The Flexible Benefits Plan
Summary Plan Description

Effective January 1, 2018
About This Summary Plan Description

This Summary Plan Description ("SPD") summarizes the main provisions of The Flexible Benefits Plan (the "Plan") effective January 1, 2018. The Plan offers a number of benefits sponsored and maintained by UPS ("Benefit Options"). General information regarding this Plan is provided in the Plan Administration Section of this SPD. For example, the Plan Administration Section identifies the Benefit Options offered by this Plan, the Plan Year for the Plan, the identity of the Plan Administrator, the identity of the Claims Administrators and Carriers, and the role they play with respect to the Benefit Options. We encourage you to read the Plan Administration Section of this SPD when you receive this SPD so that you are better familiar with the Plan and how it operates.

It is important that you understand the importance of this SPD and how to use it. This SPD describes many of the terms and conditions that govern eligibility for, participation in and benefits received by the Benefit Options. Other governing terms and conditions of the Benefit Options are described in separate summary plan descriptions or certificates of coverage prepared by the applicable claims administrators and insurance carriers that administer and/or insure the benefits ("Benefit Plan Documents"). This SPD and the Benefit Plan Documents together constitute the “Summary Plan Description” for the Plan.

This SPD provides important information about the rights and obligations of both the Plan and you. We encourage you to read this SPD and the Benefit Plan Documents carefully and share them with your covered family members.

This Plan also is maintained pursuant to separate written documents—a plan document maintained by the Company and insurance policies issued by the insurance carriers that fully insure the Benefit Options (collectively, the plan document and the insurance contracts are referred to as the "Plan Document") that are available to you upon request. The Summary Plan Description (i.e. this SPD and the Benefit Plan Documents) is incorporated into and made a part of the Plan Document. If there is a conflict between the Plan document and the Summary Plan Description with respect to matters expressly covered in the Plan Document, the Plan Document controls. If you have any questions about your benefits, this SPD, the Benefit Plan Documents, or the Plan Document please contact the UPS Benefits Resource Center at 1-844-877-8588.

UPS is referred to throughout as “UPS” and “Company”.

NOTE: You will receive from time to time supplemental materials from the Company, the Plan Administrator, the Claims Administrator, and/or the Insurance Carriers regarding your benefits that are intended to educate you regarding the benefits offered by the plan ("Supporting Materials"). For example you may receive a benefits guide during your initial or annual enrollment period. You also may receive a summary of benefits and coverage that is required by the Affordable Care Act. Only this SPD, those materials identified in this SPD as a Plan Document or Benefit Plan Document, or that are expressly incorporated into the Plan Document or this SPD control the terms of the Plan. If there is a conflict between the Supporting Materials and the Plan Document or the Summary Plan Description, the Plan Document/Summary Plan Description control. If you have questions, please contact the UPS Benefits Resource Center at 1-844-877-8588.
About Your Participation

This section includes important information about your eligibility for the Flexible Benefits Plan. This section also contains important information about how to enroll in the Plan and when coverage for the Benefit Options you choose begins and ends.

NOTE: Except for certain Default Benefits described below, you not only have to be eligible to receive benefits from a Benefit Option, but you have to enroll in the Benefit Option in accordance with this SPD and you have to satisfy any applicable waiting period.

Eligibility
The terms of eligibility in this Summary Plan Description control in the event of a conflict with any other document.

Employee Eligibility
You are generally eligible to participate in The Flexible Benefits Plan if you are designated as an employee by UPS in the Human Resources system and are regularly working in one of the eligible job classes as described below.

- Active full- and part-time union-free employees
- Eligible U.S. expatriate employees
- Eligible union employees who are in a transition period described in this SPD
- Eligible Canadian residents employed by UPS in the U.S.

Eligibility for short-term disability benefits will be subject to additional terms and/or limitations set forth in the insert applicable to your business unit.
You’re not eligible to participate if you are:

- An employee classified by the Company as a temporary or contract employee, intern, or co-op;
- A part-time employee of Region 20, District 28 (UPS Teleservices);
- Union-free employee in Puerto Rico, U.S. Virgin Islands and Guam;
- An employee whose terms of employment are covered by a collective bargaining agreement, except as specified above.

Employee Eligibility-Special Rules

- Employees designated as part-time employees are not eligible for the Long-term Disability Benefit Option under this Plan; however, a part-time employee who becomes permanently and totally disabled may qualify for an advance lump sum payment of the life insurance benefit. See the Life Insurance certificate for more details.
- You may be able to continue your participation in one or more of the Benefit Options if you take an approved leave of absence from the Company, even though you don’t satisfy the above mentioned requirements. See the What If section for more details.
- You may be eligible to continue coverage for a period of time following a layoff or retirement from UPS. See the What If section for more details.
- Additional eligibility requirements may apply with respect to a Benefit Option. See the Benefit Option section for more information.
**Dependent Eligibility**

Your family members also may be eligible for one or more of the Benefit Options if they meet the following requirements:

**Medical, Dental, Vision, Life, AD&D, and EAP Benefits**
- Your legal Spouse (subject to the Working Spouse Eligibility Rule described below);
- Your child who is under age 26 or;
- Your incapacitated child who is age 26 or older if that child satisfies the Incapacitated Child eligibility requirements described below.

Your “Spouse” is any individual to whom you are legally married.

Your “Child” includes any of the following:
- Your natural child;
- Your adopted child or a child that has been placed with you for adoption;
- Your step-child. A “step child” is the natural or adopted child of your current Spouse;
- A child for whom you are the legal guardians determined by a court or applicable administrative agency.

Additional eligibility requirements may apply with respect to a Benefit Option. See the Benefit Option section of this SPD for more information.

**Incapacitated Child Eligibility**

A covered child who becomes incapacitated while covered under the applicable Benefit Options identified above and before he or she turns age 26 is eligible to continue coverage after turning age 26 as long as you are eligible and as long as the following conditions are satisfied: (i) the incapacity exists, (ii) the child is unmarried, (iii) the child is primarily dependent on you for support and maintenance, and (iv) appropriate certification of incapacitation is provided to the Benefits Resource Center prior to your child turning age 26. The child must have a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the Benefits Resource Center.

**Health and Dependent Care Spending Accounts**

See the sections of this SPD applicable to each spending account for details regarding the definition of eligible dependent for those accounts.

**All Other Benefit Options**

For all other benefits, see the applicable Benefit Option section of this SPD and the applicable Benefit Plan Documents for more information.

**Proof of Dependent Status**

Enrollment in the Plan is conditioned on timely receipt of information requested by the Company, the Plan Administrator (or its designee), a Claims Administrator or a Carrier (collectively a “Reviewer”) that verifies, in the Reviewer’s sole discretion, the enrolled individual’s eligibility for this Plan. See the Enrollment section of this SPD for more details regarding dependent eligibility verification.
**Working Spouse Eligibility**

Spouses who are eligible for coverage as an employee (other than as a qualified beneficiary under COBRA) under another employer’s medical plan (e.g., the spouse’s employer’s major medical plan) are not eligible for the Medical Benefit Option offered through this Plan to the extent that such other employer coverage constitutes “minimum essential coverage” for purposes of the individual mandate under the Affordable Care Act (other than COBRA continuation coverage). NOTE: The plan will apply the individual mandate rules to define minimum essential coverage even if the individual mandate is repealed by Congress. For this purpose, a spouse is considered eligible for other employer coverage if the spouse satisfies the terms of eligibility to participate in the other employer coverage as an employee (other than COBRA coverage), even if not otherwise permitted to currently enroll (e.g. the plan year of the other employer plan has already begun and the Spouse did not elect to participate in the spouse’s employer’s plan for that plan year). This exclusion applies even if your spouse works for UPS (i.e. you cannot enroll your spouse as a dependent under your medical plan if your spouse is eligible for coverage as an employee under a UPS Administered or Union Administered Plan). However, if the spouse is subject to a waiting period under the other employer plan, the spouse will not be considered to be eligible for other employer coverage during the waiting period.

The spousal exclusion applies without regard to whether the other coverage is considered “affordable” for purposes of the Affordable Care Act or whether the other coverage provides “minimum value” (as defined by the Affordable Care Act).

If the other employer coverage constitutes “minimum essential coverage”, you will receive a Summary of Benefits and Coverage (SBC) provided by your employer that indicates that the coverage is minimum essential coverage. You also can contact your spouse’s employer for this information.

If your spouse is enrolled as a dependent in The Flexible Benefits Plan and later becomes eligible for other employer coverage, it is your responsibility to notify the Plan Administrator as soon as possible but no later than 30 days after becoming eligible for the other employer coverage. If your Spouse loses eligibility for other employer coverage, your Spouse once again becomes eligible and you may enroll the spouse in accordance with the Life Events section of this SPD.

**Tobacco Use Certification**

Tobacco usage status is collected from eligible employees and spouses at the time of their Initial Enrollment Period and each subsequent Annual Enrollment period. If you are a tobacco user (that means you smoke cigarettes or use other tobacco products or e-cigarettes), a tobacco user surcharge will be added each pay period to your Medical Benefit Option contribution amount. This surcharge also applies if your covered spouse is a tobacco user.

Employees must certify their tobacco user status during each enrollment period, otherwise the surcharge will be applied to your Medical Benefit Option contribution. If you do not actively enroll or you incorrectly answer the affidavit question, the surcharge can be stopped on a prospective basis only and you must call the Benefits Resource Center to report this. If you did not actively enroll but use tobacco, you will still have the opportunity to participate in the tobacco cessation program and receive a refund of the surcharge incurred in the year you complete the program (see below for details). Employees with an Initial Enrollment period after August 1 are not subject to the surcharge for that plan year.
If you and/or your covered spouse use tobacco, you can participate in a Company-provided tobacco cessation program to have the tobacco surcharge removed and refunded. If you complete the “Quit For Life” tobacco cessation program through Alere by November 30, you can get a refund of the tobacco user surcharge for that plan year. The timing to receive the refund will be based on when you complete the program.

