-term and ongoing prescription needs
- Solutions for mental health and substance abuse treatment
- Dental for routine preventive care, basic and restorative services, and orthodontia
- Vision for exams and corrective lenses

Later, this section explains your coverage once you become eligible for Medicare.

A handy reference guide, the Summary of Network Plus Benefits, gives you a quick glance at the benefit levels under Network Plus coverage.

For an expense to be covered by your medical benefits, it must be “medically necessary.” Managed care coverage uses terms such as “in-network,” “out-of-network,” and “copayment.” An indemnity plan uses terms such as “deductible,” “coinsurance” and “reasonable and customary.” To help you understand your medical benefits, we have defined some of the terms in the back of this booklet.
Network Plus Coverage  
Before Age 65
This section describes your retiree health care coverage until you reach age 65. Your coverage includes medical/prescription drug, dental, and vision benefits. You can elect medical/prescription drug, dental, and/or vision benefits separately.

Default Coverage
If you do not make elections for REHCP when initially eligible, you automatically will be enrolled in default coverage. Default coverage is based on the value of your credits. For example, if you have enough credits to cover the entire cost of medical, dental, and vision benefits, you automatically will be enrolled in all three benefits. If your credits can only cover the cost of medical and dental coverage and not vision, you automatically will be enrolled in medical and dental. If your credits can only cover the cost of medical and not dental and vision, you automatically will be enrolled in medical. No matter how many credits you have, you automatically will be enrolled in medical coverage and, if applicable, be billed for the difference (see section titled Paying for Coverage).

A Guide to Managed Care

What is Managed Care?
Managed care is a system where all aspects of medical care are managed — from quality to cost. Care is provided by PCPs who participate in a network. Each time you need health care services, you can choose whether to go to a network provider or go outside the network; in other words, you choose the coverage you want at the point of service.

The network managers for Network Plus are Aetna, Blue Cross/Blue Shield, CIGNA, or United Healthcare depending on where you live. For additional information, contact your network manager. The network manager’s name and toll-free telephone number appear on your medical identification card.

What is a network?
A network is a group of doctors, hospitals, and other health care providers who have agreed to provide their services to participants at contracted rates. When services are provided in-network:
- You pay less
- Preventive care including periodic routine physicals, gynecological exams, screening exams and well-baby care is covered
- No annual deductible must be met
- In-network care is always within reasonable and customary limits
- Your care is coordinated through your primary care physician
- You usually do not have to file claim forms.

Understanding In-Network Benefits
Under the Retired Employees’ Health Care Plan, you are always considered in-network if you have a referral from your primary care physician (PCP) to a network specialist or a network facility. Referrals are usually good for a limited number of visits and a limited amount of time. Be sure you and your specialist contact your PCP for further referral authorization if necessary.

In rare instances, your network PCP or specialist may refer you to a non-network specialist. When your network doctor (PCP) refers you to a non-network physician, the network manager (insurance company) must also approve the referral in advance in order for you to receive in-network benefits.

The key to network care is your PCP referral to network specialists and facilities, and the network manager’s approval for all non-network providers and facilities. The only exception to this would be the case of emergencies, in which case you are advised to seek care at the nearest facility. For urgent care when you are away from the network area, seek the appropriate care and call your PCP as soon as possible.
If you go out of network for care:
- You pay a higher percentage of eligible charges after you meet an annual deductible
- You must pre-certify all hospitalizations except as stated otherwise
- You don’t receive benefits for most preventive care
- You must file claim forms for all benefit payments
- You have to pay any expenses that exceed reasonable and customary limits.

Can I change networks later?
You are allowed to change networks at any time with an address change. Otherwise, you may change your network once per calendar year. You must keep that new network until the end of that calendar year. Changing networks changes the list of network providers available. It does not change the benefits.

For instance, you have Network A beginning January 1. In May, you decide that you would rather have Network B. You may change to Network B, but you must keep Network B until the end of the year.

Your network election will roll over from year to year unless you call the Benefits Service Center to request a change.

Your Primary Care Physician (PCP)
When you use the network, your primary care physician will provide most of your care, refer you to a specialist when necessary and coordinate any hospital services you need. PCPs are general or family practitioners, internists, and pediatricians. You must choose a PCP for each covered family member; however, you can choose a different PCP for each.

You must use your PCP to receive in-network benefits. If you go to a network doctor or hospital without your PCP’s referral, your expenses will be paid on an out-of-network basis.

There are three exceptions:
- Women may have one routine gynecological check-up each year by a network obstetrician or gynecologist. It is not necessary to go through your PCP for this annual examination.
- Women may self-refer to an obstetrician if they have confirmed their pregnancy through a home pregnancy test.
- Solutions, the program for mental health and substance abuse treatment can be contacted directly by you or your covered dependents or by a referral from your PCP.

Selecting Your PCP
You can select your PCP from your network manager’s physician directory when you first enroll. If you want to find out more about any PCP listed in the directory, call Member Services or visit the network manager’s website. Member Services can inform you of the hospitals where a PCP has admitting privileges, where a PCP was trained as a resident, and the year the PCP graduated from medical school.

A PCP must meet strict eligibility standards established and maintained by the network manager before admission to the network. For example, a PCP generally has:
- An appropriate professional degree and current, unrestricted state license
- Board certification or eligibility for board certification
- Adequate malpractice insurance
- 24-hour office coverage
- Sufficient office hours to meet patient demand
- Admitting privileges to at least one network hospital.

In most states, the network manager also selects network hospitals. Hospitals are selected based on their reputation in the community, geographic location, efficiency in providing medical services, the quality of those services, and willingness to adhere to the network manager’s guidelines and to provide appropriate, affordable care.

The network manager regularly reviews all network providers to make sure they continue to meet network standards.
Changing Your PCP

You can change your PCP at any time by calling Member Services who will record the new election and send you a new medical identification card. You should contact your current PCP and request that your medical records be transferred to your new PCP.

If Your PCP Leaves the Network

Some doctors occasionally are added to the network and some doctors occasionally leave the network. If your PCP leaves the network, your network manager will notify you and ask you to select another PCP. If you need assistance in selecting a new PCP, call Member Services. To continue receiving in-network benefits, choose a new PCP from the physician directory and then notify Member Services prior to your first visit to the new PCP.

Referral to a Network Specialist

When your PCP refers you to a specialist, you receive in-network benefits. Without an approved PCP referral, any specialist’s care is considered an out-of-network expense — even if the doctor participates in the network.

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

The network manager follows the same kind of credentials process for network specialists as for PCPs. In addition, the specialist must complete an approved residency program and be board certified or board eligible in his or her specialty.

Women Can Self-Refer to Network OB/GYN in Certain Circumstances

Women may see a network OB/GYN for an annual well-woman (gynecological) exam without a referral.

For all other OB/GYN treatment, you must have a PCP referral to receive in-network benefits. Even if a condition that requires further treatment is diagnosed during your annual check-up, you still need a referral from your PCP to receive in-network benefits. If you receive treatment from a network OB/GYN for a medical problem without a PCP referral, the treatment is covered on an out-of-network basis.

If you go to an out-of-network OB/GYN for your routine check-up, only the laboratory fees are covered. The office visit itself is not covered.

Special Situations

- If you are traveling and need emergency or urgent medical care when you are away from home, call your PCP to discuss treatment. If your doctor recommends treatment where you are, payment of your expenses will be at the in-network level. If you cannot contact your PCP, get the treatment you think you need. If you call your PCP within 48 hours, you will receive in-network benefits for the treatment. However, if treatment is provided out-of-network, you will have to file a claim form (see section titled How to File a Medical Claim).

- If your eligible dependent child attends school away from home, select a PCP for your child in your home network. The PCP will coordinate care when your child is at home, as well as non-emergency care when your child is away. If there is a medical emergency, your child should seek medical care as quickly as possible and then contact his or her PCP within 48 hours so the doctor can coordinate care. You will have to file a claim form for treatment provided out-of-network.

- If you have eligible dependent children who permanently live outside your network area, such as with a former spouse, their covered expenses will be paid as in-network benefits, even though services are provided out-of-network. In this situation, you are responsible for ensuring that the services are medically necessary. In addition, you will have to file claim forms to be reimbursed. You should not select a primary care physician for these dependent children.

- If your eligible spouse lives permanently outside your network area, covered expenses for your spouse will be paid as in-network benefits. The benefit procedure described above for dependent children who do not live with you also applies to expenses incurred by your non-resident spouse.
In the rare instance that you need to see a specialist who is not in the network, your PCP can request the network manager’s approval of the referral. If the request is approved, in-network benefits will be paid. If you do not contact your PCP before seeing a non-network specialist, your treatment will be covered on an out-of-network basis.

Planning a Move
To help coordinate your benefits during a residential move, you can call ahead with your new address, PCP information, and the exact date of your move for a seamless move from one network to another. The following information explains the process:

1. Call the Benefits Service Center up to 30 days in advance of your move.
2. Provide the exact date of your move, your new address, and your PCP selection for the new network.
3. The Benefits Service Center will forward this information to the network manager with the future effective date of your move. This will terminate your coverage in one location and begin it in the new location on the date of your move. New ID cards are generated as soon as the new network manager receives your information and new cards will be waiting for you when you arrive.
4. Once you receive your new ID cards, destroy the ID cards from your old network. You will receive new ID cards if you move back to that location.
5. Your dental and prescription ID cards will not change when you change locations.

If you do not call in advance, you still have coverage with the new network on the date of your move. However, your ID cards will be delayed, and you may have difficulty verifying coverage if you need after-hours care. Additionally, until the effective date of your move, you will be covered by the network where you used to live, and must have all care coordinated through your old PCP (except emergencies and urgent care).

Member Services
Member Services is your link to network care. Call a Member Services representative to:

- Ask questions about a network physician’s credentials
- Ask questions about your benefits
- Change your PCP
- Obtain information about a network provider or service.

The medical identification card you receive after you enroll will show a toll-free number for Member Services.

A Guide to Indemnity Benefits
If you live in a non-network area, Network Plus provides indemnity benefits. Aetna administers the indemnity benefits in Network Plus.

With an indemnity plan, you choose any doctor or health care provider you wish to provide covered services and supplies. Benefits are paid once you have paid the annual deductible. All covered expenses must be:

- Medically necessary
- Not investigational or experimental, and
- Within the reasonable and customary amount Aetna has established for the services and supplies that are received.

Choosing a Doctor
If you live in a non-network area, you do not have to choose a primary care physician. However, you may want to consider making that kind of selection for yourself and your dependents. By doing so, you will have a doctor with full knowledge of your health history. Your doctor will also be able to work with you in coordinating your care and the selection of any necessary specialists.
What Medical Expenses You Have to Pay

Network Plus pays a portion of the medical expenses you and your family may have each year. You will generally also pay a portion of the expenses incurred. Included in the following text are descriptions of the types of charges for which you will be responsible. (For information about the amount of these charges, please refer to the Summary of Network Plus Benefits section).

Copayment
If you live in a network area and receive care from your primary care physician, network obstetrician or gynecologists, or a network specialist after referral from your PCP, you pay a flat dollar amount for each visit. This amount is your copayment. The balance of the cost is paid in full. The copayment is not included in determining if your costs have reached the out-of-pocket maximum.

Copayments also apply to network care for mental health or substance abuse treatment provided through Solutions (refer to the Solutions section) and to emergency room services (refer to the Emergency Treatment section).

Deductible
The deductible is the amount you must pay before certain benefits begin each year if you live in a network area and receive out-of-network treatment, or you live in a non-network area.

In addition to an individual deductible, you have a family deductible amount that is twice the individual deductible. This means that if two or more family members have combined expenses credited to the deductible and equal to the family deductible amount, any further expenses incurred by a family member that year will be eligible for payment under the Plan. This is true even if no one person in the family has met the individual deductible amount.

For example, suppose you, your spouse, and your two children live in a non-network area and have a $200 family deductible. You can meet your family deductible if your family’s medical expenses were applied to individual deductibles in either of the following two examples:

<table>
<thead>
<tr>
<th>Eligible Medical Expenses for Enrolled Family Members</th>
<th>Example A</th>
<th>Example B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yourself</td>
<td>$100</td>
<td>$25</td>
</tr>
<tr>
<td>Spouse</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Child #1</td>
<td>$0</td>
<td>$25</td>
</tr>
<tr>
<td>Child #2</td>
<td>$0</td>
<td>$50</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$200</td>
<td>$200</td>
</tr>
</tbody>
</table>

Coinsurance
Coinsurance is the percentage of covered expenses paid by the Plan. The portion of the cost you pay is credited toward your out-of-pocket maximum for that year.

Reasonable and Customary (R&C)
Charges within the normal range of fees charged in your geographic area for similar services and similar supplies. If your expenses are considered more than reasonable and customary by the claims administrator or network manager, you will be responsible for paying the additional amount. These charges do not count toward your deductible or out-of-pocket maximum. The claims administrator periodically updates reasonable and customary charges. All benefits provided in-network through a managed care option are considered reasonable and customary.
**Hospital Admission Fee**

The hospital admission fee is the amount that you pay each time you are admitted as a hospital inpatient. The hospital admission fee does not apply to treatment as an outpatient. If you are re-admitted 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.

An additional hospital admission fee of $250 applies if a hospital admission is not coordinated by your PCP or not pre-certified by the network manager and care is provided out-of-network, or not pre-certified by the claims administrator if you live outside the network area. (See the Pre-certification of a Hospital Admission section for additional information.)

**Out-of-Pocket Maximum**

There is a limit on how much you have to pay out-of-pocket each year. After you meet the out-of-pocket maximum, 100 percent of most covered charges are paid for the rest of the calendar year. This means that your annual out-of-pocket expenses for most covered charges will never be more than a certain amount. This feature can be especially valuable if you or a dependent has a catastrophic illness or injury.

There are two separate out-of-pocket maximums that apply each year if you live in a network area: one for expenses incurred within the network, and one for out-of-network expenses. You cannot transfer in-network expenses to out-of-network expenses or out-of-network to in-network expenses.

In calculating your out-of-pocket expenses, the dollar amounts included are:

- The deductible
- The percentage you pay after the coinsurance (except for mental health and substance abuse expenses) and
- The hospital admission fee.

Copayments, the additional hospital admission fee, and any amounts over the reasonable and customary expenses are not included when calculating whether the out-of-pocket maximum has been met. In addition, expenses for prescription drugs and mental health and substance abuse do not count toward the out-of-pocket maximum.

**Lifetime Maximum Benefits**

Up to $1 million in lifetime medical benefits can be paid for each person covered by Network Plus. The maximum is a combined amount, which is the total of benefits paid while you are covered by the Retired Employees’ Health Care Plan. The lifetime maximum includes benefits payable from Solutions (for your mental health/substance abuse care). However, prescription drug benefits administered by Medco Health or Medco Mail Order Program do not count toward the $1 million lifetime maximum nor are they subject to the $1 million lifetime maximum.

The lifetime maximum differs from the out-of-pocket maximum. The out-of-pocket maximum is the dollar limit you pay each year before covered charges are paid at 100 percent for the rest of the year. Each January 1, up to $1,000 in individual benefits paid during the preceding year or years automatically will be restored to the lifetime maximum.

**Preventive Care**

Since it’s less painful and less expensive to keep people healthy than it is to treat them when they are ill, preventive services are generally covered. In determining how frequently or at what ages certain preventive care services are covered, the Plan generally follows the guidelines of medical consultants, the American Cancer Society, or the American Academy of Pediatrics. (For more information about the preventive care guidelines, refer to the Physical Evaluation Guidelines section.) While your doctor makes the final recommendation on your medical care, the Plan only covers services as described in the guidelines. Under the guidelines, physical evaluation frequency will better reflect preventive care needs based on your age.
For Network Plus in-network areas, preventive care is only covered when performed by your PCP (or specialist when authorized). In non-network areas, you are responsible for any coinsurance amounts not covered by the Plan.