- If you complete the program between January 1 and June 30, you will see a refund in your paycheck in July.
- If you complete the program between July 1 and November 30, you will see a refund in your paycheck in December.

The tobacco surcharge will not be refunded if you complete a tobacco cessation program outside of the Quit For Life program. For more details about the tobacco cessation program, see the Quit For Life section in this SPD.

**Enrollment and Effective Date of Coverage**

It is very important for you to timely enroll in the Plan during the applicable enrollment periods. There are two general enrollment periods – the Initial Enrollment Period and the Annual Enrollment Period.

**Initial Enrollment Period**

If you are a newly hired eligible employee or you become a newly eligible employee during the Plan year, and you wish to participate in a Benefit Option, you must enroll yourself and any eligible Dependents you wish to enroll at that time within your initial enrollment period described in the enrollment materials you receive when you first become eligible. The enrollment materials also will describe how you enroll. If you timely enroll, your coverage under The Flexible Benefits Plan (other than Health and Dependent Care spending Accounts) will generally begin on the first day of the first full pay period following 30 days from the date you are hired. Your Health and/or Dependent Care Spending Account elections are effective on the date you make a timely and proper election. If you fail to affirmatively enroll during your initial enrollment period, you will not receive any Benefit Option coverage for the remainder of the Plan Year except “Default Benefits” described in the enrollment materials. The enrollment elections that you make (including your election not to enroll) may not be changed for the remainder of that Plan year except as otherwise permitted in the *Life Events* section of this SPD.

If you are rehired as an eligible employee in the same calendar year in which you lost coverage, the Benefit Option elections (except for Health and/or Dependent Care Spending Accounts) in effect when your employment terminated will automatically be reinstated, effective on your return date; however, you may be allowed to change those elections if you experience a Life Event during the period that you were not employed with UPS. See the *Life Events* section for more details.
**Annual Enrollment Period**

Each year, UPS will conduct an Annual Enrollment period during which you may enroll yourself or, if you are already enrolled, your eligible Dependents. You also may make changes to your current Benefit Option elections if you are an eligible Employee (e.g. change Medical Benefit Options). You will be notified in advance of the Annual Enrollment period each year and the enrollment materials will describe how to enroll. If you do not affirmatively enroll or make changes, then the Benefit Option elections you have in effect at the end of that year (if any) will continue unchanged for the following plan year.

The elections you make during the Annual Enrollment period are effective the following January 1 and may not be changed during the plan year that begins January 1 except as permitted in the *Life Events* section of this SPD.

A two-year election rule applies to long-term disability option choices. If you do not make an election you will automatically default to the lowest coverage option and will not be able to change the option for two years.

Additional rules may apply, as set forth in the Benefit Option specific sections of this SPD or the applicable Benefit Plan Documents.

NOTE: You cannot enroll a spouse or dependent in the Plan unless you also are enrolled in the Plan.

**Request for Additional Enrollment Information**

The Plan Administrator reserves the right to request information regarding you and your dependents as a condition of enrollment in the Plan (including continuing enrollment). This information is necessary for proper and effective administration of the Plan and in some cases, required by federal law. The Plan Administrator also authorizes the Claims Administrators and/or the Carrier to request such information as necessary to process claims and/or to administer that particular Benefit Option.

If you do not provide the requested information within the time period noted in the request for information, the enrollment is deemed ineffective and coverage will end immediately for failing to satisfy the Plan’s terms of enrollment (and no continuation of coverage will be offered). If it is determined that you have fraudulently provided information, coverage may be retroactively terminated (subject to applicable law). If coverage is terminated retroactively, you may be required to pay the Plan back for any benefits paid for the dependent(s). See the *Right of Reimbursement* section in this SPD for more details on the Plan’s right of recovery.

NOTE: If you are enrolling a dependent, you are required as a condition of enrollment in the Plan to provide the dependent’s Social Security number. The Social Security number is not only required for proper and effective administration of the Plan (e.g. to verify and monitor eligibility) but it also is required to be reported to the Federal Government in connection with this Plan. If your dependent was unable to obtain a Social Security Number in accordance with applicable law, contact the UPS Benefits Resource Center for assistance (e.g. you may be able to provide other federally approved identification). Otherwise, coverage for your spouse will be delayed until that Social Security number is provided. Coverage for a dependent child will begin but will be terminated if not promptly provided. In no event will the dependent’s Social Security number (or other identification) be used for any purpose other than Plan administration and it will be kept strictly confidential.
**Qualified Medical Child Support Orders**

You (if you are eligible) and your child will be automatically enrolled in the Plan’s health coverage options in accordance with the terms of a qualified medical child support order (QMCSO), as defined in ERISA Section 609, that has been received and processed by UPS. A QMCSO is an order or judgment from a court or administrative body that requires the Plan to cover a Child of an eligible employee under the health plan. Federal law—ERISA Section 609—provides that a medical child support order must meet certain formal and content requirements in order to be a QMCSO. When an order is received, each affected employee and each child (or the child’s representative) covered by the order will be given notice of the receipt of the order and a copy of the plan’s procedure for determining if the order is valid.

Coverage under the Plan pursuant to a medical child support order will not become effective until the plan administrator determines that the order is a QMCSO and then not until the first day of the following month. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the UPS Benefits Resource Center at 1-844-877-8588.

If the plan administrator receives a QMCSO and you are not already enrolled, you will be enrolled automatically in accordance with the QMCSO and the Plan’s QMCSO procedures. If you are already enrolled, your child will be enrolled with you in the Benefit Option you previously elected. Contributions for coverage under the Benefit Option will be automatically withheld.

If the QMCSO expires during the year but the enrolled child is still an eligible dependent, you will not be able to revoke coverage for that child solely because the QMCSO expires.

All QMCSO orders should be submitted to:

WTW QMCSO Service Center
P.O. Box 712728
Los Angeles, CA 90071
1-855-481-2661

**Other Orders or Judgments**

The Plan is not obligated to nor does it recognize or comply with any other orders purporting to provide coverage under the Plan that is not a QMCSO. For example, the Plan will not recognize a judgement or order in a divorce decree that requires an employee to provide employer sponsored coverage for an ex-spouse.

**Transition Coverage**

In certain very specific conditions, The Flexible Benefits Plan may provide you and your family with transition coverage while you are making your elections for The Flexible Benefits Plan or waiting to become eligible for a union administered plan to which UPS contributes. Details of this transition coverage are described in this section.

**Current Employees Transferring to The Flexible Benefits Plan From a Union-Administered Plan**

If you’re a current UPS union employee covered under a union-administered health care plan to which UPS contributes and are transferred to a union-free position eligible for The Flexible Benefits Plan, you become eligible for full coverage under The Flexible Benefits Plan.
Plan on the first day of the first full pay period following 30 days from the transfer date. The Flexible Benefits Plan will provide Transition Coverage at no cost for you and your eligible dependents as listed in the table below until you become eligible for full coverage under the Plan.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Plan Option</th>
<th>Coverage Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, including prescription drug</td>
<td>You’ll be enrolled in the lowest cost plan with the lowest cost carrier (excluding Kaiser Permanente)</td>
<td>Employee plus family</td>
</tr>
<tr>
<td>Dental</td>
<td>No coverage</td>
<td>Employee plus family</td>
</tr>
<tr>
<td>Vision</td>
<td>No coverage</td>
<td>Employee plus family</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>1x Base Pay</td>
<td>Employee plus family</td>
</tr>
<tr>
<td>Basic AD&amp;D</td>
<td>1x Base Pay</td>
<td>Employee only</td>
</tr>
<tr>
<td>Short-term disability (STD)</td>
<td>Refer to insert for eligibility</td>
<td>Employee only</td>
</tr>
<tr>
<td>Employee Assistance Plan (EAP)</td>
<td>N/A</td>
<td>Employee plus family</td>
</tr>
<tr>
<td>Tobacco cessation program</td>
<td>N/A</td>
<td>Employee plus family</td>
</tr>
</tbody>
</table>

**Current Employees Transferring From A UPS Subsidiary that is not Flexible Benefits Plan Eligible**

If you are a current employee working for a UPS subsidiary that is not eligible for Flexible Benefits coverage who transfers to a position eligible for The Flexible Benefits Plan, you become eligible for coverage under the Plan on the first day of the first full pay period following 30 days from the transfer date. The Flexible Benefits Plan will provide Transition Coverage at no cost for you and your eligible dependents as listed in the table above until you become eligible for full coverage under the Plan. You will be given credit toward your initial coverage eligibility period from your “Original Hire Date” as recorded in the UPS Human Resources system.

**Employee Transferring from International Subsidiary**

If you’re an employee who transfers from an international subsidiary, you will become eligible for coverage in the Flexible Benefits Plan as though you are a newly hired employee as of the date of transfer or hire date in the United States.

**UPS Acquisition**

If you are an employee who becomes eligible for the Flexible Benefits Plan due to a company acquisition, you will become eligible for coverage in the Flexible Benefits Plan as though you are a newly hired employee, unless there is specific language pertaining to health care eligibility to the contrary in the acquisition agreement.