Medicare-eligible participants are not covered by the Guidelines, since preventive coverage ends when you become eligible for Medicare. Please take time to carefully read the UPS Physical Evaluation Guidelines and be sure to take it with you to the doctor when you or a dependent receives preventive care services. (For more information on covered preventive services, see the Summary of Network Plus Benefits chart.)

**Emergency Treatment**

In an emergency, seek medical care as quickly as possible. Contact your doctor so he or she can coordinate your care.

An emergency is defined as a sudden and serious situation that happens unexpectedly and requires immediate medical attention. Examples include an apparent heart attack, loss of consciousness, excessive bleeding, severe or multiple injuries, or serious burns. Hospital emergency rooms and other emergency treatment centers are to be used only when an emergency occurs. You should contact your doctor if you have concerns whether your illness or injury is consistent with the definition of an emergency. All PCPs have 24-hour office coverage. Your level of reimbursement will depend on whether the situation is a medical emergency as defined above.

**Summary of Benefits for Emergency Treatment — Including Ambulance Expenses**

Emergency benefits are the same for in-network, out-of-network, and non-network care. If the situation meets the definition of an emergency, all related covered charges (such as charges for the emergency room, physician services, laboratory fees, X-rays, etc.) are reimbursed after you pay a $50 copayment. The $50 copayment is waived if you are admitted to the hospital from the emergency room. If the situation does not meet the definition of an emergency, related covered charges are reimbursed at the applicable coinsurance level after you pay a $100 emergency room copayment.

Contact your PCP within 48 hours so that he or she can coordinate any follow-up care. If an emergency occurs or if urgent care is necessary, and you are unable to have the service provided by your PCP, you may have to pay the charge yourself and file a claim for reimbursement. If you contact your PCP within 48 hours of the emergency and your treatment meets the definition of a true emergency, your treatment will be considered in-network.

Non-emergency use of an ambulance will be covered only if it is medically necessary.

If hospitalization occurs and you do not contact your PCP within 48 hours or you live in a non-network area and do not notify the claims administrator within 48 hours, a $250 additional hospital admission fee applies if the stay was not certified as described in the next section. In addition, all care received after the initial 48 hours is considered out-of-network if you do not call.

**Pre-certification of a Hospital Admission**

Pre-certification is the approval of a non-emergency hospital admission before the hospital stay begins. Through the pre-certification process, you and your doctor will be notified in advance when an alternative should be considered, and benefit payments will be approved in advance.
If you live in a network area and the hospitalization is under your PCP’s direction (or a network specialist to whom your PCP referred you to), the hospitalization is automatically pre-certified. There is nothing further for you to do.

If you do not use your network doctor or you live outside the network area, you must have a non-emergency hospital admission pre-certified by your network manager or claims administrator or you will have to pay an additional $250. This $250 fee does not count toward the deductible or the annual out-of-pocket maximum. The $250 fee is in addition to the hospital admission fee. To pre-certify, call the toll-free phone number shown on your medical identification card.

If you are admitted to a hospital as the result of an emergency, you or your doctor must contact your network manager if you live in a network area, or call Aetna if you live outside the network area. You must call within 48 hours for approval of the admission. If you do not, the $250 fee will apply.

**Covered Expenses**

Your medical benefits cover the following types of medical services and supplies, as long as the care is medically necessary, neither investigational nor experimental, and within the standards for the reasonable and customary amount.

### Hospital Services

**Inpatient**

Hospital charges for semiprivate room and board and related services and supplies are covered. Other covered hospital services include:

- Use of operating, recovery, and treatment rooms and their equipment
- 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
- Cost and administration of blood and blood plasma
- Intravenous injections and solutions
- X-ray and radium therapy
- Prescribed drugs.

**Outpatient**

The following outpatient hospital services provided on an outpatient basis or by a licensed freestanding emergency care center, surgical center or birthing center are covered:

- 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 due to an accidental injury or for emergency treatment of a life-threatening sudden and serious illness.

### Surgical Services

Covered surgical services include pre-operative and post-operative care within the 14-day period after surgery. These include:

- Surgeon’s services
- Anesthesiologist’s services
- Assistant surgeon’s services, when medically necessary.

### Professional Services

The following professional services are covered:

- Doctor’s and osteopath’s services
- Chiropractor’s services (limited to 60 visits per calendar year)
- Podiatrist’s services (limited to 60 visits per calendar year)
- Services by a registered graduate nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN)
- Examinations and other services for the treatment of an illness or injury, including radiation therapy and chemotherapy
- Medical consultations when requested by the physicians 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 for an adult (must be prescribed by an otolaryngologist)
 Charges for 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 facility to treat a patient's medical condition
 Hemodialysis
 Second surgical opinions (is paid as a normal office visit).

Maternity and Obstetrical Services

Maternity and obstetrical services are covered like any other condition requiring medical treatment. Under a new federal law effective January 1, 1998, the Plan may not 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 normal vaginal delivery, or less than 96 hours following a cesarean section. The Plan may not require physicians to obtain prior authorization for these minimum stays.

In Network Plus, benefits for in-network maternity care are as follows: A copayment applies to each visit to your PCP that is necessary to diagnose that you are pregnant, and to your initial visit to a network obstetrician. After your initial visit to your network obstetrician, the balance of the cost for maternity care for that pregnancy will be paid based on network coverage with no further office visit copayments applying.

Covered services include:
- Normal delivery or delivery by cesarean section
- Prenatal and postnatal care
- Treatment of complications due to pregnancy
- Services in connection with a miscarriage or abortion (including a voluntary abortion)
- Surgery related to an extra-uterine or ectopic pregnancy
- Lamaze or other child-birth preparation classes (upon completion of the class)
- Services of a registered midwife.

Expenses for an amniocentesis or a sonogram are covered only if a documented reason of the medical necessity for this diagnostic procedure is presented to the network manager or claims administrator. Before either an amniocentesis or a sonogram is performed, you or your doctor should contact the network manager or claims administrator to determine if it will be covered.

Amniocentesis that is medically necessary to determine if the baby is fully developing is covered, but an amniocentesis performed to determine the sex of the baby is not covered. If a sonogram is performed during an uncomplicated pregnancy, it will not be covered because it is not necessary for treatment of pregnancy, disease, or injury.

Maternity care for dependent children is not covered.

Women’s Health and Cancer Rights Act Notice

The Women’s Health and Cancer Rights Act requires that we notify you annually that the Retired Employees’ Health Care 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 prosthesis, and
- Treatment of physical complications of all stages of a mastectomy, including lymphedemas.

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

Medical Supplies

The following medical supplies are covered:
- Rental or purchase of durable medical equipment required for therapeutic use and prescribed by a physician, for example: respiratory devices, resuscitators, hospital beds, wheelchairs, and walkers
(In determining if rental or purchase is appropriate, call Member Services at the toll-free number on your medical identification card.)

- Purchase of artificial limbs or other prosthetic appliances, for example: orthopedic braces, breast prostheses, or removable dental prostheses to replace teeth lost as a result of an accidental injury if purchased within 12 months of the accident
- 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.

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

**Allergy Treatment**

For in-network allergy treatment, your PCP can refer you or your dependents for allergy testing by an allergist, a specialist in this field. For injections, you pay either the office visit copayment or the cost of the injection, whichever is less. In all other circumstances, treatment for allergies is covered like any other medical expense.

**Infertility Treatment**

The diagnosis of the cause of infertility and/or the treatment to correct that cause are covered. Both men and women are covered for infertility treatment. The following procedures are not covered because they do not correct the underlying causes of infertility:

- Artificial insemination
- In-vitro fertilization with embryo transfer
- Intra-fallopian transfer.

In addition, services for sperm banking/semen specimen storage or artificially assisted fertilizations and infertility counseling related to artificially assisted fertilizations are not covered.

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 is covered.

**Chiropractic Treatment**

Up to 60 visits per calendar year to a chiropractor are covered. However, if you live in a network area, it is important to keep in mind that you must have a referral from your PCP for treatment to be covered in-network.

**Podiatric Treatment**

Up to 60 visits per calendar year to a podiatrist are covered. However, if you live in a network area, it is important to keep in mind that you must have a referral from your PCP for treatment to be covered in-network.

**Special Types of Therapy**

Short-term rehabilitation therapy and speech therapy are covered. Here are the procedures for each type of coverage.

**Short-Term Rehabilitation Therapy**

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

Short-term rehabilitation means therapy to an eligible Plan participant or dependent that is not confined to a hospital or other facility for medical care. The therapy should result in significant improvement of the condition within 60 days from the date treatment begins. 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 or supplies covered to any extent by any other group plan sponsored by UPS
- Services and supplies received while you or your dependent is confined to 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.

**Speech Therapy**

Benefits can be paid for speech therapy needed to correct a problem caused by an illness or injury.

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, submit information to the network manager or claims administrator for advance review. You then will 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 and both rehabilitative and preventive treatment. As a result, treatment of these kinds of speech problems is not a covered expense.

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

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

- Certain speech problems in children that are classified as developmental delays that may correct themselves without treatment
- Speech problems caused by learning disabilities or articulation disorders (if there is an underlying psychological reason for the conditions, 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
- Services rendered for the treatment of delays in speech development, unless resulting from injury or illness
- 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 for the following alternative to a hospital stay.

**Individual Case Management**

While none of us likes to think about a lengthy hospitalization due to a long-term illness or a serious accident, sometimes it can happen. In addition to the added financial burden, stress also is placed on the patient or other family members. Arranging for the patient to be in an alternate, more home-like setting reduces the stress for the patient and family members.

The Individual Case Management (ICM) program can offer you and your dependents an alternative to these lengthy hospitals stays, allowing the patient to recover in a more comfortable and natural setting. The principles of ICM are an automatic feature of in-network care. If you receive out-of-network care or live in a non-network area, a nurse consultant contacts your doctor or a social worker at the hospital to determine if alternative care — based on the ICM program — is available. Your doctor must approve any alternative care arrangement. You also have a say in planning what type of alternative care best fits the needs of you and your family. You do not forfeit any benefits, whether or not you choose the proposed treatment plan.

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

- Quadriplegia, paraplegia
- AIDS and certain associated symptoms
- Newborn respiratory distress, newborn apnea
- Brain injury, including traumatic brain injury
- Spinal cord injury.
Contact your network manager or claims administrator for more information about the ICM program. Early identification allows the patient, family, physician, social worker, and nurse consultant to work together to arrange the alternate care program in a timely manner.

**Outpatient Private Duty Nursing**

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

Charges of private duty nurses in a hospital are not covered because hospitals provide staffs of registered nurses for care given during hospitalization. Those charges are included in the hospital’s room and board charges. If you have a private duty nurse in the hospital, you are responsible for those charges.

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
- Be ordered by the attending physician as necessary treatment.

Skilled nursing care is not the same as custodial care. Benefits are not payable for custodial care 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 are reviewed to determine the portion of nursing care that qualifies for benefits.

In addition, no benefits are paid for services given by a nurse who lives with you.

**Hospice Care**

Charges for hospice care are covered. Hospice care provides terminally ill patients and their families with an alternative to hospital care while assuring them 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.

**What is the difference between hospice and home health care?**

Hospice care provides specialized treatment directed by a doctor to help care for a terminally ill person as an alternative to hospital care. Care can be received in a patient’s home. Generally, care is available 24 hours a day, seven days a week.

Home health care is a plan for care and treatment of a person in their home. To qualify, the plan must be outlined by a doctor who certifies that the person would require confinement in a hospital or skilled nursing facility if home health care were not being used.

Skilled nursing facilities provide intermediate care (following a hospital stay) such as room, board, and 24-hour nursing care for a limited period. A skilled nursing facility is used as an alternative to a hospital because a patient may no longer require that same level of care. Keep in mind a skilled nursing facility is not used mainly as a rest facility or a facility for the aged.

**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. For these expenses to be eligible, the home health care plan must be outlined by your physician.
Covered home health care expenses include:

- Part-time or intermittent nursing care by an RN or LPN when prescribed by your physician
- Part-time or intermittent home health aide services, consisting primarily of caring for the patient in conjunction with skilled nursing care
- Physical, occupational, or speech therapy
- Drugs and most medical supplies prescribed by a physician
- Laboratory services.

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

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.

**Skilled Nursing Facility**

There is sometimes a need for intermediate care following a hospital stay. While the patient may no longer need the level of care provided in a hospital, he or she may require 24-hour nursing care for a limited period. In these circumstances, benefits for a skilled nursing facility (or convalescent care facility) are paid.

There are no limits on the number of days of skilled nursing facility care if provided in-network. Up to 60 days per calendar year are covered in an out-of-network skilled nursing facility or if you live in a non-network area.

**What’s Not Covered by Your Medical Benefits**

In addition to the items not specifically identified as covered and those specifically identified as excluded above, your medical benefits do not cover the following:

- Services or supplies that are not medically necessary
- Charges that exceed the reasonable and customary charge
- Additional expenses for a private room in a hospital, or private duty nursing while confined
- Treatments or procedures and related materials that are investigational or experimental in nature. Investigational or experimental means the medical use of a service or supply is still under study. In fact, the service or supply is not yet formally recognized throughout the medical profession in the U.S. as safe and effective for diagnosis or treatment. If a service or supply is furnished in connection with a service or supply that is investigational or experimental, as determined by the appropriate network manager or claims administrator, it is not covered.
- Services provided before coverage becomes effective or for services given after coverage ends
- Maternity coverage for dependent children
- Personal hygiene or convenience items, such as air conditioners, humidifiers, and physical fitness equipment
- Non-prescription dietary supplements
- Services or supplies related to any eye surgery, 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
- Reversal of a sterilization procedure
- Services or supplies for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, including surrogate parenting
- Acupuncture therapy, except when acupuncture is performed by a physician as a form of anesthesia in connection with surgery that is covered
Weight reduction programs, unless pre-approved by the network manager or claims administrator
Treatment of an intentionally self-inflicted injury
Cosmetic surgery on any part of the body except for corrective reconstructive surgery following a mastectomy or when medically necessary as the result of an accident, injury, or congenital defect
Charges for a missed or broken appointment
Charges for a doctor’s travel
Charges for dental or vision care
Custodial or sanitarium care or rest centers
Services or supplies that are provided by reason of past or present service in the armed forces of any government
Services or supplies for which benefits are provided by any government law
Occupational conditions, ailments, or injuries for which coverage is provided by Workers’ Compensation or by a similar law
Treatment of a condition caused by war (declared or undeclared) or any act of war
Treatment of a condition caused by committing an unlawful act of aggression, including a misdemeanor or a felony
Charges for claims filed 12 months after the service or treatment was provided.

In addition to this listing of what is not covered by your medical benefits, certain portions of the program have special limitations. For example, this description of your medical benefits also mentions items not covered under Infertility Treatment, Special Therapies, Home Health Care, Prescription Drugs, and Solutions.

Coordinating with Dental Coverage

If you live in a network area and need dental surgery that requires hospitalization, your PCP must be notified in advance of the hospitalization in order for you to receive in-network benefits. If you live outside the network area, you should follow the required steps to pre-certify your hospital admission. (See page 12 for a complete explanation.) In all cases, if you are 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 Medical Claim

If You Live In a Network Area
If you live in a network area, the procedure that applies to filing claims depends on whether the treatment provided was in- or out-of-network.

For In-Network Care
For in-network care provided by or coordinated by your PCP, you generally do not have to file a claim form. Simply pay the copayment when you receive the service. The network manager handles all other paperwork.