**From a UPS-Administered Plan**

If you are a union employee covered under a UPS-administered health care plan transferring to a union-free position, you become eligible for coverage under The Flexible Benefits Plan effective the date of your transfer.
**Current Employees Transferring From The Flexible Benefits Plan To a Union-Administered Plan**

If you’re a current employee transferring from The Flexible Benefits Plan to a union-administered plan contributed to by UPS, The Flexible Benefits Plan will continue certain types of coverage (as listed in the table below) for you and your family at no cost to you, during the waiting period to establish your eligibility under the union-administered Plan. Your transition coverage ends if you terminate employment during the waiting period or the day you become eligible for medical coverage under the union-administered Plan.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Plan Option</th>
<th>Coverage Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical, including prescription drug</td>
<td>Your current election</td>
<td>Your current coverage level, applicable payroll deductions are discontinued</td>
</tr>
<tr>
<td>Dental</td>
<td>Your current election</td>
<td>Your current coverage level, applicable payroll deductions are discontinued</td>
</tr>
<tr>
<td>Vision</td>
<td>Your current election</td>
<td>Your current coverage level, applicable payroll deductions are discontinued</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>1x Base Pay</td>
<td>Employee plus family</td>
</tr>
<tr>
<td>Basic AD&amp;D</td>
<td>1x Base Pay</td>
<td>Employee only</td>
</tr>
<tr>
<td>Short-term disability (STD)</td>
<td>Refer to insert for eligibility</td>
<td>Employee only</td>
</tr>
<tr>
<td>Long-term disability (LTD)</td>
<td>Your current election</td>
<td>Employee only, applicable payroll deductions are discontinued</td>
</tr>
<tr>
<td>Employee Assistance Plan (EAP)</td>
<td>N/A</td>
<td>Employee plus family</td>
</tr>
<tr>
<td>Tobacco Cessation Plan</td>
<td>N/A</td>
<td>Employee plus family</td>
</tr>
</tbody>
</table>

All employee supplemental coverage under this Plan will end on the date of your transfer. If you are eligible for UPS-administered supplemental coverage, your current supplemental coverage will be automatically transferred up to your new plan limits and your payroll deductions will continue. If you have any questions about your eligibility for this coverage contact 1-800-UPS-1508.

**Current Employees Transferring From The Flexible Benefits Plan To Another UPS Administered Plan**

If you are a current employee transferring from The Flexible Benefits Plan to another UPS administered plan, your new plan is effective the date of your transfer. You will still need to make elections during your initial enrollment period or you will receive default coverage per the terms of that Plan.

**Coverage Provided by the Plan**

The Plan provides a variety of coverage options designed to meet your individual needs. A table of the coverage options is provided under “Benefit Options” in the Plan Administration section of this SPD.
Paying for Coverage

Required Contributions
The enrollment materials furnished by the Company will identify the amounts that you are required to pay for the Benefit Options (“Required Contributions”). The Company will determine the Required Contributions for the Benefit Options for similarly situated Participants on a uniform and nondiscriminatory basis. The Company reserves the right to change those Required Contributions at any time.

If you elect to enroll in a Benefit Option with Required Contributions, and you are actively employed, a pro-rata share of the Required Contributions will be withheld from each paycheck that you receive. If the Benefit Option is a Cafeteria Plan Benefit, the Required Contributions will be withheld from your pay prior to any applicable federal or state taxes (except in certain jurisdictions) being withheld. If you are deemed to have elected to enroll in a Default Benefit, the Required Contributions will be withheld from your paycheck as described above.

If you are on a leave of absence and you are permitted to continue your coverage under a Benefit Option, you must make the Required Contributions in accordance with the What If section of this SPD.

One of the advantages of the Plan is that it contains an Internal Revenue Code Section 125 cafeteria plan component. This means you can pay your portion, if any, of the cost of many benefits with pre-tax payroll deductions. The following table shows which benefits are paid for before taxes are withheld (which means they are part of the cafeteria plan), and which are paid after taxes (which means they are not part of the cafeteria plan).

<table>
<thead>
<tr>
<th>Paid for Before Taxes</th>
<th>Paid for After Taxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contributions for medical (including prescription drug), dental, and vision coverage</td>
<td>• Employee's supplemental life insurance</td>
</tr>
<tr>
<td>• Tax-advantaged reimbursement accounts (HCSA, LPSA, and C/ECSA)</td>
<td>• Spouse's supplemental life insurance</td>
</tr>
<tr>
<td>• Long-term disability</td>
<td>• Children's supplemental life insurance</td>
</tr>
<tr>
<td>• Health Savings Account contributions to Optum (not a Flexible Benefits Plan Benefit Option)</td>
<td>• Employee's supplemental AD&amp;D coverage</td>
</tr>
<tr>
<td></td>
<td>• Legal assistance</td>
</tr>
<tr>
<td></td>
<td>• Supplemental medical insurance (accident, critical illness, and hospital indemnity)</td>
</tr>
</tbody>
</table>

When Benefit Option Coverage Ends
Employees
In general, coverage for you under a Benefit Option will end on the earliest of the following to occur:
• The date that UPS terminates the Benefit Option;
• You terminate employment or otherwise cease to be eligible for the Benefit Option (see the What If section for special rules regarding the date coverage ends);
• You fail to make the Required Contributions for that Benefit Option. If you fail to make the Required Contributions, your coverage will end on the last day of the month for which you made a timely and complete required contribution;
• The date that you die. NOTE: Your covered surviving Spouse and eligible children may qualify for subsidized COBRA continuation coverage. See the What If section for more details;
• After you have been on an approved leave of absence for 12 months. If you are on an approved Long-term disability leave, you may be eligible for coverage under the Retired Employees Health Care Plan (REHCP). See the REHCP Summary Plan Description for more details.

**Dependents**

Your dependent’s coverage under a Benefit Option will end on the earliest of the following to occur:

• The date that your coverage under that Benefit Option ends (see the *What if* section for special rules for surviving spouses and children);

• The date that UPS terminates dependent coverage under the Benefit Option;

• The Date that your covered spouse ceases to be eligible for the Benefit Option;

• Coverage for dependent children will end on the last day of the month in which your dependent Child turns 26 years of age; however, if your child ceases to be eligible for any other reason (e.g. you cover your stepchild and you and your spouse divorce), coverage will end on the date of the event that causes them to be ineligible;

• You fail to make the Required Contributions;

• The date that your dependent dies;

• There are special rules that apply to dependents that are also UPS employees, see the *When your dependent is a UPSer* section for more information.

You and your eligible dependents may be able to continue group health plan coverage for a period of time following the date that coverage is lost for certain reasons. See the *Continuation of Coverage under the COBRA* section for more details.

**Life Events**

The Flexible Benefits Plan is regulated by the Internal Revenue Code, and changes during the year are restricted. However, the IRS realizes that certain life events do occur that create the need for you to change your benefit choices in the middle of a Plan year.

As a general rule, you will be allowed to make coverage changes only if the life event results in you, your spouse, or your dependents gaining or losing coverage eligibility under an employer sponsored plan. Your change in coverage must be consistent with the life event. For example; if you have a baby, you can change your level of medical coverage from employee only to employee plus family, but you may not decrease your life insurance.
<table>
<thead>
<tr>
<th>When Changes Become Effective:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All benefits not described below</td>
<td>Retroactive to the date of the event</td>
</tr>
<tr>
<td>Life Insurance and AD&amp;D</td>
<td>For life insurance requiring evidence of insurability (EOI), the requested level of coverage is effective when approved by Securian. Until then, the highest level of coverage (up to the level requested) not requiring evidence of insurability is effective. In certain circumstances, coverage for you or your dependents could be delayed. See the Life Insurance and AD&amp;D section of this SPD for further details.</td>
</tr>
<tr>
<td>All Benefits for which you are required to pay the total cost (e.g. Critical Illness) other than Reimbursement Accounts— Applies only when you add a dependent</td>
<td>First day of first pay period following the date that your election is received.</td>
</tr>
<tr>
<td>Reimbursement Accounts (Health FSA including Limited Purpose Health FSA and Dependent Care FSA)</td>
<td>The date you notify the Benefits Resources Center (if the change is approved).</td>
</tr>
</tbody>
</table>

All life events will be administered in accordance with the requirements in Code Section 125 and the applicable regulations. In addition, if a Benefit Plan Document (e.g. a certificate of coverage) allows you to make a change that is not otherwise permitted by Code Section 125, we will apply the Code Section 125 rules.
# Allowable Mid-Year Coverage Changes

Only the changes listed in the table below are allowed.