In certain special situations, such as when you are traveling and need medical care away from home, or if you or an eligible dependent child attends school away from home, or if you have eligible dependents who do not live in your network area, you have to submit a claim form for in-network care. You can obtain a claim form from the network manager at the toll-free number shown on your identification card. The claim form, along with the invoice for services provided, should be submitted to the network manager at the address shown on the form.

If you have any questions about procedures affecting benefits for you or your eligible dependents, simply contact Member Services.

For Out-of-Network Care
If you live in a network area and receive treatment out-of-network, to be reimbursed you must submit a completed claim form with all required documentation to the network manager.

If You Live Outside the Network Area
If you live outside the network area, you must submit a completed claim form with all completed documentation to the claims administrator to receive reimbursement.

Where to Get a Claim Form
You can obtain a claim form from your network manager or claims administrator at the toll-free number shown on your medical identification card.
Completing a Claim Form

The claim form must be completed by you and the provider of services. Be sure to:

- Provide all the information requested, including your Social Security number
- Use a separate form for each family member
- Indicate whether you want payment to be made to you or 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
- Doctor's full name, address, and tax identification number
- Diagnosis
- Date the service was provided
- Charge for each service.

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

If a claim is not received within 12 months after the date the service or treatment is given, no benefits will be paid.

Prescription Drugs

Your medical coverage provides prescription drug benefits for participants under age 65. UPS no longer provides prescription coverage for participants age 65 and over. You will need to enroll in a Medicare Part D prescription drug plan when you reach age 65.

Prescription drug benefits for participants under age 65 are administered by Medco through the following:

- Medco Health Prescription Drug Program — for your short-term and immediate prescription drug needs at retail pharmacies, including the major national drug store chains
- Medco by Mail Order — mail order program for long-term and ongoing maintenance prescription drug needs.

Medco Health Prescriptions

The Medco prescription program is designed to meet your short-term and immediate needs. When you get a prescription filled, you are charged a percentage (rather than flat copay) of the actual drug cost, whether retail or mail order.

You will pay 20 percent of the cost of the prescription drug for generic medications and brand-name drugs without a generic equivalent whether your prescription is filled at a local retail or mail order pharmacy.

For brand-name drugs with a generic equivalent, you will pay 20 percent of the cost of the generic equivalent in addition to the cost difference between the brand and generic medication.

Coinsurance Example

<table>
<thead>
<tr>
<th>You Pay</th>
<th>Generic Drug</th>
<th>Brand-name Drug (No Generic Equivalent)</th>
<th>Brand-name Drug (Has Generic Equivalent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>$30</td>
<td>$100</td>
<td>$30 x 20% = $6</td>
</tr>
<tr>
<td>x 20%</td>
<td>x 20%</td>
<td>$100 - $30 = $70</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Your cost: $6</td>
<td>Your cost: $20</td>
</tr>
</tbody>
</table>

You will receive a Medco Health identification card. The number on this card differs from the number on your medical identification card. Use the Medco Health number to locate a participating pharmacy near you or to request additional identification cards.

With retail prescription purchases, you can receive up to a 30-day supply per prescription, plus refills. Mail order purchases will allow you up to a 90-day prescription, plus refills. Contact Medco at 1-800-346-1327 to request additional identification cards, mail order forms, or to locate a participating pharmacy near you.

You can also visit Medco’s website (www.medcohealth.com) to find out about prescriptions and benefits, health and wellness, or forms and envelopes.
At a Participating Pharmacy

Although you may use any pharmacy you wish, Medco Health Prescriptions offers the advantage of no claim forms to file and a discounted price if you go to a participating pharmacy. Each time you fill a prescription, present your identification card to the pharmacist along with your doctor’s prescription.

At a Non-Participating Pharmacy

When using a non-participating pharmacy, you pay the full amount for each prescription and submit a completed claim form for reimbursement. Your cost will equal the difference between the full retail price and the discounted amount that would have applied had you used a participating pharmacy plus your coinsurance. For claim forms, call Medco at 1-800-346-1327 or request it online at www.medcohealth.com.

Once received, mail your completed and signed claim form to:

Medco Health
P. O. Box 6121
Fair Lawn, NJ  07410-0999

Medco by Mail Order Program

If medication is necessary on an ongoing basis, you can meet your long-term needs by getting up to a 90-day supply per prescription, plus refills, through the Medco by Mail Order Program. (If your prescription is for a controlled substance, you only can receive up to a 30-day supply and a signature is necessary for the prescription when it’s delivered to you.)

The first time you order drugs through the Medco by Mail Order Program, you must complete a patient profile, available by calling the toll-free number on your prescription identification card. This helps alert the team of registered pharmacists who fill your prescription of any potential reactions to the prescriptions you submit. When you receive your prescription, enclosed is a leaflet explaining the drug’s purpose, dosage advice, and other information.

If your doctor has authorized a refill, you can mail in your prescription refill or you can call Member Services at 1-800-346-1327. Have your refill slip with your prescription information handy when you call.

To prevent delays in filling your mail order prescription, check the written prescription to ensure that the following are legible prior to leaving your doctor’s office:

- Doctor’s name
- Exact daily dosage
- Strength and quantity
- Patient’s first and last name.

If you choose to order your drugs through the Medco by Mail Order Program, your prescription is immediately filled and shipped and you are not charged any shipping expenses. To order drugs through the Medco by Mail Order Program, send the prescription(s) to:

Medco by Mail Order Program
P. O. Box 650522
Dallas, TX 75265-9610

Summary of Your Prescription Drug Benefits

<table>
<thead>
<tr>
<th></th>
<th>Medco Health</th>
<th>Medco by Mail Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>When to use</td>
<td>Short-term and immediate medications</td>
<td>Long-term and on-going maintenance medications</td>
</tr>
<tr>
<td>Supply as per prescription as doctor prescribes</td>
<td>Up to a 30-day supply plus refills</td>
<td>Up to a 90-day supply plus refills</td>
</tr>
<tr>
<td>Claim form required</td>
<td>No, at participating pharmacies</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Yes, at non-participating pharmacies</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Voluntary Formulary
A formulary is a list of commonly prescribed medications you should present to your physician. By asking your doctor to prescribe drugs listed in the formulary, you can help control the rising cost of prescription medications to both you and UPS. A formulary list is sent to you once you receive your Medco prescriptions identification card. To obtain an additional formulary list, call Medco at 1-800-346-1327.

Out-of-Pocket Maximum
Prescription benefits will now have an annual $1,500 out-of-pocket maximum. Once reached, the Plan then covers eligible in-network drug expenses at 100 percent. See page 21 for terms regarding prescriptions filled by non-participating pharmacies. The out-of-pocket maximum for prescription benefits is separate from the medical out-of-pocket maximum.

Creditable Coverage
UPS determined that the Plan for participants under age 65 provides “creditable coverage,” which means that the Plan is expected to pay out as much as standard Medicare prescription drug coverage (on average) for all Plan participants.

Prescription Drug Benefits
Prescription drug benefits cover:
- Drugs approved by the federal government
- State-restricted drugs
- Insulin by prescription only
- Insulin needles, syringes, and chemstrips by prescription only
- Over-the-counter diabetic supplies
- Compounded medications
- Smoking deterrents (lifetime limit of 90-day supply)
- Oral contraceptives

Prescription Contraceptives
Network Plus covers all prescription contraceptives. This is part of UPS’s continued commitment to wellness and preventive coverage.
- Preventive care improves the overall health of participants over the long term. Improving our preventive coverage by offering prescription contraceptives provides women additional choices.

- Oral contraceptives are covered the same as any other prescription drug.
- Contraceptive devices, such as diaphragms and IUDs, are covered by the medical plan at the regular office visit copay for your option.
- Contraceptive injections and implants, such as Depo-Provera and Norplant, are covered by the medical plan at the regular office visit copay for your option.
- Non-prescription contraceptives are excluded from coverage.

What’s Not Covered by Prescription Drug Benefits
In addition to those prescriptions not specifically identified as covered and those specifically identified as excluded above, prescription drug benefits do not cover:
- Drugs not approved by the federal government
- Drugs used for cosmetic purposes
- Therapeutic devices or appliances
- Drugs labeled “Caution: Limited by Federal Law to investigational use,” or experimental drugs — even though a charge is made to the individual
- Medication for which the cost is recoverable by Workers’ Compensation, occupational disease law, any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the participant
- Medication that is to be taken by or administered to an individual, in whole or in part, while you’re an inpatient in a licensed medical facility that has a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order
- Dietary supplements — including any supplement for newborn infants
- Any kind of medications used for sexual dysfunction.
Solutions for Mental Health and Substance Abuse Treatment

If you participate in the Network Plus option (and are under age 65 and not covered by Medicare), benefits for medically necessary treatment for mental health and substance abuse (drug and alcohol abuse) is provided through Solutions, a program administered by ValueOptions.

For Solutions, medically necessary means care that:

- 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 Edition IV, or 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
- Is provided at the most appropriate and cost-effective level of care.

How Solutions Works

The Solutions Program operates separately from other parts of your medical plan and is a part of the total benefits you receive. Your out-of-pocket costs for mental health or substance abuse treatment do not count toward your annual out-of-pocket maximum. However, the benefits provided by Solutions do count toward your lifetime maximum benefit.

ValueOptions maintains a national network of mental health providers such as therapists, treatment programs, and hospitals. Like PCPs in the managed care options, ValueOptions’s providers meet strict membership requirements, have proper credentials, and are reviewed on a regular basis to ensure standards are met.

You will receive maximum benefits if you call Solutions for a referral. If you seek treatment on your own, Solutions will pay benefits only if treatment is provided by one of these core providers:

- Psychiatrist (MD, DO)
- Licensed Master’s Level Clinical Social Worker (e.g., Licensed MSW)
- Licensed Clinical Psychologist (Doctorial level)
- Masters Prepared Psychiatric Registered Nurse (e.g., MA, MS, or MSN).

In addition, all providers must have a current state license. Because licensing requirements vary from state to state, call Solutions at 1-800-336-9117 before you start treatment to verify the provider you are seeing is covered.

Two additional providers are available in the Solutions network in certain states:

- Licensed professional counselors (LPCs) and
- Licensed marriage and family counselors (MFCCs and/or LMFTs).

Not all states license the same mental health/substance abuse counselors. Therefore, ValueOptions only is able to offer coverage for Licensed Professional Counselors and Licensed Marriage and Family Counselors that have met the highest level of qualification and credentialing, as verified by ValueOptions. Counselors only are covered if they participate in the Solutions network.

Mental health treatment is provided as follows:

- All covered inpatient mental health treatment must be provided through a Solutions network provider
- Outpatient mental health treatment is provided through Solutions or a core provider who is not part of the Solutions network. Benefits for outpatient mental health treatment are payable for treatment outside of the Solutions network for up to 20 visits per calendar year at 50 percent of reasonable and customary charges, with no deductible applying. In addition, ValueOptions must pre-certify the following services:
  — Psychological testing
  — Electroconvulsive therapy (ECT)
  — Biofeedback
  — Hypnotherapy
  — Aversion therapy
  — Individual therapy for chemical dependency.
Up to five visits per calendar year for marital, parent/child, partner/relational, sibling/relational, and bereavement counseling provided by a Solutions network provider.

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

**Substance abuse treatment**

Substance abuse treatment — inpatient or outpatient — is provided only through Solutions.

Substance abuse treatment not approved by Solutions before treatment is provided is not covered. For substance abuse treatment arranged through Solutions, you are responsible for one fee or copayment per course of treatment, regardless of the setting (or settings) for the treatment. You and your covered dependents can contact Solutions 24 hours a day, 365 days a year by calling 1-800-336-9117. If you seek emergency treatment, you must contact Solutions within 48 hours. You can call Solutions directly, your PCP, or another doctor may refer you to Solutions.

When you first call Solutions, you will talk with a trained professional who will discuss your situation confidentially with you. You may then be referred to an appropriate provider for a more complete evaluation and development of a treatment plan. After a treatment plan is developed, Solutions will monitor the care to ensure the treatment you receive is appropriate and medically necessary.

**What’s Not Covered**

In addition to the items not specifically identified as covered and those specifically identified as excluded above, the following mental health and substance abuse services and treatment are not covered:

- Services or treatments that are not medically necessary
- Treatment not provided by one of the core providers
- Court-ordered treatment, unless assessed and certified to be in accordance with medically necessary standards
- Services and treatment for the purpose of maintaining employment or insurance, unless assessed and certified to be in accordance with medically necessary standards.
- Services and treatments which are:
  - Educational or vocational in nature
  - Required by law to be provided by a school system for a child (e.g., evaluation for attention deficit disorder)
  - For personal growth and development
  - For adjudication of marital, child support, and custody cases
  - Services and treatment that are experimental, investigational, mainly for research or not in keeping with national standards of practice; 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, pervasive development disorders, chronic organic brain syndrome, learning disability
  - Treatment for transsexualism
  - Treatment for smoking cessation
  - Treatment for obesity and/or weight reduction
  - Treatment for stammering or stuttering
  - Treatment for chronic pain, except for psychotherapy, biofeedback, or hypnotherapy rendered in connection with a psychiatric disorder.

In addition to this list, certain medical services or supplies are not covered (see What’s Not Covered). Call Solutions at 1-800-336-9117 to determine if specific mental health or substance abuse treatment is covered.
Confidentiality
Information regarding your or an eligible dependent’s participation in Solutions is kept confidential. There are some exceptions — if you give written consent or if disclosure is required by law.

How to File a Solutions Claim

For In-Network Care
For care received from a Solutions network provider, you generally do not have to file any claim forms. Pay the copayment when you receive service.

For Out-of-Network Care
If you receive outpatient mental health treatment from a provider who does not participate in the Solutions network, you must submit a completed claim form with all required documentation to Value Options for reimbursement. If you need a claim form or have a question about a claim, you may call ValueOptions at 1-800-336-9117.

Send your completed claim to:
ValueOptions
P. O. Box 1347
Latham, NY 12110-8847

Dental
The UPS Retired Employees’ Health Care Plan offers you optional dental coverage administered by Aetna.

Two-Year Rule
If you choose dental coverage, you must keep it for two years. If you elect no coverage for dental, there will be a two-year waiting period before you can elect coverage under the dental option again. The two-year period begins on your coverage effective date. For newly eligible retirees, a partial year counts as a full year in calculating the two-year period.

If you fail to make an election during your initial enrollment period and therefore have no dental coverage, you will be allowed to elect coverage at the first annual enrollment following your initial enrollment period.

If you fail to elect dental coverage at the first annual enrollment, your two-year lockout period will begin January 1 following the first annual enrollment (not with your initial coverage effective date.)

The dental plan covers four categories of necessary dental care:
- Preventive service — including check-ups, cleanings, and routine X-rays
- Basic services – including fillings, simple extractions, space maintainers, and root canal therapy
- Major restorative services – including inlays, onlays, crowns, and dentures
- Orthodontia (the straightening of your child’s teeth).

The dental plan provides varying benefit levels for covered dental services and allows you to see the dental provider of your choice. You can participate in Aetna’s Preferred Provider Organization (PPO), which means you can choose to use a participating dentist or a non-participating dentist at the point of service each time you need dental care.

Aetna Dental Preferred Provider Organization (PPO)
A central feature of your dental coverage is access to the Aetna Dental PPO, a national network of preferred dental care providers. However, you do not have to use a PPO dentist to receive benefits. Dentists in the PPO have agreed to a fee schedule which 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 PPO.

Each time you need dental care, you can choose to use a participating dentist or a non-participating dentist. While there is no penalty if you decide not to use a PPO provider, your out-of-pocket expenses may be greater if you use a non-participating dentist.

If you live outside the Dental PPO network boundaries, your coverage is the same as network coverage, but you do not receive the negotiated rates, even if you happen to see a network provider. To receive network...
rates, you must “opt in” to the network. Check availability of network providers before opting in. Call the Benefits Service Center to learn more about opting into the network. Your Enrollment Worksheet will indicate whether you live within the boundaries of the Dental PPO network.

Selecting a Network Dentist
A list of local participating dentists is available by calling Aetna. Every dentist selected to participate in the Aetna Network must meet Aetna’s selection criteria. For example, dentists must have:

- An appropriate professional degree
- A current, unrestricted state license
- Adequate malpractice insurance
- Sufficient office hours to meet patient demand.

Each member of your family can use a different participating dentist, and you may change your network dentist at any time. If you need assistance in selecting a new network dentist, call Aetna Member Services at 1-877-263-0659.

Scheduling an Appointment
When you call your participating dentist to make an appointment, make sure to identify yourself as an Aetna participant. When you visit the dentist’s office, please be sure to show your dental identification card.

Accidental Injury
If you have dental coverage under Network Plus, coverage for treatment and repair of sound teeth and gums damaged by an accidental injury is covered as a regular dental expense. For this treatment and repair of accidental injuries only, the deductible and the annual maximum is waived for 12 months from the date of the injury. All other dental care will continue to be subject to the annual deductible and annual maximum.

Orthodontic treatment required to repair sound teeth damaged by an accidental injury is covered at 50 percent (of reasonable and customary 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 for adults beyond restoration is not covered.

An example of a covered accident to sound teeth and gums would result from a car accident or a blow from an external force — such as a baseball. An example not considered an accident under this provision is breaking a decayed tooth by biting down on hard food.

Specialty Treatment
Although your participating dentist will provide most dental care, occasionally you may require a specialist’s services for more complex dental work. The Aetna PPO network includes a national listing of specialty dentists. You may also select a non-participating specialist.

Aetna Member Services
Aetna Member Services is your link to coverage. Call Member Services toll-free at 1-877-263-0659 to ask questions about your benefits, obtain information about a network provider or service, or to obtain help in filing claims.

Important Dental Coverage Features

The Deductible
The deductible is the amount you pay for covered basic and major restorative services and temporomandibular joint therapy before benefits are paid. The deductible does not apply to preventive services or orthodontia and a new deductible must be met every year. The individual deductible is $50 and the family dental deductible of $100 is determined in the same way as your family medical deductible.

Maximum Benefits
Claim payments made by your dental coverage counts toward your annual dental maximum of $1,000. The cost of preventive services also counts toward your annual maximum.
For example, assume you have incurred $100 in eligible expenses and your Plan pays $50. This means you pay $50 and your plan pays $50. The $50 paid by the Plan counts toward the annual maximum.

**Reasonable and Customary**

All eligible dental expenses from a non-participating dentist are subject to reasonable and customary limits — charges within the normal range of fees in your geographic area for similar services and similar supplies. If your non-participating dentist charges more than the reasonable and customary limit, you are required to pay any amounts considered higher. Reasonable and customary does not apply to services provided through a participating PPO dentist.

**Lifetime Maximums**

**Orthodontia**

Up to $2,000 in lifetime dental benefits can be paid for orthodontia treatment for your dependent child under 19 years of age. Your dependent child’s lifetime maximum is carried over from the UPS plan that covered you as an active employee and is applied to the UPS Retired Employees’ Health Care Plan. For example, if your child incurred $1,000 of covered expenses while you were an active employee, he or she has $1,000 of eligible benefits remaining from the UPS Retired Employees’ Health Care Plan.

**Temporomandibular Joint (TMJ) Therapy**

Up to $2,000 in lifetime dental benefits can be paid for TMJ treatment for you, your spouse, and dependent children. Your lifetime maximum carries over from the UPS plan that covered you as an active employee and applies to the UPS Retired Employees’ Health Care Plan. The $2,000 lifetime maximum limit for children’s TMJ benefits is combined with the orthodontia maximum.

**Covered Expenses**

This section describes the types of services and supplies that are covered. The exact amount paid for services and supplies depends on if you see a participating dentist, and if the dental care is necessary. All eligible dental expenses must be necessary preventive care or to diagnose and treat dental disease. In addition, your frequency limits carry forward from the UPS plan that covered you as an active employee and is applied to the UPS Retired Employees’ Health Care Plan. For example, if your active plan paid for two preventive oral exams in the calendar year in which you retired, the UPS Retired Employees’ Health Care Plan will not cover any additional preventive oral exams in that same calendar year.

**Preventive Services**

Covered preventive services are:

- Oral exams (twice per year*)
- Prophylaxis — any type (twice per year*)
- Topical fluoride applications for children under age 15 (twice per year)
- X-rays
  — Full mouth or panoramic (once every three years)
  — Bitewing (twice a year)
- Sealants for children under age 14
  — One application per tooth per 36-month period
  — Permanent first and second molars

*If additional examinations and cleanings are necessary each year, the dentist should submit a letter to Aetna Dental explaining the request. Aetna Dental will review and respond directly to your dentist.

**Basic Services**

Covered basic services are:

- Permanent fillings
  — Resin for the repair of diseased teeth
- Treatment of the gums (periodontics)
  — Periodontal scaling and root planning
- Root canal therapy
- Routine extractions
- Space maintainers for children under age 19 (includes all adjustments within six months after installation)
- Night guard (for treatment of bruxism)
- Osseous surgery
- Root canal therapy
- Removal of impacted wisdom teeth
- Anesthesia, when medically necessary
- Repairs to crowns, inlays, bridgetwork, and dentures.
**Major Restorative Services**
Covered major restorative services are:
- Inlays
- Onlays
- Crowns
- Bridges
- Removable dentures
- Relining of dentures
- Implants (if the teeth are extracted or missing while covered under the Plan).

CROWNS, INLAYS, AND ONLAYS ARE COVERED ONLY AS TREATMENT FOR DECAY OR TRAUMATIC INJURY AND ONLY WHEN TEETH CANNOT BE RESTORED WITH FILLING MATERIAL OR WHEN A TOOTH IS AN ABUTMENT TO AN ELIGIBLE PARTIAL DENTURE OR FIXED BRIDGE.

**Orthodontia**
Benefits for teeth straightening for your dependent children under age 19 are covered. Services provided by December 31 of the year in which your child turns 19 are covered, as long as treatment began before the child’s 19th birthday. Your dental coverage pays 50 percent of the reasonable and customary charge for orthodontia — up to a $2,000 lifetime maximum for each child. Orthodontia benefits are not subject to the annual deductible. Benefits pay on a periodic schedule. No lump sum payments are made in advance. Payments begin once an active appliance is installed in your dependent child’s mouth.

Covered orthodontic services are:
- Initial consultation
- Moldings and impressions
- Installation of braces
- Regular visits.

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 is covered.

If your child is involved in a course of orthodontic treatment when your coverage becomes effective, the dental plan will not pay benefits toward that treatment. This does not apply if the course of treatment was covered by the UPS plan that covered you as an active employee.

**Temporomandibular Joint (TMJ) Therapy**
Treatment for temporomandibular joint dysfunction for adults and dependent children is covered. This coverage is for TMJ appliance therapy (bite splints), adjustments, and diagnostics — such as exams, X-rays, study models, and consultations.

Your dental coverage reimburses 50 percent of the reasonable and customary cost of TMJ therapy up to a $2,000 lifetime maximum.

**What’s Not Covered by Your Dental Benefits**
In addition to services not specifically listed in the Covered Expenses section, the following expenses are not covered:
- Services not required for the treatment of a specific condition or to maintain good dental hygiene
- Services not reasonably necessary or customarily performed
- Services for which you would not be required to pay in the absence of dental coverage
- Charges covered by the UPS medical plan
- Treatment of a work-related injury
- Occlusal adjustment (unless following periodontal surgery) or retainers if charged separately from orthodontic treatment
- Appliances, restorations, or procedures needed to alter vertical dimensions or restore occlusion or for the purpose of splinting or correcting attrition or abrasion
- Dentures and bridgework when they are for the replacement of teeth that were extracted before the patient was covered by a UPS dental plan
- Relines and adjustments of dentures and partial dentures within six months after installation
- Cosmetic dental services and supplies, including personalization or characterization of dentures
- Prosthetic devices, including bridges and crowns, and expenses for fitting them if the patient is not covered by a UPS dental plan when they are ordered or if they are installed or delivered more than 30 days after the patient’s coverage ends
• Replacement of lost, stolen, or broken appliances
• Treatment by someone other than a dentist, physician, or dental technician under the direction of a dentist or physician
• Education programs, such as plaque control or oral hygiene instruction
• A crown, inlay, denture, or fixed bridge (or the addition of teeth to one) if the work involves a modification or replacement of one installed less than five years before
• Charges for your missed or broken appointment
• Charges for the dentist’s travel.

Coordinating with Medical Coverage
If you live in a network area and need dental surgery that requires hospitalization, your PCP must be notified in advance of the hospitalization for you to receive in-network benefits. If you live in a non-network area, follow the required steps to pre-certify your hospital admission. (see the Pre-certification of a Hospital Admission section.) In all cases, if you become 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 Dental Claim
You have to file a claim whether you use a participating dentist or a non-participating dentist. Send the completed claim forms to Aetna Dental at the address shown on the form or your identification card. To obtain a claim form, call Aetna at 1-877-263-0659.

Predetermination of Benefits
Your dental coverage 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) before work starts. A dental consultant will review the proposed treatment, and Aetna will inform you and your dentist of the amount of covered charges. Doing so can help you understand how or if benefits will be paid prior to beginning treatment. Unless it is an emergency, you may not wish to begin the course of treatment until you know what amount your dental option will pay.

Vision
The UPS Retired Employees’ Health Care Plan offers coverage for an eye exam each year and for frames and lenses every two years through Vision Service Plan’s (VSP) network of providers.

VSP has more than 22,000 member doctor locations that provide professional eye care, including eye examinations and the necessary corrective lenses. To use these services, call VSP at 1-800-877-7195 or go to the “View my benefits” link at UPSers.com (under the My Life and Career tab) for a current list of member doctors in your area. When making an appointment, inform the representative that you are covered by UPS and give them the retired UPSers’s Social Security number. Your VSP provider will verify your eligibility and plan coverage before your appointment.

Covered Expenses
The Plan pays 100 percent of cost of a vision exam once each calendar year if you use a VSP provider. The full cost of corrective lenses and standard frames is covered every two years if you use a VSP provider. If you choose more expensive frames or cosmetic lenses, you are responsible for additional charges at reduced prices.

There is no vision care coverage if you do not use a VSP provider.

Contact lenses are covered in lieu of glasses — up to $100. For disposable contact lenses, the entire benefit amount must be used at one time.

Medically necessary contact lenses (such as those required after cataract surgery or for special medical conditions) are paid in full through VSP providers.

Discounts From VSP Providers
VSP providers offer a 20 percent discount on a second pair of glasses, and a 15 percent discount on professional contact lens services (fitting, evaluation, and follow-up).
**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. Go to VSP’s website at [www.vsp.com](http://www.vsp.com) or call 1-800-877-7195 to learn more about laser vision correction and participating doctors.

**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:
- Frames costing more than the plan allows
- Coated lenses
- Contact lenses (except as noted earlier)
- No-line, blended bifocal lenses.

**What’s Not Covered by Vision Benefits**
The vision options will not pay benefits for the following professional services or materials:
- 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 in the last two years)
- Medical or surgical treatment of eyes
- Services or materials provided as 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
- Visual analysis that does not include a complete eye refraction
- Services by a non-VSP provider

- Vision care services, materials, or procedures covered by other provisions of the UPS Retired Employees’ Health Care Plan. For example, vision therapy after cataract surgery is covered by the medical benefits.

**Two-Year Rule**
If you choose vision coverage, you must keep it for two years. If you elect no coverage for vision, there will be a two-year waiting period before you can elect coverage under the vision option again. The two-year period begins on your coverage effective date. For newly eligible retirees, a partial year counts as a full year in calculating the two-year period.

If you fail to enroll during your initial enrollment period and therefore have no vision coverage, you will be allowed to elect coverage at the first annual enrollment following your initial enrollment period. If you fail to elect vision coverage at the first annual enrollment, your two-year lockout period will begin January 1 following the first annual enrollment (not with your initial coverage effective date.)

**How to File a Vision Claim**
If you use a VSP provider, your provider will file all necessary claim forms. Make an appointment with your VSP provider and alert your provider that you are covered by UPS and provide them your Social Security number (SSN). Your VSP provider will verify your eligibility and plan coverage before your appointment. To use these services, call VSP at 1-800-877-7195 or visit [www.vsp.com](http://www.vsp.com).

**Maintenance of Benefits Before You Are Eligible for Medicare**
Your Network Plus coverage has a maintenance of benefits provision that ensures you will not receive duplicate benefits from two plans. This means your coverage will not exceed the amount that would have been paid by the UPS Plan. However, maintenance of benefits does not apply to prescription drug benefits.

If covered by two plans, one of the plans pays claims as primary, and the other is considered secondary. The primary plan pays benefits first when submitting claims. 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 primary plan is the plan covering the person as an employee or retired employee rather than the plan covering the person as a dependent.
- 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 a 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.

When a determination cannot be made, the plan covering the eligible dependent longer is considered primary. Any other situations will be handled in accordance with guidelines established for coordination of benefits by the National Association of Insurance Commissioners.

If the Plan is secondary in accordance with these provisions, but the primary plan attempts to reduce its responsibility under the primary plan solely because you are or your family is covered under another plan, the Plan only pays benefits under this Plan in accordance with the maintenance provisions of this Plan as though the primary plan paid benefits without regard to other coverage you may have. The plan administrator has sole discretion to determine the amount that the primary plan would have paid, taking into account the governing documents of the other plan.

**Example**

To show how maintenance of benefits works, assume your spouse is covered by another plan that is primary and by the UPS Plan. Also, assume your spouse has covered expenses of $100, the other plan would pay benefits of $75 and the UPS Plan would pay benefits of $85. Since the other plan is primary, your spouse will receive $75 from that plan. The UPS Plan will pay an additional $10 to make the total reimbursement $85, or the amount that would have been paid by the UPS Plan if there were no other coverage. However, if the other plan would have paid $90, the UPS Plan will not pay any additional amount because the benefit paid by the other plan exceeds the UPS medical benefit payment.

If services are provided by a non-network provider, your benefits are considered as out-of-network. For example, assume your spouse has an office visit to a provider who participates in the network for your spouse’s medical plan, but is not a PCP in the UPS network. For purposes of the maintenance of benefits provision, that visit will be an out-of-network visit when calculating what you have to pay and what the UPS Plan will pay.

**If You are Covered by Another UPS Plan**

Although the plan coordinates with other group health plans, this is not the case with respect to any other UPS-administered plan. If you and any dependents are covered by a UPS-administered plan, you receive benefits only from the plan to which you belong as an employee or retired employee. You cannot receive benefits from both this Plan as a retired employee and from another UPS-administered plan as a dependent.

If you and your spouse are each covered by a UPS-administered plan as an employee or retired employee, your dependent child receives coverage only from the plan of the parent whose birth date falls first in the calendar year.
Coverage Once You Are Medicare Eligible

You are eligible for Medicare at the beginning of the month in which you reach age 65, unless your birthday falls on the first day of the month in which case you are eligible for Medicare at the beginning of the month prior to your birthday. If you become eligible for Medicare prior to your 65th birthday, for instance because of a disability, call the Benefits Service Center to inform a representative of your new Medicare status (1-800-353-9877).