<table>
<thead>
<tr>
<th>Event</th>
<th>Medical</th>
<th>Dental</th>
<th>Vision</th>
<th>AD&amp;D</th>
<th>Employee Life*</th>
<th>Spouse Life*</th>
<th>Child Life*</th>
<th>Legal</th>
<th>LTD</th>
<th>Health Care FSA</th>
<th>Dependent Care FSA</th>
<th>Supplemental Medical (Accident, Critical Illness, Hospital Indemnity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>If covered, change family status and coverage option. If opted out, start coverage. If now have outside coverage, can opt out.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage. If now have outside coverage, can opt out.</td>
<td>Change family status and coverage option.</td>
<td>Add or increase coverage</td>
<td>Add coverage</td>
<td>Add coverage</td>
<td>Start coverage; change family status</td>
<td>No changes</td>
<td>Start or increase contribution</td>
<td>Start, stop or change contribution</td>
<td>Change coverage option, change family status</td>
<td></td>
</tr>
<tr>
<td>Divorce; Legal Separation; Annulement</td>
<td>If covered, change family status and coverage option. If opted out, start coverage if lost under spouse's plan.</td>
<td>If covered, change family status. Increase coverage if lost under spouse's plan.</td>
<td>Change family status. Add coverage or change coverage option.</td>
<td>Increase or decrease coverage</td>
<td>Drop coverage</td>
<td>Change or remove coverage</td>
<td>Start or drop coverage; change family status</td>
<td>No changes</td>
<td>Stop or decrease contribution</td>
<td>Start, stop or change contribution</td>
<td>Change coverage option, change family status</td>
<td></td>
</tr>
<tr>
<td>Birth; Adoption or Placement for Adoption; Child Gains Eligibility</td>
<td>If covered, increase family status and change coverage option. If opted out, start coverage.</td>
<td>If covered, increase family status and change coverage option. If opted out, add coverage.</td>
<td>Increase family status</td>
<td>Increase coverage</td>
<td>Add or increase coverage</td>
<td>Start coverage; change family status</td>
<td>No changes</td>
<td>Start or increase contribution</td>
<td>Start, stop or change contribution</td>
<td>Change coverage option, change family status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death of Spouse</td>
<td>If covered, change family status and coverage option. If opted out, start coverage if lost under spouse's plan.</td>
<td>If covered, change family status. Increase coverage if lost under spouse's plan.</td>
<td>Change family status. Add coverage or change coverage option.</td>
<td>Increase or decrease coverage</td>
<td>Drop coverage</td>
<td>No changes</td>
<td>Start or drop coverage; change family status</td>
<td>No changes</td>
<td>Stop or decrease contribution</td>
<td>Start, stop or change contribution</td>
<td>Change coverage option, change family status</td>
<td></td>
</tr>
<tr>
<td>Event</td>
<td>Medical</td>
<td>Dental</td>
<td>Vision</td>
<td>AD&amp;D</td>
<td>Employee Life*</td>
<td>Spouse Life*</td>
<td>Child Life*</td>
<td>Legal</td>
<td>LTD</td>
<td>Health Care FSA</td>
<td>Dependent Care FSA</td>
<td>Supplemental Medical (Accident, Critical Illness, Hospital Indemnity)</td>
</tr>
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<td>----------------------------------------------------------------------</td>
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<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Death of Child; Loss of Child's Eligibility; Termination of Adoption Proceedings</td>
<td>Decrease family status</td>
<td>Decrease family status</td>
<td>Decrease family status</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Drop coverage</td>
<td>No changes</td>
<td>No changes</td>
<td>Stop or decrease contribution</td>
<td>Stop or decrease contribution</td>
<td>Change family status</td>
</tr>
<tr>
<td>Dependent Loses Eligibility for Spending Accounts</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Stop or decrease contribution</td>
<td>Stop or decrease contribution</td>
<td>No changes</td>
</tr>
<tr>
<td>Gain or Loss of Eligibility for Medicare or Medicaid</td>
<td>If covered, change family status and coverage option. If opted out, start coverage.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage.</td>
<td>Change family status</td>
<td>Change family status</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Start, stop or change coverage</td>
<td>No changes</td>
<td>No changes</td>
</tr>
<tr>
<td>Loss of coverage under state children's health insurance program</td>
<td>If covered, change family status and coverage option. If opted out, start coverage.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage.</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td></td>
</tr>
<tr>
<td>Become eligible for qualifying health coverage premium assistance under Medicaid or state children’s health insurance plan</td>
<td>If covered, increase family status and change coverage option. If opted out, start coverage.</td>
<td>If covered, increase family status and change coverage option. If opted out, start coverage.</td>
<td>If covered, increase family status and change coverage option. If opted out, start coverage.</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td></td>
</tr>
<tr>
<td>Event</td>
<td>Medical</td>
<td>Dental</td>
<td>Vision</td>
<td>AD&amp;D</td>
<td>Employee Life*</td>
<td>Spouse Life*</td>
<td>Child Life*</td>
<td>Legal</td>
<td>LTD</td>
<td>Health Care FSA</td>
<td>Dependent Care FSA</td>
<td>Supplemental Medical (Accident, Critical Illness, Hospital Indemnity)</td>
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</tr>
<tr>
<td>Loss of Outside Medical Coverage Eligibility with Other Employment</td>
<td>If opted out, start coverage. Increase family status if dependent lost coverage elsewhere and change option.</td>
<td>If opted out, start coverage if lost elsewhere. Increase family status if dependent lost coverage elsewhere and change option.</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
</tr>
<tr>
<td>Gain in Spouse's Employment or Coverage; Annual Enrollment Period Differs from Employee's</td>
<td>If covered, change family status and/or change in coverage option. If now have outside coverage, can opt out.</td>
<td>If covered, change family status and/or change in coverage option. If now have outside coverage, can opt out.</td>
<td>If covered, change family status and/or change in coverage option. If now have outside coverage, can opt out.</td>
<td>Change family status</td>
<td>No changes</td>
<td>Add or increase coverage</td>
<td>No changes</td>
<td>Start, stop or change coverage</td>
<td>No changes</td>
<td>Start or increase contributions if health coverage is lost due to employment change</td>
<td>Start, stop or change contribution</td>
<td>Start, stop or change contribution</td>
</tr>
<tr>
<td>Loss of DMO access</td>
<td>No changes</td>
<td>Change plan</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
</tr>
<tr>
<td>Reduction in earnings due to leave of absence**</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>Decrease coverage</td>
<td>Stop or decrease coverage</td>
<td>Stop or decrease coverage</td>
<td>No changes</td>
<td>Start or drop coverage; change family status</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
</tr>
<tr>
<td>Change Fulltime to Part time</td>
<td>Change current plan</td>
<td>No changes</td>
<td>No changes</td>
<td>Decrease coverage</td>
<td>Stop or decrease coverage</td>
<td>Stop or decrease coverage</td>
<td>No changes</td>
<td>Start or drop coverage; change family status</td>
<td>Drop coverage</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
</tr>
<tr>
<td>Change in Child/Elder Care Provider or Cost</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
</tr>
<tr>
<td>Court Ordered Coverage for Child***</td>
<td>As dictated by court order</td>
<td>As dictated by court order</td>
<td>As dictated by court order</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>No changes</td>
<td>As dictated by court order</td>
<td>No changes</td>
<td>No changes</td>
</tr>
</tbody>
</table>

*See the Life Insurance section for details about coverage maximums and evidence of insurability requirements.
**Except military leave. Personal leaves are administered according to COBRA provisions.
***Must comply with QMCSO, see page 6.
You must call the Benefits Resource Center within 60 days of the date of the event to request a change in coverage. If you don’t call to change coverage within the 60-day period, you must wait until the next Annual Enrollment period to make changes.

**Special Rules for Reimbursement Accounts**
The following rules apply to any mid-year changes you want to make to the amount you elect to contribute through payroll deductions to a tax-advantaged reimbursement account (Health Care FSA, Limited Purpose FSA or Dependent Care FSA) as a result of a qualified life event. Some life events, however, make you eligible to stop your account contributions altogether — see the Allowable Mid-Year Coverage Changes table in this section. For more information about reimbursement accounts and contribution elections, see the Tax-Advantaged Reimbursement Accounts section of this SPD.

**Increasing Your Annual Contribution**
Your new contribution per pay period is calculated by dividing the amount of the increase by the number of pay periods remaining in that calendar year. The result is then added to your current contribution per pay period. The amount of the increase is available to be reimbursed to you for expenses incurred after the effective date of the change.

For example, if you are paid monthly and increase your annual contribution from $1,200 to $1,500 in mid-September, the additional $300 is prorated over the three remaining monthly pay periods, so that $100 is added to your current contribution per paycheck.

**Decreasing Your Annual Contribution**
Your new contribution per pay period is calculated by subtracting the total amount you have contributed thus far during the year from your revised annual contribution amount. The difference is then divided by the number of pay periods remaining in that calendar year, and the result is subtracted from your current per-pay-period contribution.

For example, suppose you are paid monthly and decrease your annual contribution from $1,200 to $600 at the end of February. At that time you would have contributed $100 per month for two months, for a total of $200. The $200 you’ve already contributed is subtracted from your revised annual contribution of $600. The difference of $400 is divided by the 10 months remaining in the year. So your new contribution becomes $40 per monthly paycheck.

You may not decrease your account to an amount that is less than what you have already contributed, or for which you have already been reimbursed. In the example above, you could not decrease your account to less than $200, because you have already contributed $200.

**What If...**
This section describes how different life events may impact your plan coverage.

*If you leave UPS before taking early or normal retirement (other than a layoff)*
Your short-term disability and long-term disability coverage ends on the date you leave. For other Plan benefits, coverage for you and your eligible dependents ends on the date shown in the table on the next page.
For an employee paid... | Coverage ends on the last day of...
---|---
Weekly | The pay period following the pay period during which you became ineligible
Monthly or semi-monthly | The pay period during which you became ineligible

You and your covered dependents may be able to continue group health coverage from The Flexible Benefits Plan under COBRA for a period of time after your termination date. See the COBRA Continuation of Coverage section of this SPD for more information. You may have the option to port or convert your basic and supplemental life insurance for yourself and your dependents to individual policies if you timely request port or conversion from the Life Insurance carrier. Your AD&D coverage ends and may not be converted or ported.

**...You Retire?**

If you retire from UPS and are eligible for retiree health coverage, your active coverage ends on the last day of the month following 30 days from your retirement date. If you take early or normal retirement based on the provisions of the UPS Retirement Plan, you and your eligible dependents may be eligible for retired employee medical, dental, and vision coverage from the UPS Retired Employees’ Health Care Plan (REHCP) if you meet the eligibility rules of that Plan. You’ll receive a separate Summary Plan Description for the REHCP once you make elections under that plan.

You and your eligible dependents can continue group health plan coverage from The Flexible Benefits Plan under COBRA for a period of time after your termination or retirement date. See the Continuation of Coverage Under COBRA section of this SPD for more information.

You choose whether to elect COBRA coverage from The Flexible Benefits Plan or participate in the REHCP (assuming you meet that plan’s eligibility requirements). You can elect COBRA coverage under The Flexible Benefits Plan and then participate in the REHCP when COBRA coverage ends. After the end of your 60-day election period under COBRA, you cannot elect coverage from the REHCP and then switch to COBRA coverage under The Flexible Benefits Plan.

Coverage for supplemental benefits (e.g. supplemental life, AD&D, personal lines insurance, pre-tax accounts, etc.), under The Flexible Benefits Plan ends the date of your separation of employment for UPS. Your life insurance can be an individual policy with Securian at the current level of coverage at the time you retire, without evidence of insurability (EOI). You are not allowed to increase your life insurance coverage at that time. Your AD&D coverage ends and cannot be converted or ported.