This section describes your coverage once you reach age 65 and/or become eligible for Medicare. Your coverage includes medical care that coordinates with Medicare. If you are eligible for Medicare due to attaining age 65, your coverage does not include prescription drug, dental, or vision coverage. If you are under age 65 and Medicare eligible due to a disability, your coverage will continue to include prescription drug, dental, and vision coverage.

These rules apply even if you do not become entitled to Medicare.

Creditable Coverage

UPS determined that the Plan for participants under age 65 provides “creditable coverage,” which means that the Plan is expected to pay out as much as standard Medicare prescription drug coverage (on average) for all Plan participants.

For Medicare eligible participants age 65 and older, prescription drug benefits are not provided through the plan; however, they are delivered through a Medicare Part D prescription drug plan of the participant’s choice.

A Guide to Indemnity Benefits

Once you reach age 65 and become eligible for Medicare, your Network Plus coverage is provided by a traditional indemnity plan. You will receive a new Medical ID card. In most cases, Medicare becomes your primary coverage, while your UPS Plan is secondary. However, there are special rules relating to those who become entitled to Medicare first due to End Stage Renal Disease.

If you are entitled to Medicare first due to End Stage Renal Disease, the UPS Plan is primary during a coordination period established by applicable law.

With an indemnity plan, you choose any doctor or health care provider you wish to provide covered services and supplies. Benefits are paid subject to the Plan’s applicable limitations once you pay the annual deductible. All covered expenses must be:
- Medically necessary
- Not investigational or experimental
- Within the reasonable and customary amount as established by the carrier for the services
- Supplies that are received.

Choosing a Doctor

While you are not required to select a primary care physician, you may want to consider making that choice for you and your dependents so you have a doctor with full knowledge of your health history. You also may continue to see your PCP. Your doctor can work with you in coordinating your care and the selections of any necessary specialists.

Medical Expenses You Pay

The Plan pays a portion of the medical expenses you and your family may have each year. Generally, you also pay a portion of the costs incurred. The following information describes the types of charges for which you are responsible. (For more information, please see the Summary of Network Plus Benefits section.)

Deductible

The deductible is the amount you must pay before certain benefits begin each year. In addition to an individual deductible of $50, your coverage has a family deductible that is twice the individual deductible, or $100. This means that if two or more family members have combined expenses credited to the deductible and equal the family deductible amount, any further expenses incurred by a family member that year will be eligible for payment. This is true even if no one person in the family has met the individual deductible amount.
For example, suppose you, your spouse, and your two children each have covered medical expenses. You can meet your $100 family deductible if your family’s medical expenses apply to individual deductibles in either of the following two examples:

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<tr>
<th>Eligible Medical Expenses</th>
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<th>Example #2</th>
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<td><strong>TOTAL</strong></td>
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In the plan year in which you reach age 65, any covered expenses you have accrued toward your individual deductible for that year will count toward your new $50 deductible once you reach age 65. For instance, if you have incurred $40 in covered expenses as of your 65th birthday, you will only need another $10 in covered expenses to meet your $50 deductible for that year.

If your family deductible was met for that year, you do not need to meet a new annual individual or family deductible when your coverage changes at age 65. If your spouse is under age 65, coverage for the spouse and dependent children does not change.

Individual and family deductibles are not affected by your change in coverage (moving to the age 65 and over coverage).

**Coinsurance**

Coinsurance is the percentage of covered expenses paid by the Plan. Generally, the Plan pays 80 percent of your reasonable and customary covered medical expenses after you meet the deductible. The portion of the cost you pay credits toward your out-of-pocket maximum under the UPS Retired Employees’ Health Care Plan.

**Out-of-Pocket Maximum**

There is a limit on how much you have to pay out-of-pocket each year. After you pay $1,500 in covered expenses, 100 percent of most covered changes are paid for the rest of the calendar year. This feature can be especially valuable if you or a dependent has a catastrophic illness or injury. In the plan year in which you reach age 65, any covered medical expenses you paid toward your individual $1,000 medical out-of-pocket maximum for that year (prior to becoming eligible for Medicare) counts toward your new $1,500 medical out-of-pocket maximum.

For instance, if you paid $1,000 in covered out-of-pocket expenses as of the date you became eligible for Medicare, you then only need to pay $500 in covered out-of-pocket expenses to meet your new age 65 and over $1,500 out-of-pocket maximum for that year.

In calculating your out-of-pocket expenses, the dollar amounts included are the deductible and the percentage you pay after the coinsurance. Any amount considered over reasonable and customary charges are not included to calculate the out-of-pocket maximum.

**Reasonable and Customary (R&C)**

Charges within the normal range of fees charged in your geographic area for similar services and similar supplies. If your expenses are considered more than reasonable and customary by the claims administrator or network manager, you will be responsible for paying the additional amount. These charges do not count toward your deductible or out-of-pocket maximum. The claims administrator periodically updates reasonable and customary charges.

**Emergency Treatment**

In an emergency, seek medical care as quickly as possible. Contact your doctor so he or she can coordinate your care.

Emergency treatment is covered at 80 percent (R&C) after you meet your deductible — whether provided in a clinic, a doctor’s office, or the outpatient department of a hospital. Keep in mind that treatment in a hospital outpatient department is normally more expensive than similar care given in a clinic or a doctor’s office. Hospital emergency rooms and other emergency treatment centers only should be used in an emergency.
What is an Emergency?
An emergency is a sudden and serious situation that happens unexpectedly and requires immediate medical attention. Examples include an apparent heart attack, loss of consciousness, excessive bleeding, severe or multiple injuries, or serious burns. You should contact your doctor if you are unsure whether your illness or injury is an emergency.

If You Travel Abroad
If while traveling abroad you need medical attention, your coverage will still apply. You should arrange to pay all your medical expenses you have in that country and then submit the itemized bill(s) to your claims administrator as you normally would after you return to the U.S. You are reimbursed in U.S. dollars.

What’s Covered
Your medical benefits once you reach age 65 cover many of the same medical services and supplies that were covered while under age 65. The services and supplies must be:
- Medically necessary
- Neither investigational nor experimental
- Within the standard for the reasonable and customary amount.

Solutions — for Mental Health and Substance Abuse Treatment
Your mental health and substance abuse coverage, like your medical coverage, changes to an indemnity plan when you reach age 65. Mental health or substance abuse treatment is covered like any other medical condition.

You still have access to Solutions as a referral and assessment service on a voluntary basis. You are encouraged to use this service (contact Solutions) at 1-800-336-9117 if you are seeking treatment.

Medical Benefits Not Covered at Age 65 and Over
In addition to the services and supplies listed in the What’s Not Covered by Your Medical Benefits section, the following benefits are not covered by your Plan once you reach age 65:
- Preventive care
- Hearing exams and hearing aids
- Dental
- Vision
- Prescription drugs.

How to File a Medical Claim
You must submit a completed claim form with completed documentation to the claims administrator with a copy of your Medicare Explanation of Benefits to receive reimbursement. You may also enroll in Aetna’s Medicare Direct program by contacting Aetna for a registration card at 1-800-297-7145.

Medicare Direct is a no-cost-to-you, claim-filing service available to Plan participants and covered dependents currently enrolled in Medicare Part B. Medicare Direct automatically transfers Medicare Part B claims from Medicare to Aetna for processing under the Retired Employees’ Health Care Plan.

If you enroll in Medicare Direct and see a physician for any of the following typical covered Medicare Part B expenses it is no longer necessary to submit claims to Aetna:
- Medical and surgical services (including anesthesia)
- Diagnostic testing and procedures (as part of treatment)
- Radiology and pathology services (as a hospital inpatient or outpatient)
- Treatment for mental illness.

Where to Get a Claim Form
You can obtain a claim form by calling the claims administrator at the toll-free number shown on your medical identification card.
Completing a Claim Form
The claim form must be completed by you and the service provider. When completing the form, be sure to:
- Provide all the information requested, including your medical identification or Social Security number
- Use a separate form for each family member
- Indicate whether you want payment to be made to you or to your health care provider.

You can 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
- Doctor’s full name, address, and tax identification number
- Diagnosis
- Date the service provided
- Charge for each service.

Send the completed form along with your Medicare payment summary to the claims administrator at the address shown on your identification card or register for Aetna’s Medicare Direct program for automatic claims submission.

If a claim is not received within 12 months after the date the service or treatment is given, no benefits will be paid.

Prescription Drugs for Age 65 and Over
For Medicare eligible participants age 65 and older, prescription drug benefits are not provided through the plan; however, they are delivered through a Medicare Part D prescription drug plan of the participant’s choice. Therefore, you should consider enrolling in a new Medicare Part D prescription drug plan to replace your under age 65 UPS prescription drug coverage if you do not have creditable prescription drug coverage elsewhere.

Coordination with Medicare
Once Medicare becomes your primary coverage, your UPS medical coverage is coordinated with your Medicare benefits. Generally, you become eligible for Medicare when you reach age 65, although you may become eligible sooner if you become disabled.

Medicare Part A
- Covers hospital expenses only
- Coverage begins at age 65 if you’re receiving Social Security benefits; if you’re not receiving benefits, you must apply for Part A coverage
- Generally does not require a monthly premium.

For more information on Medicare Part A, call the Social Security Administration at 1-800-772-1213. (TTY users should call 1-800-325-8778.)

Medicare Part B
- Covers medical expenses (e.g., doctor’s visits, X-rays, lab tests, home health care, and out-patient hospital services, but not prescription drugs)
- Coverage begins at age 65 if you’re receiving Social Security benefits; if you’re not receiving benefits, you must apply for Part B coverage
- You pay a monthly premium
- Monthly amounts may be higher if you don’t sign up for Part B when you first become eligible
- The cost could go up 10 percent for each full 12-month period that you could have signed up for it, but didn’t except in some special cases (refer to the Medicare and You booklet)
- Medicare deductible and premium rates may change every year in January
- Must pay a Part B deductible each year before Medicare starts to pay its share
- If you didn’t sign up for Medicare Part B when you first became eligible, call the Social Security Administration at 1-800-772-1213 to apply. TTY users should call 1-800-325-0778.

You may choose not to receive Medicare Part B coverage. However, you should understand that the UPS Plan will pay medical benefits assuming you are covered by both Part A and Part B.
It is important to understand that your UPS coverage is not a Medicare supplemental plan. Instead, your Plan works along with Medicare to help cover most of your medical expenses.

For example, if you have hospital expenses covered by Medicare Part A, your UPS Plan will pay 80 percent of the Medicare hospital deductible (less the UPS deductible if it has not been met.) Together with expenses paid by Medicare, your UPS-provided benefits will not exceed more than 80 percent of your submitted expenses. Keep in mind that you may not always receive a benefit from your UPS Plan for claims submitted. However, you are fully protected from catastrophic losses.

**Two Benefit Examples**
These examples are for illustrative purposes only. Any changes to Medicare are beyond the Plan’s control.

These two examples show how your UPS coverage coordinates with Medicare. For these examples, let’s assume that:
- The submitted charges are $900
- Medicare’s approved (R&C) amount is $825
- The claims administrator's approved (R&C) amount is $850
- The Medicare deductible is $100
- This is your first medical claim of the calendar year, and you have not reached your UPS Plan’s or Medicare annual deductible.

Let’s take a look at the steps used to calculate your benefit.

**Example 1: Providers Who Accept Medicare Assignment**

Medicare “assignment” means that doctors (or other providers of service) agree to bill you only for the amount that is approved by Medicare even if their usual charge for the same service is more than that amount. When doctors accept assignment, the claims administrator uses the approved Medicare assignment amount as the basis for calculating benefits from the UPS Plan.

1. **Determine Medicare covered charges**
   Subtract the Medicare R&C from the total submitted expenses
   
   $900 Submitted charges
   $825 Medicare R&C
   $ 75 Balance
   
   You are not responsible for the $75 balance because your provider has agreed to accept the Medicare assignment

2. **Determine your Medicare benefit**
   Subtract the Medicare deductible from the Medicare R&C
   $825 Medicare R&C
   – $100 Medicare deductible
   $725 Balance
   
   Multiply the balance by Medicare’s coinsurance, which is 80 percent
   $725 Balance from above
   x 80% Medicare coinsurance
   $580 Medicare benefit

3. **Determine your maximum possible UPS Plan benefit**
   (because the provider accepts Medicare assignment, the UPS Plan bases its calculation on the Medicare R&C, rather than on the claims administrator’s R&C amount). Subtract your UPS Plan deductible from the Medicare R&C
   $825 Medicare R&C
   – $ 50 UPS Plan deductible
   $775 Balance
   
   Multiply the balance by the UPS Plan’s coinsurance, which is 80 percent
   $775 Balance
   x 80% UPS coinsurance
   $620 Maximum possible UPS Plan benefit
4. Determine coordination of benefits with Medicare

Subtract Medicare’s benefits from the UPS Plan’s maximum possible benefit to determine your UPS Plan’s benefit

$620 maximum possible UPS plan benefit
– $580 Medicare benefit

$40 UPS Plan benefit

5. Determine the amount you pay

Add Medicare and UPS Plan benefits to determine total combined benefit

$580 Medicare benefit
+ $40 UPS Plan benefit

$620 Total Medicare + UPS Plan benefit

Subtract the total combined benefit from the Medicare R&C

$825 Medicare R&C
– $620 Total Medicare + UPS Plan

$205 Your out-of-pocket payment

You are responsible only for the difference between the Medicare R&C and the combined benefit paid by Medicare and UPS because your provider accepts Medicare assignment. You pay only the remaining balance of $205. The entire $205 applies toward your UPS Plan out-of-pocket limit.

Example 2: Providers Who Do Not Accept Medicare Assignment

If your doctor (or provider of service) does not accept Medicare assignment, you are responsible for the full amount billed. (However, legislation limits the amount doctors or hospitals may charge over the approved Medicare amount. For more information, contact your local Medicare office.)

1. Determine your Medicare benefit

Subtract the Medicare deductible from the Medicare R&C

$825 Medicare R&C
– $100 Medicare deductible

$725 Balance

Multiply the balance by Medicare’s 80 percent coinsurance

$725 Balance from above
x 80% Medicare coinsurance

$580 Medicare benefit

2. Determine your maximum possible UPS Plan benefit

(when the provider does not accept Medicare assignment, the UPS Plan bases its calculation on the claims administrator’s R&C amount, rather than on the Medicare R&C). Subtract your UPS Plan deductible from the claims administrator’s R&C

$850 Claims administrator’s R&C
– $50 UPS Plan deductible

$800 Balance

Multiply the balance by the UPS Plan’s coinsurance, which is 80%

$800 Balance from above
x 80% UPS coinsurance

$640 Maximum possible UPS Plan benefit

3. Determine coordination of benefits with Medicare

Subtract Medicare’s benefits from the UPS Plan’s maximum possible benefit to determine your UPS Plan’s benefit

$640 Maximum possible UPS Plan benefit
– $580 Medicare benefit

$60 UPS Plan benefit
4. Determine the amount you pay
Add Medicare and UPS Plan benefits to determine total combined benefit

\[ \begin{align*}
$580 & \quad \text{Medicare benefit} \\
+ \quad $60 & \quad \text{UPS Plan benefit} \\
\hline
$640 & \quad \text{Total Medicare + UPS Plan benefit}
\end{align*} \]

Subtract the total combined benefits from the total submitted expenses

\[ \begin{align*}
$900 & \quad \text{Total submitted expense} \\
- \quad $640 & \quad \text{Total Medicare + UPS Plan benefits} \\
\hline
$260 & \quad \text{Amount you pay for treatment}
\end{align*} \]

Because your provider does not accept Medicare assignment, you are responsible for the difference between total billed charges and the combined benefit from Medicare and the UPS Plan, or $260.

5. Determine amount that applies toward your UPS Plan out-of-pocket limit
Subtract the claims administrator’s R&C amount from the total submitted expenses

\[ \begin{align*}
$900 & \quad \text{Total submitted expense} \\
- \quad $850 & \quad \text{Claims administrator’s R&C} \\
\hline
$50 & \quad \text{Balance}
\end{align*} \]

This balance is the amount of your total submitted expenses that will not apply toward your UPS out-of-pocket limit. The UPS Plan does not consider amounts above the claims administrator’s R&C as covered expenses, and only covered expenses apply toward your out-of-pocket limit.

Subtract the balance above from the amount you pay for treatment

\[ \begin{align*}
$260 & \quad \text{Amount you pay for treatment} \\
- \quad $50 & \quad \text{Balance from above} \\
\hline
$210 & \quad \text{Amount applied toward your UPS Plan out-of-pocket limit}
\end{align*} \]
### Summary Of Network Plus Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Under Age 65</th>
<th>Age 65 &amp; Older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>None</td>
<td>$350/person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$700/family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>all out-of-network benefits except emergency room, prescriptions, and mental health/substance abuse are subject to the deductible.</td>
</tr>
<tr>
<td>Coinurance</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$1,000/person</td>
<td>$4,500/person</td>
</tr>
<tr>
<td>Physician Services</td>
<td>$15/visit</td>
<td>70%</td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td></td>
<td>70%</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$30/visit</td>
<td>70%</td>
</tr>
<tr>
<td>High Performance Physicians (HPPs)</td>
<td>$15/visit</td>
<td>70%</td>
</tr>
<tr>
<td>In-Hospital Physician Services</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>Allergy Testing and Treatment Services</td>
<td>70%</td>
<td>85%</td>
</tr>
<tr>
<td>Diagnostic X-ray and Laboratory</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>Routine Physical Evaluation</td>
<td>$15/visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Well-Baby Care</td>
<td>$15/visit</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Mammograms</td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>Routine OB/GYN Exam</td>
<td>$30/visit</td>
<td>70%</td>
</tr>
<tr>
<td>Surgery</td>
<td>85%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### Lifetime Maximum $1,000,000

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<table>
<thead>
<tr>
<th>Benefit</th>
<th>Under Age 65</th>
<th>Non-Network Area</th>
<th>Age 65 &amp; Older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Area</td>
<td>Non-Network Area</td>
<td>Age 65 &amp; Older</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>Indemnity</td>
</tr>
<tr>
<td>Maternity Initial OB/GYN visit</td>
<td>$15</td>
<td>70%</td>
<td>85%</td>
</tr>
<tr>
<td>Hospital admission fee</td>
<td>$150</td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>$150</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Then 85% of all hospital charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td>$150</td>
<td>$350</td>
<td>None</td>
</tr>
<tr>
<td>Hospital Admission Fee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This is paid each time a covered individual is admitted to the hospital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>85%</td>
<td>70%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>85%</td>
<td>70%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>An emergency is a sudden and unexpected illness or injury that requires immediate medical attention.</td>
<td></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Non-Emergency Use of Emergency Room</td>
<td>85% after $100 copay</td>
<td>70% after $100 copay</td>
<td>85% after $100 copay</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>You pay 20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>SOLUTIONS PROVIDER</td>
<td>OTHER PROVIDER</td>
<td></td>
</tr>
<tr>
<td>Call Solutions for benefits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-800-336-9117</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(PCP referral not required)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$150</td>
<td>Not Covered</td>
<td>Same as Network Area</td>
</tr>
<tr>
<td>Admission Fee</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Call Solutions for referral or assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>$15/visit</td>
<td>None</td>
<td>Same as Network Area</td>
</tr>
<tr>
<td>Copayment</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Call Solutions for referral or assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>SOLUTIONS PROVIDER</td>
<td>OTHER PROVIDER</td>
<td></td>
</tr>
<tr>
<td>Call Solutions for benefits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-800-336-9117</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(PCP referral not required)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$150</td>
<td>Not Covered</td>
<td>Same as Network Area</td>
</tr>
<tr>
<td>Treatment Plan fee</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Call Solutions for referral or assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Failure to pre-certify hospital admissions will result in an additional $250 fee.
### Summary Of Network Plus Benefits (continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Under Age 65</th>
<th>Age 65 &amp; Older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Area</td>
<td>Non-Network Area</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Other Covered Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care — Inpatient</td>
<td>85%</td>
<td>70% limited to 30 days</td>
</tr>
<tr>
<td>Hospice Care — Outpatient</td>
<td>85%</td>
<td>70% limited to $5,000</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>85%</td>
<td>70% limited to 60 days/year</td>
</tr>
<tr>
<td><strong>Outpatient Private Duty Nursing</strong></td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td>Maximum 70 shifts per calendar year. One shift is equal to eight hours of private-duty nursing care provided by an RN or LPN.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Emergency</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>85%</td>
<td>70% if medically necessary</td>
</tr>
<tr>
<td><strong>Non-Emergency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>85%</td>
<td>70% limited to 120 visits/year</td>
</tr>
<tr>
<td>One visit equals up to four hours of care by an RN, LPN, or therapist to provide physical, occupational or speech therapy, or services from a home health aide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>85%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Chiropractors</strong></td>
<td>$15/visit</td>
<td>70% limited to 60 visits/year</td>
</tr>
<tr>
<td></td>
<td>limited to 60 visits/year</td>
<td></td>
</tr>
<tr>
<td><strong>Podiatrists</strong></td>
<td>$15/visit</td>
<td>70% limited to 60 visits/year</td>
</tr>
<tr>
<td></td>
<td>limited to 60 visits/year</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
<td>$15/visit</td>
<td>70% limited to 60 visits/year combined inpatient and outpatient</td>
</tr>
<tr>
<td>Defined as services consisting of physical, occupational, or speech therapy that are expected to improve a body function lost or impaired due to an injury, disease, or congenital defect.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td>PPO PROVIDER</td>
<td>OTHER PROVIDER</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive*</td>
<td>$50/$100</td>
<td>$50/$100</td>
</tr>
<tr>
<td>Basic</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Major</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontia*</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Annual Maximum per individual (excluding orthodontia)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Lifetime Limit for orthodontia and TMJ treatment for child under age 19</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Lifetime Limit for TMJ treatment for adults (age 19 and over)</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

*Preventive and orthodontic services are not subject to the dental deductible.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Under Age 65</th>
<th>Age 65 &amp; Older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network Area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Exam</td>
<td>100%</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Lenses and Frames</td>
<td>100%</td>
<td>No Coverage</td>
</tr>
<tr>
<td>(every two years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$100 allowance</td>
<td>No Coverage</td>
</tr>
<tr>
<td>— Elective (every two years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Medically necessary</td>
<td>100%</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Physical Evaluation Guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Birth-12 Months</td>
<td>13-24 Months</td>
</tr>
<tr>
<td>Visits</td>
<td>Well Baby Visit¹</td>
<td>Well Baby Visit¹</td>
</tr>
<tr>
<td>Exam Frequency</td>
<td>7 Exams</td>
<td>2 Exams</td>
</tr>
<tr>
<td>Immunizations</td>
<td>DPT¹, OPV², HIB³, Hepatitis B⁻, Tetramune¹³</td>
<td>Varicella⁵, DPT or DTaP⁷, OPV⁹, MMR¹¹, Hepatitis B¹², Tetramune¹³</td>
</tr>
<tr>
<td>Tests</td>
<td>Urinalysis¹⁴, Hemoglobin &amp; Hematocrit¹⁵, Tuberculin skin test¹⁶, PKU</td>
<td>Urinalysis¹⁴, Hemoglobin &amp; Hematocrit¹⁵, Tuberculin skin test¹⁶, PKU</td>
</tr>
<tr>
<td>If female:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If male:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This chart represents only a summary of the actual benefits available as detailed in the Summary Plan Description (SPD). If in the process of abbreviating the descriptions, any coverage was summarized differently than detailed in the SPD, the SPD will govern.

Visits
1. Clinical screening, height and weight; physical/development assessment
2. Clinical screening, blood pressure, height and weight, physical/psychosocial/developmental assessment
3. Clinical screening, blood pressure, height and weight, physical/psychosocial/developmental/mental assessment. For 13-18 years, scoliosis check, clinical testicular exam or breast exam
4. Basic Evaluation includes a comprehensive history and physical examination:
   - Chief complaint (if present)
   - History of present illness (if present)
   - Past medical history (medications, allergies, prior operations and hospitalizations, immunization status)
   - Family history
   - Social history (marital status, use of drugs, alcohol and tobacco, education, current employment, occupational history)

Immunizations
1. Varicella: chickenpox vaccine; one dose given between 12 months and 2 years, or between 2-6 years if not done earlier, or between 7-12 years if not done earlier
2. DPT: Diphtheria-Pertussis-Tetanus vaccine; given at ages 2, 4, and 6 months (see footnote 13)
3. DPT or DTaP: Diphtheria-Tetanus-a cellular Pertussis vaccine: once between 12-18 months and once between 4-6 years
4. Tetanus-diphtheria: given once between 14-16 years and once every 10 years after age 18
5. OPV: oral polio vaccine: given at ages 2-4 months and between 6-18 months and between 4-6 years (continued on next page)
### Physical Evaluation Guidelines (continued)

<table>
<thead>
<tr>
<th>Age</th>
<th>20-29 Years</th>
<th>30-39 Years</th>
<th>40-49 Years</th>
<th>50 Years and up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visits</strong></td>
<td>Basic Evaluation¹</td>
<td>Basic Evaluation¹</td>
<td>Basic Evaluation¹</td>
<td>Basic Evaluation¹</td>
</tr>
<tr>
<td><strong>Exam Frequency</strong></td>
<td>Every 5 years</td>
<td>Every 3 years</td>
<td>Every other year</td>
<td>Every year</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>Tetanus-diphtheria⁸</td>
<td>Tetanus-diphtheria⁸</td>
<td>Tetanus-diphtheria⁸</td>
<td>Tetanus-diphtheria⁸</td>
</tr>
<tr>
<td></td>
<td>MMR¹¹</td>
<td>MMR¹¹</td>
<td>MMR¹¹</td>
<td>MMR¹¹</td>
</tr>
<tr>
<td><strong>Tests</strong> (same frequency as exams unless otherwise noted)</td>
<td>Urinalysis</td>
<td>Urinalysis</td>
<td>Urinalysis</td>
<td>Urinalysis</td>
</tr>
<tr>
<td></td>
<td>12 Lead EKG</td>
<td>12 Lead EKG</td>
<td>12 Lead EKG</td>
<td>12 Lead EKG</td>
</tr>
<tr>
<td></td>
<td>Chest X-ray</td>
<td>Chest X-ray</td>
<td>Chest X-ray</td>
<td>Chest X-ray</td>
</tr>
<tr>
<td></td>
<td>SMA 18/22</td>
<td>SMA 18/22</td>
<td>SMA 18/22</td>
<td>SMA 18/22</td>
</tr>
<tr>
<td></td>
<td>CBC</td>
<td>CBC</td>
<td>CBC</td>
<td>CBC</td>
</tr>
<tr>
<td></td>
<td>Lipid Profile</td>
<td>Lipid Profile</td>
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¹⁴**HIB**: Haemophilus influenza type B (see footnote 13): Age at start (months) Number of doses
- 2-6: 4
- 7-11: 3
- 12-24: 2
- 25-59: 1
- 60+ or over: 1

HIB: at 60 months or older only for children with chronic illness known to be associated with increased risk for H-Influenza disease.

¹⁵**MMR**: Mumps, measles and rubella virus vaccine: this two-dose series is given between 12-15 months, and between 4-6 years. It may also be obtained between 7-12 years if not previously administered, or later if born after 1956 with no prior booster.

¹⁶**Hepatitis B virus vaccine series is now recommended for all infants. The series can be obtained through age 19 if not previously completed.

¹⁷**Tetramune** is a combination of the DPT and HIB vaccines and may be substituted. Given at ages 2, 4, and 6 months and between 15-18 months.

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### Tests

¹⁴**Urinalysis**: once during first two years, once between 2-6 years, once between 7-12 years, once between 13-19 years

¹⁵**Tuberculin Skin Test**: Tine or intradermal Mantoux skin tests: once during first 2 years. If not done earlier: once between 2-6 years (or if mandated for entry into school), or once between 7-12 years, or once between 13-19 years

¹⁶**PKU**: Phenylketonuria: up to two PKU tests during first 3 weeks of life

¹⁷**Hearing screening**: once between 2-6 years

¹⁸**Gynecological Exam, including Pap smear**: for females only, annually from age 18, or earlier if sexually active.

¹⁹**Chest X-ray**: 2 views, every 3 years, unless indicated

²⁰**Occult Blood**: For blood in stool: three cards

²¹**Exercise stress test**: Can be performed every 3-5 years if high risk (multiple risk factors, and/or strong family history)

²²**Sigmoidoscopy**: For colorectal cancer: every 3-5 years

²³**Mammogram**: Baseline at age 35, every year age 40 and up

²⁴**PSA**: Prostate Specific Antigen: Annually beginning at age 45 if high-risk (African American or prostate cancer in first degree relative)
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 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 up to the lesser of the actual attorney fees and other expenses or one-third of the Plan’s lien. Otherwise the lien shall apply to the entire proceeds of any recovery by the Covered Individual. This includes any recovery by judgment, settlement, arbitration award, or otherwise.

The Plan’s right to recover shall not be limited by application of any statutory or common law “make whole” doctrine (i.e., the Plan has a right of first reimbursement out of any recovery, even if the Covered Individual is not fully compensated) or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. The Plan shall have a lien against the proceeds of any recovery by the Covered Individual and against future benefits due under the Plan in the amount of any claims paid. This lien shall attach as soon as any person or entity agrees to pay any money to or on behalf of any covered individual that would 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 paid in error (e.g., benefits paid to an ineligible person) or benefits that were obtained in a fraudulent manner, as determined by the Plan Administrator. Benefits may be recovered by either direct payment to the Plan by you or a beneficiary (through voluntary payments or legal action) or by an offset of future benefits equal to the amount of the overpayment.

Reinstatement of Lifetime Maximum Following Subrogation
In the event the Plan recovers in accordance with the Plan’s Right of Recovery Provisions, the Plan will reinstate your lifetime maximum under the Plan equal to the amount recovered minus the Plan’s costs incurred to obtain the recovered amount.

Uncashed Reimbursement Checks
Any benefit payments that are unclaimed (e.g., uncash benefit checks) by December 31st of the year following the Plan Year in which the expense was incurred, or if earlier, the end of the shortest period under any state law, shall be forfeited.

The Retiree Health Access Program (RHA)
A coalition of FORTUNE 100 employers — including UPS — created RHA to offer affordable retiree health care options to retirees across the country. RHA offers choices that may better meet your health care needs. It also strengthens your buying power through the coalition’s better rates.

Since there are more affordable health care options to choose from, RHA may be an excellent alternative for retirees with a small number of credits or for those with no credits (access only), thus potentially reducing premiums and out-of-pocket expenses. You pay the Retiree Health Access premium directly to RHA and then file for reimbursement with Aetna from a Retiree Reimbursement Account. (See the Retiree Reimbursement Account section.)

One difference to note between the RHA plans and the UPS Plan is that no dental or vision coverage is available at this time with an RHA plan.

If you decide to join an RHA plan, RHA will send you a separate summary plan description. The RHA benefits are described in a separate document provided to you by the carrier, and the language in the carrier’s document controls.

Please note: If you are enrolled in REHCP due to being disabled (on long-term disability), you are not eligible for RHA until you actually retire.