**...You Die?**

If you die while you’re covered by The Flexible Benefits Plan as an active employee, UPS will continue coverage under COBRA for your eligible dependents — at no cost to your dependents — through the last day of the 13th calendar month following the date of your death. For example, if your death occurs on February 2, dependent coverage continues through March 31 of the following year. Your covered dependents are automatically enrolled for this 13-month coverage period.
When this UPS-paid coverage ends, your dependents may extend health care coverage in keeping with COBRA provisions for up to an additional 23 months, for a total of 36 months of coverage from the date of your death. The full cost of extended coverage beyond the initial 13-month period will be billed to your dependents according to the COBRA provisions of this Plan. See the Continuation of Coverage section of this SPD for more information. Life insurance for your spouse and children may be converted to individual policies.

Your dependents are eligible for this 13-month extension of coverage only if you and your dependents were covered by The Flexible Benefits Plan at the time of your death. Alternatively, if you meet the eligibility criteria for the REHCP plan at the time of your death, your surviving spouse and/or dependent children may still be eligible for coverage under the Retired Employees’ Health Care Plan as if you retired. See the Retired Employees Health Care Plan Summary Plan Description for details.

...You are laid off?
If you’re laid off from your UPS position (and are recorded as such in the UPS eligibility system), your Flexible Benefits Plan coverage is continued until the last day of the month following the month in which your layoff begins. You continue to pay your share, if any, of the Required Contributions. You can elect to continue your group health plan coverage through COBRA. See the Continuation of Coverage Under COBRA section for more information. You also may choose to convert life insurance for yourself, your spouse and your children to individual policies if you timely request conversion from the Life Insurance carrier.

...You Have Jury Duty?
If you have jury duty, your Flexible Benefits Plan participation continues. You make contributions as if you were at work.

...You Become Disabled?
Coverage continues for up to 12 months for you and your eligible dependents while you are on an approved disability leave. See the Income Protection section of this SPD for a full description of your short-term and long-term disability benefits, including health care coverage extension periods.

...You Take an Approved Leave of Absence?
FMLA Leave
If you’re on an approved leave of absence as provided by the Family and Medical Leave Act of 1993 (FMLA) or UPS policy, full medical, dental, vision, life insurance, AD&D, and employee long-term disability coverage for you and your dependents can be continued during your leave for up to the approved FMLA time period. You’ll need to continue to pay your share, if any, of the costs of the coverage.

While on leave, if your payroll deductions are unable to be taken on two consecutive pay periods, you will be direct billed and must make full and timely payments or your coverage will be terminated. If you are billed, you must pay the billed amount; it will not be deducted from your paycheck when you return to work. If you elect not to pay for coverage during your FMLA time period, your coverage will be reinstated when you return to work and you will experience a gap in your coverage. Your coverage for supplemental life insurance will be reinstated upon Evidence of Insurability (EOI) approval by the life insurance carrier.
If you notify UPS in writing that you want to extend your leave beyond the applicable approved FMLA time period, your approved extension of leave is considered a personal leave. Your coverage from the Plan can continue under COBRA, provided you make an election and you pay the full cost of coverage. See Personal Leave in this section for more information.

Special rules apply to Health Care FSA and Limited Purpose FSA contributions during your FMLA leave. See Special FSA Rules for FMLA Leaves Only in this section.

**Military Leave**
Except for military leaves of less than 31 days (or as otherwise required by federal law), your group health plan benefits end. However, you may be eligible to continue group health coverage for you and your covered dependents up to 24 months from either the date the leave began or the date that you fail to return to work — whichever is earlier — as required under USERRA. The USERRA continuation period will run concurrently with the COBRA period described in the Continuation of Coverage Under COBRA section of this SPD.

Although non-health care coverage (such as long-term disability, legal plan, and supplemental life, and AD&D insurance) is not subject to COBRA, you also may elect to continue any or all of your non-health care coverage during your leave. If you choose not to continue your supplemental life insurance, you must provide evidence of insurability (EOI) in order to begin coverage again when you return to work.

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

**Parental Leave (that is not otherwise FMLA)**
You may be able to continue coverage in accordance with UPS’ Parental Leave policy.

**Personal Leave**
You may continue coverage for you and your covered dependents if you are on an approved personal leave of absence. You are responsible for paying the full cost of coverage — not just the Required Contributions — during a personal leave. Group health plan coverage can be continued through COBRA, according to the COBRA provisions described in the Continuation of Coverage Under COBRA section of this SPD.

Although non-health care coverage (such as long-term disability, legal, and supplemental life and AD&D insurance) is not subject to COBRA, you also may elect to continue your supplemental coverage during your leave. If you choose not to continue your supplemental life insurance, you must provide evidence of insurability (EOI) in order to begin coverage again when you return to work. Regardless of whether you elect to continue your coverage, UPS-provided basic life and AD&D insurance coverage is continued up to 12 months, or until the date you terminate employment, whichever is earlier.

**If You Don’t Make Timely Payments While on a Personal Leave**
If you are responsible for some or all of the cost of your health plan coverage while on leave and elect to continue coverage, you must make full and timely payments. If you fail to do so, your coverage will be terminated according to the following guidelines:

- Any amounts received by the COBRA administrator will be applied first to your COBRA coverage.
• If the amount is insufficient to pay for your COBRA coverage, all COBRA and non-health care coverage will be terminated.
• If the amount is sufficient to pay for your COBRA coverage, but insufficient to pay for your non-health care coverage, your non-health coverage will be terminated.

If your supplemental life insurance coverage is dropped due to non-payment, you must provide evidence of insurability (EOI) to begin coverage again upon return to work. Upon return from your leave, your coverage other than reimbursements accounts will be reinstated.

Payroll Deductions
As long as you are receiving a paycheck from UPS, deductions or credits will continue to be applied to your paycheck while you are on leave. However, if we are not able to collect your deductions from two consecutive payroll periods, you will be direct billed. If you fail to make timely payment of this bill, your coverage will be terminated. If your supplemental life insurance coverage is dropped due to non-payment or while on an approved leave of absence, you must provide evidence of insurability (EOI) to begin coverage again upon return to work. Upon return from leave, your coverage other than reimbursement accounts will be reinstated.

When You Return to Work
If you return to work within the same calendar year, your coverage is reinstated the day you return. If your coverage was terminated during your leave and you return across plan years, you will have to establish coverage based on the Plan’s new hire rules. If your supplemental life insurance was dropped due to non-payment, you must provide evidence of insurability (EOI) to begin coverage again upon return to work. Upon return from leave, your coverage other than reimbursement accounts will be reinstated.

FSA Accounts
Your FSA contributions will stop during an approved leave. Upon return to work within the same plan year, your contribution amount per pay period will be reinstated automatically, unless you notify the Benefits Resource Center, within 60 days upon your return to work, to revoke your election. If you experienced a qualified life event, you may change certain elections. See the Life Events section of this SPD. Only eligible expenses incurred prior to your date of leave and after your return to work (unless you revoke your election) will be eligible for reimbursement.

Special rule for FMLA
If you chose not to make contributions during your FMLA leave, you also may choose, upon return from your FMLA leave, to reinstate your full annual FSA contribution amount and “catch up” on contributions you missed while on leave. You must call the Benefits Resource Center within 60 days of your return to work to activate this option. The total amount of contributions that you do not make while on a FMLA leave will be divided by the number of remaining pay periods during the Plan year and added to your regular contribution amount per pay period. Expenses incurred during your FMLA leave are not eligible for reimbursement from your FSA.

Your Plan Options
As an eligible employee, you can choose to enroll in a variety of Benefit Options offered to you. These Benefit Options are described in the sections below. In addition to the information
below in each Benefit Option section, you will find additional details regarding the following later in this SPD:

- Claims and Appeals
- Rights of Reimbursement and Subrogation
- Plan Administration

**Medical Plans**
Choice is a central part of the medical care provided through The Flexible Benefits Plan. For medical coverage you can enroll in one of the UPS Medical Plans offered to you based on your home address. The Plan Administration section at the back of this SPD will identify the various Medical Benefit Options that are available to you. You will find more details in the Benefit Plan Documents provided by each claims administrator. The following additional rules apply.

**Minimum Essential Coverage**
The medical coverage provided by the Medical Benefit Options 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).

**Rescission**
In general, UPS is not allowed to rescind (i.e., retroactively cancel or terminate) your (or your dependent’s) medical plan coverage once you (or your dependents) become covered under the plan. However, your (and/or your dependent’s) coverage under the plan may be rescinded (i.e., cancelled or discontinued with a retroactive effective date) if you (and/or your dependent) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact as prohibited under the terms of this plan. For example, if UPS determines that you have enrolled an individual who does not meet the plan’s eligibility requirements as stated in this SPD or as stated in the enrollment materials, your enrollment of such plan ineligible individual(s) will be treated as an intentional misrepresentation of a material fact, or fraud, and UPS reserves the right to rescind your (and/or your dependent’s) plan coverage.

If UPS seeks to rescind coverage for fraud or an intentional misrepresentation of a material fact, UPS will provide at least 30 days advance written notice to each participant who would be affected before coverage is rescinded. Your (and/or your dependent’s) coverage also may be terminated retroactively for failure to pay the required premiums or contributions on a timely basis, or in certain other limited circumstances without UPS having to provide 30 days advance written notice.

**Health Savings Account**
The UPS $1,500 Deductible and $2,000 Deductible medical plan options are high deductible health plans as defined by the Internal Revenue Code Section 223. If you enroll in either of these plan options through UPS, you may be eligible to establish a tax-advantaged Health Savings Account (HSA). The HSA is a personal savings account that belongs to you. It is not a group benefit sponsored or maintained by UPS and is not subject to the Employee Retirement Income Security Act. We describe it here only as a convenience to you. You will receive additional information from your HSA custodian when you enroll in an HSA. You can also find additional information in IRS Publication 969.
**HSA Contributions**

If you open an HSA administered by Optum Bank, you may elect to make contributions to your HSA through automatic pre-tax payroll deductions. You may elect, on a prospective basis only, to change the amount you contribute to your HSA at any time during the year. Contribution elections or changes will be effective the next available pay period.