Retiree Reimbursement Account
Retiree Reimbursement accounts reimburse you for Medicare Part D or Retiree Health Access (RHA) premiums. You are eligible for an RRA if:

- You are age 65 or older and retired prior to January 1, 1993
- You are age 65 or older and have enough credits to pay the premium for the Retired Employees’ Health Care Plan medical coverage and any portion of a Medicare Part D prescription drug plan including prescription drug coverage chosen through Retiree Health Access up to the maximum reimbursement amount. (The maximum reimbursement amount for a Medicare Part D prescription drug plan is equal to the average premium charged in the highest cost region for Standard Medicare Part D prescription drug coverage. This amount is updated annually.)
- You have chosen to enroll in one of the Retiree Health Access plans for both medical and prescription drug coverage and have credits eligible for reimbursement.

Participants Under Age 65
The Retiree Reimbursement Account helps reimburse premiums for participants under age 65 who elect a Retiree Health Access plan. Each year, UPS credits the account with the lesser of the total dollar value of your credits (if applicable) or the annualized premium of the Retired Employees’ Health Care Plan.
Participants who enroll in an RHA plan pay their monthly premiums directly to the RHA plan of choice and file claims for premium reimbursement from their Retiree Reimbursement Account.

All claims for premium reimbursement must be submitted within 90 days from the end of the calendar year. Submit claims for reimbursement from your RRA to:

Aetna Retiree Reimbursement Account
P. O. Box 4000
Richmond, KY 40476

UPS will credit your account each January 1 with the applicable annual amount. Any amount not used for premium incurred before year-end, December 31, will be forfeited (i.e., they will not be carried over to the next year).

Participants Over Age 65
The Retiree Reimbursement Account is designed to help reimburse premiums for those participants age 65 and over who elect a Retiree Health Access plan or a Medicare Part D prescription drug plan. Each year UPS will credit the account with the following:

- If you retired prior to January 1, 1993, the annualized premium cost of your health care coverage under the UPS Retired Employees’ Health Care Plan, plus an amount equal to the average premium of national plans in the highest cost Medicare region for Standard Medicare Part D prescription drug coverage. These amounts are determined by the Plan annually.

- If you retired on or after January 1, 1993, lesser of the value of your credits (if applicable) or the annualized premium of the Retired Employees’ Health Care Plan for medical coverage plus an amount equal to the average premium of national plans in the highest cost Medicare region for Standard Medicare Part D prescription drug coverage. These amounts are determined annually by the Plan.

Participants who enroll in an RHA plan or Medicare Part D prescription drug plan pay their monthly premiums directly to the plan of choice and file claims for premium reimbursement from their Retiree Reimbursement Account.

All claims for premium reimbursement must be submitted within 90 days from the end of the calendar year. Submit claims for reimbursement from your RRA to:

Aetna Retiree Reimbursement Account
P. O. Box 4000
Richmond, KY 40476

UPS will credit your account each January 1 with the applicable annual amount. Any amount not used for premium incurred before year-end, December 31, will be forfeited (i.e., they will not be carried over to the next year).

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.

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 Term Life brochure, the Contract-Certificate provisions apply.

Conversion and Portability
You are eligible to convert your life insurance at retirement.

Your spouse and dependent children may convert their coverage when you are eligible to convert yours, as stated above, or if your spouse loses coverage due to a divorce, legal separation, or your death; or your child loses coverage because of your divorce, legal separation, your death, or reaching the limiting age.

When your life insurance coverage ends, as stated above, it is your responsibility to request a conversion kit from Prudential within 31 days of your last day of coverage. When you apply for conversion coverage, Prudential will explain the individual policies that are available to
you. To request a Conversion Kit or to make inquiries regarding Conversion, please contact the Prudential Group Conversion Office at 1-877-889-2070.

If you elected supplemental life insurance for you and your spouse, you may choose to continue to participate and be direct-billed for your coverage. Your spouse may elect to continue coverage individually if coverage under the Plan is lost due to divorce or death of the employee. If you retire, your spouse can only continue coverage individually if you have supplemental life insurance and elect to continue your individual coverage. Prudential will notify you directly regarding your portability options for this coverage. For questions regarding portability, please contact 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.

Because your life insurance can be continued without evidence of insurability and at UPS group rates, you may wish to evaluate your coverage during the last annual enrollment prior to your retirement date. At the time of retirement, you are not allowed to increase your life insurance coverage.

### Cancer Insurance

Cancer insurance, underwritten by American Family Life Assurance Company (AFLAC), offers a personal health insurance policy expressly designed to reimburse you if you are diagnosed or treated for cancer. Cancer insurance pays cash directly to you unless you assign the benefit to a provider — regardless of any other insurance you have. Some items covered under cancer insurance also are covered by the UPS Retired Employees’ Health Care Plan.

Although cancer insurance is summarized in this booklet, it is not intended to be nor should it be construed to be part of the Retired Employees’ Health Care Plan. It is a personal policy for which the Company has no fiduciary responsibility (see Fiduciary Chart).

#### Eligibility

You are eligible to purchase cancer insurance if you are eligible for the Retired Employees’ Health Care Plan and age 70 or under in all states except California, Massachusetts, and New Jersey. If you live in California, you may purchase this insurance through age 65. Cancer insurance is not available in Massachusetts or New Jersey.

Cancer insurance is a guaranteed renewable for life subject to AFLAC’s right to change the applicable table of premium rates for all policies of this class.

#### When Coverage Starts

If you are enrolling for the first time, coverage is effective on the first date AFLAC approves your application. Your cancer insurance application must be postmarked by your Retired Employees’ Health Care Plan enrollment deadline, as indicated on your Enrollment Worksheet. At annual enrollments AFLAC coverage is effective on January 1 following the annual enrollment period.

#### 30-Day Waiting Period in Florida, Iowa, and Mississippi

In Florida, Iowa, and Mississippi, there is a 30-day waiting period before coverage begins. This means that no benefits are payable for any covered person who has cancer diagnosed before coverage has been in force 30 days from the effective date shown in the Policy Schedule. If a covered person has cancer diagnosed during the waiting period, benefits for treatment of that cancer will apply only to treatment occurring after two years from the effective date of the policy. Or, at your option, you may elect to void the policy from its beginning and receive a full refund of the premium.

#### When Coverage Ends

Generally, cancer insurance continues as long as you make premium payments. If you retire, you can continue your policy on a direct-billed basis. If you have paid at least one-month’s premium by payroll deduction, you may retain the payroll deduction rates after leaving the Company. If you have not paid by payroll deduction, you will be billed at a direct rate.
Benefits
Benefits, limitations, and exclusions are described in AFLAC’s cancer insurance brochure. The following summarizes the key benefits:

- First occurrence
- Hospital confinement
- Radiation and chemotherapy
- Outpatient surgery
- Waiver of premium
- Cancer wellness screening.

Taxes and Cancer Insurance
Any benefits received from AFLAC that exceed your unreimbursed medical expenses are taxable. You are responsible for determining the amount of any excess reimbursement and including it in your tax return. Consult your tax advisor.

Please keep in mind that if you paid less Social Security (FICA) taxes because of your participation in this plan, then your Social Security benefits at retirement, death, or disability may also be lower. You paid 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 this plan and future pay levels.

How to Enroll
You may enroll for cancer insurance during either your initial enrollment period or during annual enrollment. Once you receive your policy from AFLAC, you have a 30-day review period during which you may decline coverage. You may only add or drop cancer insurance between enrollments if you have a change in status.

Member Services
If you have questions, or would like to obtain a copy of AFLAC’s cancer insurance brochure, call AFLAC at 1-800-992-3522.

How to File a Claim
Call AFLAC for claim forms and filing instructions at 1-800-992-3522.

Long-Term Care Insurance
Long-Term Care Insurance, underwritten by Metropolitan Life Insurance Company (MetLife), protects you and your family from the high cost associated with long-term care. Long-term care is the care you need when you have an accident or illness and are unable to care for yourself over an extended period. It provides assistance with daily activities like eating, bathing, and dressing. Most health care plans — including those offered by the Company — do not cover long-term care or custodial care.

Although Long-Term Care Insurance is summarized in this booklet, it is not intended to be nor should it be construed to be part of the Retired Employees’ Health Care Plan. Long-Term Care Insurance is a group insurance policy for which the Company has no fiduciary responsibility (see Fiduciary Chart). If you enroll in Long-Term Care Insurance, you receive a Certificate of Insurance. If there is any conflict between the certificate and this description, the certificate will apply. This Plan may not be available in all states. Plan features may vary by state. To confirm availability in your state, call MetLife at 1-800-UPS-1508 (listen for “Life and Disability” prompt).

How to Enroll
You may enroll in the Long-Term Care Insurance plan at any time during the year. Call MetLife Monday through Thursday, 8:00 a.m. to 10:00 p.m., Friday, 8:00 a.m. to 9:00 p.m., and Saturday, 9:00 a.m. to 4:30 p.m. ET. Call 1-800-UPS-1508 and listen for the “Life and Disability” prompt. Hearing impaired individuals with a TDD may call 1-800-638-1004. MetLife sends an enrollment packet and application.

Visit MetLife’s website from a link at UPSers.com or contact MetLife at 1-888-526-8495.
Signature LegalCare

The legal option helps protect you from the financial expenses that may arise if you need legal services. The option offers a range of commonly needed legal services as well as access to a legal hotline and individual consultation administered by Signature LegalCare. You and your covered family members can use an attorney who participates in the Signature network of attorneys. You then receive full coverage for most covered services from a Signature network attorney. You may also use any attorney of your choice; however, benefits are limited if you use a non-participating attorney.

Although the legal option is summarized in this booklet, it is not intended to be nor should it be construed to be part of the Retired Employees’ Health Care Plan. The Company has no fiduciary responsibility (see Fiduciary Chart).

How Legal Benefits Work

If you enrolled for legal coverage as an active employee, benefits will continue as a retired employee. Signature LegalCare will bill you automatically or you can sign up for automatic deductions from a checking and/or savings account or you can pay by credit card. You may call the Signature LegalCare Service Center from 5:00 a.m.-11:00 p.m. (Eastern time), Monday-Saturday and 5:00 a.m.-4:00 p.m. on Sundays by dialing 1-800-UPS-1508 when a legal issue or concern arises (listen for the “Company Programs” prompt). Your call, handled by the Interactive Customer Assistance System, offers the following options:

- Verify your membership in the plan
- Order a Participating Attorney Directory
- Order a claim form
- Check the status on your claim.

You may also visit the Signature LegalCare website from a link at UPSers.com. You’ll be asked to enter your company name and this password: 38099. Signature LegalCare direct phone number is 1-800-848-2012 (hearing impaired 1-800-535-2348).

In an emergency, the toll-free number can be used 24 hours a day, every day. An attorney is always on call.

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

- Telephone Service — You have unlimited access to advice, consultation, and direction regarding personal legal matters that are not specifically excluded under the plan at no cost.
- Signature LegalCare Attorneys — If you need an attorney, you can choose one from Signature’s national network of attorneys throughout the United States who have agreed to provide covered services to LegalCare participants. If you use a Signature LegalCare network attorney, you will receive benefits for most covered matters.
- Non-Participating Attorneys — You can also receive legal counsel from an attorney who does not participate in the Signature LegalCare attorney network. When you use a non-participating attorney, you are reimbursed for covered legal services up to a scheduled maximum amount. You are responsible for any costs in excess of the scheduled benefit amount.

Covered Legal Services

Examples of covered services* include:

- Administrative hearings
- Adoptions
- Debt collection defense
- Defendant civil action
- Document review and preparation
- Estate administration and estate closings
- Guardianship/conservatorship
- Lawyer office work
- Matrimonial matters
- Preparation of a will, living will
- Real estate matters
- Telephone advice.

*Which services are covered and which services are excluded are governed by the contract with Signature LegalCare. Covered and non-covered services are subject to change.
Excluded Legal Services

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

How to File a Claim

After legal services are provided, you must file a claim form. When completing the claim form, indicate whether you want Signature to pay the attorney directly or reimburse you. Claim forms are available by calling the Signature LegalCare Service Center at 1-800-UPS-1508 (listen for the “Company Programs” prompt) or by calling 1-800-848-2012.

Personal Lines Insurance

To help employees purchase auto and homeowner’s insurance at discounted group rates and pay for coverage through convenient payroll deductions, the Company offers Liberty Mutual’s Liberty For All program of personal lines insurance.

Coverage is available through a program of individual policies for employees who are eligible to participate in the Retired Employees’ Health Care Plan. For more information about the Liberty For All program, link to their site from UPSers.com or call 1-800-UPS-1508 (listen for the “Company Programs” prompt). Identify yourself as a Retired Employees’ Health Care Plan participant. Current policyholders should call 1-800-713-7377.

Enrollment

You can enroll in Liberty For All at any time of the year by contacting Liberty Mutual directly. The program is voluntary. Enrollment in any Liberty For All coverage is separate from enrollment in the Retired Employees’ Health Care Plan.

Available Coverage

The program offers you a variety of personal insurance coverage:
- Automobile insurance (discounts available*)
- Homeowner’s insurance (discounts available*)
- Personal catastrophe liability insurance (local laws may affect the availability of this coverage in some states. Check with your Liberty Mutual representative for availability in your specific area.)
- Valuable possessions protection
- Yacht and motorboat insurance
- Protection for seasonal dwellings and recreational vehicles.

How to Purchase Insurance

To obtain a quote from Liberty Mutual, visit their website from a link at UPSers.com, or call the company directly at 1-800-UPS-1508 (listen for the “Company Programs” prompt). Liberty Mutual’s voice response system will give you a choice of speaking with a representative located in your community or a representative in Liberty Mutual’s Insurance Counseling and Service Center. This service is available 7:00 a.m. to 7:00 p.m. local time, Monday through Saturday.

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

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

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

If you have concerns about any aspect of your relationship with Liberty Mutual, you should contact your local Liberty Mutual office, or call 1-800-UPS-1508 (listen for “Company Programs” prompt).

The Company does not interpret Liberty Mutual’s insurance policies, claims payment procedures, or any other administrative procedures. Questions and claim inquiries about personal lines insurance are between you and Liberty Mutual. Although summarized in this booklet, Personal Lines coverage is not part of the Retired Employees’ Health Care Plan.

How to File a Claim

If you need to file a claim, contact your Liberty Mutual representative for instructions or call 1-800-UPS-1508 (listen for the “Company Programs” prompt).

If a Claim Is Denied

If your claim for any benefits from 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

An insurance carrier provides certain benefits offered under the Plan through an insurance contract issued to UPS. 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 neither the Company nor UPS has any discretionary authority with respect to benefit claims 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 you should submit to the insurance carrier.

Fiduciary Chart

<table>
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<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>
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<td>Medco RX</td>
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<td>Life Insurance, AD&amp;D (Prudential)</td>
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**Denial of Claims**

For all other claims, the UPS Claims Review Committee (the Committee) makes the final decision (with the exception of claims involving urgent care, which are decided by the applicable claims administrator), and the following claims review procedures apply.

**Types of Claims**

There are three types of group health claims: Pre-Service, Concurrent Care, and Post-Service Claims. In addition, certain pre-service or concurrent care claims may involve “urgent care.”

- **Pre-Service Claim** — a claim for health care where prior approval for any part of the care is a condition to receiving the care
- **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** — any claim for which the Plan does not require pre-authorization and once a claim for care is received
- **Urgent Care Claim** — 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).

**Appeals Procedures**

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

**Step 1: Notice is received from claims administrator**

If your claim is denied, you will receive written notice from the claims administrator that your claim is denied (in the case of urgent claims, notice may be oral). The time frame in which you will receive this notice is described in the 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 for reasons beyond the claims administrator’s control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The time period during which the claims administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information-gathering period.