Contributions to an HSA are subject to certain annual limits and can be made only if you participate in a health plan that qualifies as a high deductible health plan under IRS rules and you do not participate in any disqualifying non-high deductible health plan. The IRS determines the total maximum amount (for employer and employee combined) that can be contributed to an HSA each year. The contribution limit is based on the coverage level you choose under the high deductible health plan, up to IRS annual limits. If you are between ages 55 and 65 and not enrolled in Medicare, you can make additional catch-up contributions.

**HSA Expenses**

The IRS defines the type of health care expenses that are eligible to be paid from an HSA. The HSA can be used to pay current and future qualified health care expenses (such as deductibles and coinsurance) on a tax-free basis for yourself and your spouse or any tax dependents. You can pay your dependents’ eligible expenses even if they are participating in a different health care plan that is not a high deductible plan. You can also pay your eligible expenses after you no longer participate in a high deductible health plan, even if you have other non-high deductible health plan coverage. There is no limit on what you can withdraw in any one year but you can only withdraw up to the balance in your account.

You also may withdraw HSA money for a purpose other than paying eligible health care expenses. If you do, you must pay federal income tax on the withdrawal and, if you’re under age 65, a 20% penalty tax. The 20% penalty tax does not apply if you are age 65 or older or if you are disabled, but ordinary income taxes continue to apply.

Unused funds roll over from calendar year to calendar year. You take the account with you if you leave the Company or retire. For more information on the HSA, contact Optum Bank at 1-866-234-8913. You can also refer to Publication 969 and the instructions to Form 8889 for more information regarding the IRS HSA rules.

NOTE: The definition of dependent for purposes of the Health Savings account rules differs from the definition of eligible dependent under this Plan. Consequently, a dependent covered under this Plan may not qualify as an eligible dependent under the HSA Rules. See Publication 969 for more details.

**Prescription Drug Benefits**

If you are a participant in a UPS Medical Plan with coverage through Aetna, Anthem, or United Healthcare you are automatically enrolled in prescription drug coverage through CVS/caremark. You do not need to make a separate election to receive this coverage.

With this CVS/caremark prescription drug coverage, your cost is lower for generic and preferred brand-name prescription drugs. CVS/caremark has contracts with chain and independent pharmacies nationwide.
Under the CVS/caremark prescription drug coverage, you can obtain prescription drugs either through your local participating pharmacy, at a CVS pharmacy or through the CVS/caremark Mail Service Pharmacy for mail order service. If you take maintenance drugs, after you have filled the original prescription and two refills, you will be required to use your local CVS Pharmacy or the mail order service to receive the highest level of benefits. If you don’t use one of these options, you will pay the entire cost of the prescription after your third supply of the same medication received at the pharmacy. Benefits are paid for prescriptions purchased in-network only.

With CVS/caremark prescription drug coverage, for select preventive medications, you either pay a flat dollar copayment or a coinsurance amount and you do not need to meet a deductible. For all other prescriptions covered under the plan and received at a participating in-network retail pharmacy or a CVS pharmacy, or through the CVS Mail Service Pharmacy for mail order service, the amount you pay varies according to the medical option you select. Under all Medical Benefit Options, select preventive drugs are not subject to the deductible and are either covered at 100% (as required by Health Care Reform) or are subject to applicable copay/coinsurance (non-ACA Health Care Reform Preventive). The prescription drugs that are classified as preventive under Health Care Reform are covered at 100%.

Please note that if you select a brand name drug that is not on the formulary or has a generic equivalent, you also may have to pay the difference between the generic and the brand name drug you selected. For more information on how prescription drug coverage works, please review the following table.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>$500 Deductible</th>
<th>$1,500 Deductible w/HSA Option</th>
<th>$2,000 Deductible w/HSA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Individual</td>
<td>$500*</td>
<td>$1,500*</td>
<td>$2,000*</td>
</tr>
<tr>
<td>- Family</td>
<td>$1,000*</td>
<td>$3,000*</td>
<td>$4,000*</td>
</tr>
<tr>
<td>Does Deductible apply to Rx?</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (includes medical and pharmacy expenses, including deductible)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Individual</td>
<td>$2,000*</td>
<td>$3,000*</td>
<td>$4,000*</td>
</tr>
<tr>
<td>- Family</td>
<td>$4,000*</td>
<td>$6,000*</td>
<td>$6,850*</td>
</tr>
<tr>
<td>Type of deductible and OOP maximum accumulation method</td>
<td>Aggregate</td>
<td>Aggregate</td>
<td>Aggregate</td>
</tr>
<tr>
<td>Preventive Drugs:</td>
<td>Prescription drugs classified as preventive by the Affordable Care Act are covered at 100% and are not subject to the deductible. Other select preventive drugs require copays/cost share, but are not subject to the deductible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Rx</td>
<td>Patient pays (deductible does not apply):</td>
<td>Patient pays after deductible:</td>
<td>Patient pays after deductible:</td>
</tr>
<tr>
<td>Plan Name</td>
<td>$500 Deductible</td>
<td>$1,500 Deductible w/HSA Option</td>
<td>$2,000 Deductible w/HSA Option</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>- Generic</td>
<td>$10</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>- Preferred Brand-Name</td>
<td>30%, $25 min/ $75 max</td>
<td>30%, $25 min/ $75 max</td>
<td>30%, $25 min/ $75 max</td>
</tr>
<tr>
<td>- Non-Preferred Brand-Name</td>
<td>40%, $50 min/$100 max</td>
<td>40%, $50 min/$100 max</td>
<td>40%, $50 min/$100 max</td>
</tr>
<tr>
<td><strong>Mail Rx</strong></td>
<td>Patient pays (deductible does not apply):</td>
<td>Patient pays after deductible:</td>
<td>Patient pays after deductible:</td>
</tr>
<tr>
<td>- Generic</td>
<td>$25</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>- Preferred Brand-Name</td>
<td>30%, $62.50 min / $187.50 max</td>
<td>30%, $62.50 min / $187.50 max</td>
<td>30%, $62.50 min / $187.50 max</td>
</tr>
<tr>
<td>- Non-Preferred Brand-Name</td>
<td>40%, $125 min / $250 max</td>
<td>40%, $125 min / $250 max</td>
<td>40%, $125 min / $250 max</td>
</tr>
</tbody>
</table>

*These amounts are intended to summarize the deductible and out-of-pocket amounts of the Medical Benefit Options as of the effective date of this SPD so that you are able to better understand your prescription drug benefit; however, the actual Medical Benefit Option deductible and out of pocket amounts are described in the Benefit Plan Documents provided by each of the Claims Administrators and/or Carriers. If there is a conflict between the amounts identified in the Benefit Plan Documents and this SPD, the Benefit Plan Documents control.

**Additional Guidelines**

<table>
<thead>
<tr>
<th>For short-term medications (up to a 30-day supply)</th>
<th>To view participating in-network retail pharmacies near you, sign in at <a href="http://www.caremark.com">www.caremark.com</a>, and then Log In, or call Customer Care 1-855-282-8412.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For long-term medications (up to a 90-day supply)</td>
<td>Visit <a href="http://www.caremark.com">www.caremark.com</a>, sign in and then log in and choose which of your current maintenance medications you’d like to receive through the CVS/caremark Mail Service Pharmacy or go to your local CVS Pharmacy.</td>
</tr>
<tr>
<td>If you choose a brand name drug that has an available generic equivalent</td>
<td>You will pay the generic drug cost share plus the cost difference between the brand-name drug you choose and the available generic drug. Note that the maximum cost difference amount that will be charged to you is $600 per fill. This amount is in addition to the standard generic copay cost share. The difference in cost does not apply to your out-of-pocket maximum or deductible.</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>If you receive a prescription designated as a specialty drug by CVS/caremark you must use Caremark Specialty home delivery to receive benefits under this plan. Specialty drugs are filled for up to a 30-day supply and follow the copay structure described in this table. Select medications may be available or required to fill in a 90 day supply. If filled in a 90 day supply, you will pay the equivalent to three 30-day supplies.</td>
</tr>
<tr>
<td>To access CVS Caremark from your mobile device</td>
<td>To view participating in-network retail pharmacies near you, sign in at <a href="http://www.caremark.com">www.caremark.com</a>, and then Log In, or call Customer Care 1-855-282-8412.</td>
</tr>
</tbody>
</table>
Your Prescription ID Card
When you first enroll in a UPS Medical Plan, you will receive two prescription drug identification cards from CVS/caremark. If you need additional cards (for instance, if your child is attending college out of town), you can request them by calling CVS/caremark at 1-855-282-8412. In an emergency, you can print a temporary identification card from the CVS/caremark website, www.caremark.com and log in. It is important to remember to use your CVS/caremark prescription drug coverage ID card at the pharmacy and not your medical plan ID card.

When You Need to Fill a Prescription
When you need to fill a prescription, you can choose to go to your local participating in network retail pharmacy or your local CVS Pharmacy or, for mail order, use the CVS/caremark Mail Service Pharmacy.

If your prescription is for a one-time 30-day supply of a medication or less, the in-network retail option is best. If you are filling a long-term maintenance medication (one that you need for more than 60 days), you can get the original prescription plus two refills at any in network retail pharmacy, but after that, you will need to refill that prescription through the CVS/caremark Mail Service Pharmacy or at your local CVS Pharmacy for up to a 90-day supply.

Regardless of whether you choose a local in network retail pharmacy, the local CVS Pharmacy or the CVS/caremark Mail Service Pharmacy, generic drugs are used to fill prescriptions whenever possible unless your doctor specifies otherwise.

CVS/caremark also provides “safety checks” at both its in network retail and mail order pharmacies. Examples include checking for possible drug allergies or adverse interactions, incorrect dosage or strength, and age- and sex-appropriate drugs. If there are any problems, CVS/caremark contacts your doctor. CVS/caremark, and not the plan, is solely responsible for these safety checks.