**Step 2: Review your notice carefully**

Once you have received your notice from the claims administrator, review it carefully. The notice will contain the following:

- The reason(s) for the denial and the Plan provisions on which the denial is based
- A description of any additional information necessary for you to perfect your claim, why the information is necessary and your time limit for submitting the information
- A description of the Plan’s appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a final denial of your appeal
- A statement indicating whether an internal rule, guideline, or protocol was relied upon in making the denial and that a copy of the rule, guideline, or protocol is provided free of charge upon request
- If the denial is based on a medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request
- If the claim is an Urgent Care Claim, a description of the expedited appeals process. The notice can 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 First Level Appeal with the claims administrator.

If you do not agree with the decision of the claims administrator, you may 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: First Level Appeal notice is received from claims administrator.

If the claim is again denied, the claims administrator will notify you 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 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 Second Level Appeal with the Committee.

If you still do not agree with the claims administrator’s decision, you may file a written appeal to the Committee within 60 days after receiving the first level 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 NE
Atlanta, GA 30328

If the Committee denies your Second 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 referenced in Step 2 above.

A claim is not deemed to be “filed” for purposes of these claim review procedures until it is filed in accordance with the “How to File a Claim” sections of this SPD and it is received by the claims administrator, or where applicable, the UPS Claims Review Committee.

Important Information

Other important information regarding your appeals:
- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal)
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have the right to request documents and records (as defined by ERISA) that are relevant 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 first and second level appeal who has expertise in the specific area involving medical judgment.
- If you wish to submit relevant documentation to be considered in reviewing your claim or appeal, you must submit it at the time you file your claim and/or appeal.
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Limitation on Legal Action

Any legal action to receive Plan benefits must be filed the earlier of:
- Six months from the date a determination is made under the Plan or should have been made in accordance with the Plan’s claims review procedures, or
- Three years from the date the service or treatment was provided or the date the claim arose, whichever is earlier.

Your failure to file suit within this time limit results in the loss/waiver of your right to file suit.
# Claims and Appeals Procedures Chart

This chart shows the time limit for you to submit appeals, and for the claims administrator or UPS Claims Review Committee to respond to your claim or appeal. This chart is intended to be used in conjunction with the remainder of information in this section.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Initial Claims</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service</strong></td>
<td>You’ll be notified of determination as soon as possible but no later than...</td>
<td>Extension period allowed for circumstances beyond claims administrator’s control...</td>
<td>You must file your appeal within...</td>
</tr>
<tr>
<td><strong>Pre-Service involving Urgent Care</strong></td>
<td>15 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
<tr>
<td><strong>Concurrent: To end or reduce treatment prematurely</strong></td>
<td>72 hours (24 hours if additional information is needed from you)</td>
<td>None</td>
<td>48 hours (claims administrator must notify you of determination within 48 hours of receipt of your information or the specified time period for providing information, whichever is earlier)</td>
</tr>
<tr>
<td><strong>Concurrent: To deny your request to extend treatment</strong></td>
<td>Notification to end treatment will allow time to finalize appeal before end of treatment</td>
<td>Denial letter will specify filing limit</td>
<td>15 days from receipt of appeal</td>
</tr>
<tr>
<td><strong>Concurrent involving Urgent Care</strong></td>
<td>24 hours, if your claim is submitted at least 24 hours before the scheduled end date of treatment. Otherwise, treated as Pre-Service Urgent Care</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
<tr>
<td><strong>Post-Service</strong></td>
<td>30 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
</tbody>
</table>

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Continuation of Coverage under COBRA

In certain circumstances, health care coverage for 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).

As the retired employee (or LTD participant), you are offered COBRA continuation in the UPS health plan that covered you at the time of your retirement (or, for LTD participants, when your coverage ended as an active employee), and are therefore not eligible for further COBRA continuation coverage under this Plan — even if you lose coverage. There are special rules that apply if the employer files for bankruptcy.

A “Qualified Beneficiary” is a spouse and/or dependent child who has health coverage under this Plan immediately preceding a qualifying event. Qualified beneficiaries have independent COBRA election rights and can elect to continue group health plan coverage for themselves.

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 are given more information that reflects your situation at the time.

How COBRA Works

Eligibility for COBRA is triggered by a “qualifying event.” The following table 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, except as otherwise stated in this SPD. If you decide to continue coverage, you must pay the full cost of that coverage, plus a two percent administrative cost. The monthly premium amount will be provided to you at the time a qualifying event occurs. The initial premium must be paid within 45 days of your enrollment date (no grace period). Subsequent premiums are due on the first of each month. Failure to make subsequent payments within 30 days of the due date will cause your coverage to terminate retroactive to the end of the last month for which full payment was received.

<table>
<thead>
<tr>
<th>Qualifying Events</th>
<th>Continuation of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your spouse divorce or legal separation</td>
<td>36 months</td>
</tr>
<tr>
<td>Your dependent child</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child ceases to be a qualified dependent</td>
<td>36 months</td>
</tr>
</tbody>
</table>

When Coverage Ends

In general, your UPS Retired Employees’ Health Care Plan coverage continues as long as you meet the Plan’s eligibility requirements. Your dependents’ coverage will continue as long as you remain eligible for the Plan and your dependents meet the eligibility requirements. However, in certain circumstances, coverage will end sooner:

Coverage for your spouse will end in the event of your divorce or legal separation.

Coverage for your children will end when they cease to be eligible dependents. Your children’s eligibility for coverage ends on December 31 of the calendar year in which they had their 19th birthday (or 25th birthday if full-time students). If your children graduate from school before the age limit is reached, coverage continues through December 31 of the year in which they graduate, or until they become covered through another plan, if earlier. Eligibility also ends if your children marry.

If any of the events above occur, immediately contact the Benefits Service Center, who administers changes in coverage, at 1-800-UPS-1508. You may be required to reimburse the Plan for any erroneously paid claims (in accordance with the Plan’s right of recovery provisions).
Qualified Medical Child Support Orders

The UPS Retired Employees’ Health Care Plan will comply with the terms of a Qualified Medical Child Support Order (QMCSO) to the extent required by applicable law.

A QMCSO is an order or a judgment from a state court directing the Plan Administrator to cover a child by the company’s group health plans. Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. When a court order is received, each affected participant and each child covered by the order will be notified of the company’s procedures for determining if the order is valid.

If you have any questions or would like to receive a copy of the company’s written procedure for determining whether a QMCSO is valid, please contact the Plan Administrator.

ERISA and Other Important Information

Plan Administration

The information contained in this book, including the schedule of benefits, is a summary of the applicable administrative and legal documents relating to the UPS Retired Employees’ Health Care Plan. In the event there is any difference between the booklet and the applicable Plan documents or certificates, the Plan 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 Plans’ terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents. The Plan Administrator may delegate certain discretionary authority to one or more committees.

The Plan does not give you a right to any benefit or interest in the Plan except as specifically provided in the Plan document. This Plan permits you to have benefit payments sent directly to your provider.

However, you may not assign your rights, benefits, or any other interest in this Plan to a provider or any other individual or entity.

UPS sponsors this Plan. The Plan’s Administrator is the Administrative Committee of the UPS Retirement Plan. Coverage and benefits for you and your eligible dependents are paid for by United Parcel Service from its general assets and are funded partly by means of UPS contributions to a special account for retirees medical benefits established as part of the UPS Retirement Plan, and partly by means of contributions by covered retirees.

Records for the UPS Retired Employees’ Health Care Plan are maintained on a calendar-year basis from January 1 through December 31 (Plan Year).

The UPS Retired Employees’ Health Care Plan is reported to the government as a welfare plan, as providing health benefits. For reporting purposes, the company’s Employer Identification Number (EIN) is 95-1732075. The Plan Number (PN) for all coverages described in this booklet is 001, which is the same as the Retirement Plan. Please use both numbers if you make any written reference to any of the coverage provided by the Plan.

If you have any questions regarding your benefit protection from this Plan, you should first contact the Benefits Service Center at 1-800-UPS-1508. If you need more information, you may contact:
Plan Administrator
UPS Retired Employees’ Health Care Plan
55 Glenlake Parkway, NE
Atlanta, GA 30328
404-828-6044

The Plan’s agent for legal process is the Plan Administrator at the above address.
Presently, certain administrative services with regard to the processing of claims and the payment of benefits are provided under contract as follows:

**Medical coverage is administered by the following:**
Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
1-800-435-7324 (Network Coverage)
1-800-217-2386 (Non-Network Coverage)
1-800-297-7145 (Indemnity Coverage)

Blue Cross and Blue Shield of Illinois
300 East Randolph Street
Chicago, IL 60601
1-800-516-1270

CIGNA
900 Cottage Grove Road
Bloomfield, CT 06002
1-800-900-4877

United Health Care
9900 Bren Road East
Minnetonka, MN 55343
1-877-838-7528

**Prescription drug coverage (for under age 65 only) is administered by the following:**
Medco Health Solutions
P. O. Box 6121
Fair Lawn, NJ 07410-0999
1-800-346-1327

Medco by Mail Order Program
P. O. Box 650522
Dallas, TX 75265-9610
1-800-346-1327

**Mental Health/Substance Abuse coverage under Network Plus is administered by:**
ValueOptions
3110 Fairview Park Drive
Falls Church, VA 22042
1-800-336-9117

**Dental coverage under Network Plus is administered by:**
Aetna
151 Farmington Avenue
Hartford, CT 06156

**Vision coverage under Network Plus is administered by:**
Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
1-800-877-7195

**General Information**

Name of Plan
The UPS Retired Employees’ Health Care Plan

Plan Number
001

Plan Year
January 1 through December 31

Employer and Plan Sponsor
United Parcel Service of America, Inc.
55 Glenlake Parkway, NE
Atlanta, GA 30328
404-828-6044

Employer Identification Number (EIN)
95-1732075

Plan Administrator
Administrative Committee of the UPS Retirement Plan
United Parcel Service of America, Inc.
55 Glenlake Parkway, NE
Atlanta, GA 30328
Your ERISA Rights

The Retired Employees' Health Care Plan is an employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA). As a participant in the Plan, you have 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 Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

… continue Group Health Plan coverage

You may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. You should review this Summary Plan Description for information concerning your COBRA continuation coverage rights.

You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your Group Health Plan, if you move to another plan and you have creditable coverage from this Plan. The Retired Employees' Health Care Plan 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 Retired Employees’ Health Care 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 $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If a claim for benefits is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, 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, Employee Benefits Security Administration listed in your telephone directory, or

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U. S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C.  20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Plan Amendment or Termination

UPS has established this Plan with the expectation that it will continue indefinitely. Nevertheless, UPS reserves the right to amend or terminate the Plan at any time by written resolution of the Board of Directors which is duly accepted. No amendment or termination of this Plan will reduce or eliminate benefits for claims incurred prior to the effective date of the amendment of termination.
Key Terms

**Claims administrator** — The company that administers the indemnity plan and is responsible for claims processing is the claims administrator.

**Coinsurance** — The percentage of covered expenses paid by the Plan is your coinsurance.

**Copayment** — A dollar amount that represents your share of the cost when service is provided through a network is considered a copayment.

**Covered expenses** — Expenses incurred for medically necessary and appropriate treatment of a non-occupational disease or injury.

**Deductible** — The amount you have to pay each year before benefits are payable from the Plan. Certain benefits could be paid without a deductible applying.

**Emergency** — A sudden and serious situation that happens unexpectedly and requires immediate medical attention.

**Indemnity plan** — Coverage through a plan that does not provide a choice of care through a network. With an indemnity plan, you can see any doctor you select, but the charge must be for medically necessary care and within reasonable and customary limits.

**Investigational or experimental** — The medical use of a service or supply is still under study and the service or supply is not yet formally recognized throughout the medical profession in the U.S. as safe and effective for diagnosis or treatment. If a service or supply is furnished in connection with a service or supply that is investigational or experimental, as determined by the appropriate network manager or claims administrator, it is not covered.

**High Performance Physicians (HPPs)** — When treated by an Aetna Aexcel or United Health Premium designated high quality, high-performing specialist, you may reduce the specialist copay by 50 percent. (HPP designations are only available in certain locations.)

**Medically necessary** — Required treatment for an illness, injury, or pregnancy, in accordance with generally accepted medical practice as determined by the network manager or claims administrator.

**Member Services** — The customer service line answered by the network’s trained representatives. You can call this line to ask questions about your benefits and obtain information about a network provider or service.

**Network** — A selected group of doctors, hospitals, and other health care providers who have contracted with the network manager to provide medical benefits to UPS Plan participants and their eligible dependents.

**Necessary Dental Care** — Preventive dental care and certain other care necessary to diagnose and treat dental disease.

**Network Participating Dentist** — A network dentist who has agreed to provide care at negotiated rates. You may use any participating dentist for yourself and each of your covered dependents each time you seek treatment.

**Network manager** — The company (Aetna, Blue Cross/Blue Shield, CIGNA, or United Healthcare) that establishes and maintains the network for Network Plus coverage. The network manager is also responsible for processing claims for in- and out-of-network treatment.

**Non-network area** — ZIP Codes that do not have network access. If your home ZIP Code is in a non-network area, your medical benefits are provided through an indemnity plan, unless you contact the Benefits Service Center and request inclusion in a managed care network.

**Out-of-pocket maximum** — The dollar amount you have to pay before the Plan pays 100 percent of most covered charges incurred during the balance of the calendar year.

**Point-of-Service (POS)** — Your right to choose whether to receive treatment through the network or outside the network, each time you need care.

**Primary Care Physician (PCP)** — The PCP is the doctor who coordinates your in-network benefits. You may select a different PCP for yourself and for each of your covered dependents.

**Reasonable and Customary (R&C)** — Charges within the normal range of fees charged in your geographic area for similar services and similar supplies. If your expenses are considered more than reasonable and customary by the claims administrator or network manager, you will be responsible for paying the additional amount. These charges do not count toward your deductible or out-of-pocket maximum. The claims administrator periodically updates reasonable and customary charges. All benefits provided in-network through a managed care option are considered reasonable and customary.
Notes
Summary of Material Modifications
UPS Retired Employees' Health Care Plan
October 2016

This notice details plan improvements, changes, clarifications and required notifications effective January 1, 2017, unless otherwise noted below. You should keep this with your UPS Retired Employees’ Health Care Plan Summary Plan Description ( SPD) for reference. The terms of the plan are not changing and remain in full force and effect, except as specifically described in this summary.

Transgender Benefits
Effective January 1, 2017, services and treatments related to gender dysphoria and gender transition may be covered in accordance with the generally applicable terms of the plan (including but not limited to medical necessity and experimental and investigative).

HIPAA Privacy Notice
Your group health plan maintains a Notice of Privacy Practices that describes how the plan, and those that administer the plan, can and will use your protected health information (PHI). You receive a copy of the notice when you first enroll in the plan. You can request a copy of the notice by calling the UPS Benefits Service Center at 1-800-UPS-1508.
More Information

Benefits Service Center
1-800-UPS-1508
Enrollment is available 24 hours a day (except between 1 a.m. and 12 p.m. on Sundays)
Service center representatives are available from 8 a.m. to 8 p.m., CST, Monday through Friday

Retiree Reimbursement Account
1-888-238-6226
Monday through Friday
8 a.m. to 9 p.m., EST
www.aetna.com

Retiree Health Access
1-866-643-8742

Medicare HelpLine
1-800-MEDICARE
(1-800-633-4227)
1-877-486-2048 (TTY)
24 hours a day, 7 days a week
(English- and Spanish-speaking representatives)
www.medicare.gov