Annual Deductible
There is a combined annual deductible for your medical and prescription drug expenses (see table above for amounts). For the HSA-eligible options ($1,500 Deductible or $2,000 Deductible plans), except for select preventive drugs, the plan does not begin reimbursing expenses until you have met the deductible. This means that you must meet your deductible before the plan begins reimbursing pharmacy benefits unless your prescription is for select preventive medications in which the deductible does not apply.

For the $500 Deductible option, you do not need to meet a deductible before your plan begins reimbursing pharmacy benefits and the amounts you pay for medications do not apply to the medical deductible.

Annual Out-of-Pocket Maximum
There is a combined annual out-of-pocket maximum for your medical and prescription drug expenses (see table above for amounts). This means that once your out-of-pocket costs for covered medical services and supplies, deductibles and CVS/caremark prescription drug copayments and coinsurance reach your medical plan option’s out-of-pocket maximum for the year, your covered prescriptions will be filled at no additional charge to you for the remainder of that calendar year. Any penalties, such as any extra costs you pay for a brand
name drug when a generic is available, do not count toward your out-of-pocket maximum and continue to apply after you have met the maximum.

**Retail Pharmacies**

CVS/caremark has contracted with nearly 67,000 retail pharmacies, including most major drug stores and more than 7,400 local CVS Pharmacy locations. These in network retail pharmacies in the CVS/caremark network are referred to as “in network” and “participating pharmacies.”

To locate a participating pharmacy close to your home or other location, you can call CVS/caremark Customer Care at 1-855-282-8412 or check the CVS/caremark website at www.caremark.com. You can purchase up to a 30-day supply at one time at any in network retail pharmacy.

**CVS Mail Service Pharmacy for Maintenance Drugs**

CVS/caremark offers the Mail Service Pharmacy to fill your long-term maintenance drug prescriptions (for up to a 90-day supply) through mail order. You also can fill your long-term prescriptions (for up to a 90-day supply) at your local CVS Pharmacy.

When you use the CVS/caremark Mail Service Pharmacy or your local CVS Pharmacy, you can get a larger supply of your medication at a lower cost than what you would pay for the same amount at a retail (non-CVS) pharmacy. You also will have the convenience of having your medications delivered right to you if you use the Mail Service Pharmacy option. The coinsurance you pay for up to a 90-day supply will be the same whether you use the CVS/caremark Mail Service Pharmacy or your local CVS Pharmacy.

**Using the CVS Caremark Mail Service Pharmacy Program**

First-time users of the CVS/caremark Mail Service Pharmacy can sign up for the program either online or by telephone. If you have a prescription, you can choose one of two ways to submit it:

- Mail your prescription and a completed order form to CVS/caremark. You can print out an order form at www.caremark.com
- Ask your doctor to call in your prescription toll-free at 1-800-378-5697 or Fax 1-800-378-0323

If you need a prescription, choose from two FastStart® options to get started:

- Phone: Call FastStart toll-free at 1-800-875-0867
- Online: Log on to www.caremark.com/faststart and sign in or register, if necessary

You will receive your prescription within 7-10 days of when your order is placed. You may want to ask your doctor to write you a prescription for a 30-day supply of medication to be filled at an in network retail pharmacy and one for up to a 90-day supply to be filled through the CVS/caremark Mail Service Pharmacy so that you have medication on hand while your mail order prescription is being filled.

**Covered Medications**

CVS Caremark provides coverage for federal legend drugs, which are drug products bearing the legend, “Caution: Federal law prohibits dispensing without a prescription.”
For CVS Caremark to cover a prescription, the prescribed item must meet the following requirements:

- It must be a valid prescription written by a licensed physician.
- It must be approved by the Federal Food and Drug Administration (FDA).
- It must be dispensed by a pharmacy.
- It must not be listed as a Formulary or compound exclusion under this plan.

Prescription drugs covered by the plan are classified as either generic or brand-name drugs. Brand-name drugs are then considered either preferred brand-name or non-preferred brand name. Exclusions also apply.

**Preventive Drugs Covered at 100%**

To comply with the Patient Protection and Affordable Care Act (ACA), CVS/caremark will cover certain drugs (with the limitations shown) in full and you do not need to meet a deductible under any plan option. Certain penalties will apply if you choose brand when a generic equivalent is available. A link to review the list of Preventive Drugs is provided on the Benefits Resource Center website or you can contact CVS/caremark for more information.

**Preventive Drugs Subject to Copays**

Other preventive (non-ACA) drugs require copays/coinsurance but are not subject to the deductible. The prescription drugs classified as preventive are subject to change; other rules and limitations related to dosage, age and quantities may apply. Members also should contact CVS Caremark at 1-855-282-8412, or visit www.caremark.com and log in for more information and to confirm if a prescription drug is considered preventive.

**CVS/caremark Specialty Pharmacy Services**

In general, the drugs on the Specialty Pharmacy list will not be covered by any pharmacy except for CVS/caremark Specialty Pharmacy, regardless of their medical necessity, their approval, or if the member has a prescription from a physician or other provider. In limited circumstances, coverage may be allowed through an alternate provider.

Prior authorization and specialty preferred drug plan design management may be required regardless of the benefit under which the drug is covered or the identity of the provider who is administering the drug. See the section “Prior Authorization” for more information.

In addition, for designated specialty medications where coverage is still allowed under the medical benefit, the drug, drug dosage and site of care for infusion therapy may require prior authorization for medical necessity, appropriateness of therapy and patient safety.

To contact CVS/caremark specialty pharmacy, please call specialty Customer Care at 1-800-237-2767 between 7:30 a.m. and 9:00 p.m., ET, Monday through Friday and between 9 a.m. and 4 p.m. on Saturday.

**When You Need to File a Claim Form**

If you do not have your ID card with you and you need to obtain a prescription drug from a participating in network retail pharmacy, you must pay the full cost of the prescription. Then, you may submit a paper claim form along with original receipts within 12 months from the date of service directly to CVS/caremark for reimbursement of the covered expenses.
To obtain a claim form, call CVS/caremark’s toll-free Customer Care number 1-855-282-8412 or visit www.caremark.com. You should submit your claim form to:

CVS Caremark Claims Department
P.O. Box 52136
Phoenix, AZ  85072-2136

Your claim will be reimbursed according to the regular cost-sharing provisions of your prescription drug coverage applicable to prescriptions purchased at a local CVS Pharmacy.

**Limitations**

If you are uncertain whether the drug that your physician has prescribed is covered under the CVS/caremark prescription drug coverage, please call CVS/caremark at 1-855-282-8412 to confirm. Or visit the website, www.caremark.com, and log in.

**Supply Limits**

Some prescription drug medications are subject to supply limits based on CVS/caremark’s criteria. Supply limits, which are subject to periodic review and modification by CVS/caremark, may restrict the amount dispensed per prescription order or refill and/or the amount dispensed for each supply.

Limits are based on manufacturer suggested prescribing guidelines and may change from time to time. This does not affect the day supply limits which are part of the plan design and would only change if the plan design is changed. Currently the days supply limit in place is up to a 30-day supply at retail and, for maintenance drugs, up to a 90-day supply by mail through CVS/caremark Mail Service Pharmacy or at a local CVS Pharmacy. You may obtain information on maximum dispensing limits by either visiting www.caremark.com or by contacting CVS/caremark at 1-855-282-8412.

**Quantity Management**

To help promote safe and effective drug therapy consistent with plan limits, certain covered medications may have quantity restrictions. These quantity restrictions are based on product labeling or clinical guidelines and are subject to periodic review and change. Examples include anti-migraine drugs, rheumatoid arthritis and osteoarthritis drugs, sleep aids, and pain management drugs.

**Prior Authorization**

For certain medications, CVS/caremark prescription drug coverage requires “prior authorization” by CVS/caremark before benefits will be paid. This prior authorization uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective.

There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, CVS/caremark asks your doctor for more information than what is on the prescription before the medication may be covered under your plan.
The list of medications that require prior authorization will change from time to time and drugs that do not require prior authorization may require it in the future. To find out whether a medication requires prior authorization, log in to www.caremark.com anytime, hover over “Understand My Plan & Benefits” at the top, and then click “Check Drug Coverage and Cost.” You then need to enter the drug name and coverage is tested and priced.

Prior authorizations are typically approved for a one year period, unless otherwise noted by CVS. Your physician may call CVS/caremark at 1-800-294-5979 to request a prior authorization approval.

Medications also may require a coverage review based on:
- Whether certain criteria have been met, such as age, sex or condition, and/or;
- Whether treatment of an alternate therapy or course of treatment has failed or is not appropriate.

In either of these instances, CVS/caremark pharmacists will review the prescription to ensure that all criteria required for a certain medication have been met. If the criteria have not been met, a coverage review will be required. If so, CVS/caremark will automatically notify the pharmacist, who in turn will tell you that the prescription needs to have a coverage review.

**Step Therapy Requirements**
Step therapy is a program designed to help people with certain health conditions that may require maintenance medications to save money by using the most cost effective treatments. It requires that newly diagnosed individuals first try a generic drug to treat their medical condition. Then, based on your doctor’s review, if necessary, move to a brand name drug. However, if a brand drug is dispensed and there is a generic available you will pay the cost difference between the generic and the brand drug. Some of the drugs listed in the Prior Authorization section fall into this step therapy program. Please contact CVS/caremark at 1-855-282-8412 for more specific information on the program.

**Drugs That Are Not Covered**
The following are not covered under the CVS/caremark prescription drug coverage:
- Therapeutic devices or appliances, including hypodermic needles, syringes (except those used for diabetes management), support garments, ostomy supplies, durable medical equipment, and non-medical substances regardless of intended use
- Any over-the-counter medicine, unless otherwise specified
- Blood products, blood serum
- Experimental medicines since they do not have National Drug Code (NDC) numbers
- Drugs used for cosmetic purposes
- Drugs that are excluded by the Formulary

Please contact CVS/caremark at 1-855-282-8412 or log in at www.caremark.com for more information on specific drug coverage rules, including the list of drugs covered and excluded from the Formulary.
**Drug Coverage Provided by Your Company Medical Plan**
Prescription drugs that are dispensed to you while in a hospital, either as an inpatient or as an outpatient at an approved outpatient facility, or while a patient in your doctor’s office are covered under your UPS Medical Plan. You must follow normal medical claim procedures for reimbursement for these drugs.

**Appeals**
If your claim for prescription drug benefits is denied in whole or part by CVS, you have the right to file an appeal. See the *Appeals* section of this SPD for more details.

**Dental Plan**
The Flexible Benefits Plan offers you a choice of three dental plan options, all administered by Aetna. The benefit payable by the Plan differs from one option to another. You also can choose no dental coverage.

The Dental Benefit Options that are offered under the Plan are identified in the Plan Administration Section of this SPD. One of the dental options provides benefits pursuant to an insurance contract issued to the Company by Aetna. Refer to the Benefit Plan Documents prepared by Aetna for complete details regarding the dental benefits.

See the *Filing a Claim* section for details on how and when to file a claim. See the *Appeals* section of this SPD for details regarding your rights and obligations if your claim for benefits is denied in whole or part.

**Vision Plan**
The Flexible Benefits Plan offers you a choice of two vision plan options. The Plan options are titled High and Low and both plans provide comprehensive vision benefits, including an annual eye exam. The vision benefits are provided pursuant to an insurance contract issued to the Company by United Healthcare.

Refer to the Benefit Plan Documents (e.g. Insurance Certificate) prepared by United Healthcare for complete details regarding the vision benefits.

See the *Filing a Claim* section for details on how and when to file a claim. See the *Appeals* section of this SPD for details regarding your rights and obligations if your claim for benefits is denied in whole or part.

**Employee Assistance Program (EAP)**
Aetna Resources For Living provides one point of access to information and services designed to help balance your work, home, and personal responsibilities.

**Eligibility**
You and your family members are eligible to use Resources For Living starting when you become eligible under The Flexible Benefit Plan — regardless of whether you are enrolled in a UPS medical plan. Your eligibility is automatic, and the company pays the cost of the program.
Accessing Services
Convenient, confidential access to all Resources For Living services is available 24 hours a day, seven days a week.
- Call 1-877-374-2779 to talk to a Resources For Living consultant. You will be directed to the appropriate service based on your situation.
- Spanish-speaking consultants are available, and simultaneous translation is offered in 140 other languages. TDD access is available.
- You also can access the EAP program online at www.resourcesforliving.com (Username: UPS and the Password: RFL)

Confidentiality
All contact that you or your family members have with Resources For Living is completely confidential to the maximum extent permitted by law.

Program features
Resources For Living provides resources and referrals and individual, group and family counseling that can help you address many of the concerns of everyday living, as well as assist you in managing commitments both at work and in your personal life. Resources For Living consultants may help you with the following topics:

Home life
- Adoption
- Adult care resources/referral
- Child care resources/referral
- Consumer credit counseling resources
- Education and education loans
- Individual, group and family counseling
- Legal and financial counseling and referral services
- Parenting
- Special needs
- Summer care

Daily life
- Changes
- Relationships
- Stress
- Time management
- Parenting issues

Individual, family and group counseling
For each eligible employee household, up to six counseling sessions are provided annually at no cost to you for each situation or episode that occurs. Your counselor also may refer you to other services you may need, including:
- Self-help/support groups
- Budgeting help
- Legal, financial, and career counseling services
- Emergency services to provide food, shelter, and clothing
If you need additional services beyond the six counseling sessions, the additional counseling session may be covered under your medical plan subject to the Plan’s terms and conditions.

**Legal services**
You, your spouse, and your dependents can receive immediate legal resources or request a referral to a lawyer in your community. A thirty (30) minute phone or in-person consultation with selected participating attorneys per year are available at no cost to you. Consultations are available for the following topics:
- General law (certain topic areas are excluded including employment law, etc.)
- Mediation services
- Special needs, including emergency matters

If you retain the lawyer to provide further services, these services will be discounted at 25 percent off the fee for services beyond the initial consultation. There is no discount for flat legal fees and contingency fees.

The Resources For Living program does not provide legal services for the following situations:
- Discrimination or other employment issues involving you or your spouse, your partner, or other family or household members
- Any business or commercial enterprise that belongs to you and/ or your spouse or partner, such as a home-based business
- Second opinions on how another lawyer is handling a legal matter for you
- Third-party advice (i.e., a question involving the legal affairs of someone other than you or your eligible family/household members)

**Financial services**
You and your eligible family members can receive a 30-minute initial consultation with a selected participating financial counselor for each new financial counseling topic each plan year. Counseling topics include credit repair, debt management, or debt consolidation. Services are available during regular business hours. If financial services are required beyond this, a referral will be made to a financial services professional in your community, but you will be responsible for any associated fees beyond the initial 30-minute consultation.

**Online resources**
- Discount Center – find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel and more. Save on gym memberships and home fitness equipment.
- myStrength – offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse, chronic pain, and/or insomnia. You can even practice mindfulness through guided meditations.

**Quit For Life Tobacco Cessation Program**
Quit For Life® is available to all employees who otherwise satisfy the eligibility requirements for The Flexible Benefits Plan, including such employees on an approved leave of absence. Individuals who otherwise satisfy the requirements to be a dependent age 18 or older are also eligible for this program.
You must enroll in the Quit For Life program in order to participate and receive the tobacco cessation benefits of the program. To enroll, access the Web site at the following URL: www.freeclear.com/ups or call 1-866-QUIT-4-LIFE.

Program benefits are provided at no additional cost to participants who enroll and include:

- Up to five outbound counseling and intervention calls to you.
- In-depth assessment to evaluate readiness to quit tobacco use.
- Assistance and support with over-the-counter Nicotine Replacement Therapy (NRT) in the form of patch or gum only. If you decide that NRT is right for you, this program provides an eight-week supply of NRT via direct mail order. There is no cost to you 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.*
- A Quit Guide sent to your home following program registration.
- Unlimited, easy, toll-free access to Quit Coaches® for 12 months from the time of enrollment.
- Access to Web Coach, an interactive website that helps you stay on track between calls.

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

**Life Insurance and AD&D**

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

The Flexible Benefits Plan provides the following group life insurance benefits:

- Employee basic and supplemental term life insurance
- Spouse’s basic and supplemental term life insurance
- Children’s basic and supplemental term life insurance
- Employee basic and supplemental AD&D insurance
- Family supplemental AD&D insurance

The Company provides basic term life for you and your dependents and AD&D insurance for you, but you may elect additional supplemental life and AD&D insurance for yourself and your dependents. Life insurance and AD&D benefits are provided through an insurance policy issued to the Company by Securian. Refer to the Benefit Plan Documents (i.e., Insurance Certificate) prepared by Securian for complete details regarding the life insurance and AD&D benefits. Notwithstanding anything to the contrary in the Benefit Plan Documents prepared by Securian, the following terms and conditions also apply.

**Benefits**

Benefits for the following coverages are calculated and paid based on your Base Pay.

- Employee basic term life insurance
- Employee basic AD&D insurance

Please refer to the insert applicable to your business unit for the definition of Base Pay.
**When Coverage Begins**

The following exceptions apply to the effective date of coverage otherwise described in the Enrollment section:

- If you’re ill or injured and absent from work on the date your coverage should start, coverage starts on the first day after you return to work for at least one full day (considered "active at work"). You are considered "absent from work" for these purposes even if you perform limited work from home while you are ill or injured. Your dependents’ coverage also is delayed until your coverage starts.
- If you increase your coverage for any reason and are ill or injured and absent from work on the date the increased coverage should start, the incremental amount of the increased coverage will not be effective until after you return to work for at least one full day. If the increased coverage never becomes effective because you do not return to work, you will continue to be covered at the lower level of coverage that was in effect prior to the requested increase.
- If evidence of insurability (EOI) is required, any amounts requiring approval will be delayed until the date approval is granted by Securian.
- If your dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date will be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before your insurance is effective.

**Beneficiaries**

To name a beneficiary for your life insurance and AD&D benefits, or to change your current beneficiary at any time, you can add or update your designations online at the UPS Benefits Resource Center. Your designations are not effective until they are saved on the UPS Benefits Resource Center. You should print and save your confirmation statement in a secure place.

The following beneficiary guidelines apply:
- You are automatically the beneficiary for your spouse’s and children’s life insurance and AD&D coverage.
- AD&D benefits other than for your death are payable directly to you.
- You may name anyone you choose as beneficiary for your life insurance benefits and AD&D benefits.
- If you do not name a beneficiary, or if the beneficiary(ies) you name are not living at your death, Securian will pay benefits in accordance with the certificate.

**Imputed Income**

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

**Total and Permanent Disability Benefit for Part-Time Employees**

If you are a part-time employee not eligible for long-term disability (LTD) coverage and you become permanently and totally disabled while a participant in The Flexible Benefits Plan, you may be eligible to have your basic employee life insurance paid to you as a lump-sum benefit. In order to qualify for this benefit, you must be permanently and totally disabled from engaging in any occupation which could be considered reasonable — taking into account your age, education, and prior work experience — as determined by Securian. If you have
questions or would like a claim form, call Securian at 1-877-282-1752 and request the Total and Permanent Disability Benefit option.

**Claims and Appeals**

See the *Filing a Claim* section for details on how and when to file a claim. See the Appeals section of this SPD for details regarding your rights and obligations if your claim for benefits is denied in whole or part.

**Income Protection Plan**

A total disability following an accident or illness is something that most people don’t like to think about. However, should such a tragedy occur, the Income Protection Plan helps you bridge the financial gap caused as a result of lost income. There are two components to the income protection plan: short-term disability and long-term disability.

**Short-term Disability**

Short-term disability (STD) protects your income if you have an absence caused by an illness or accidental injury, as determined by Aetna Disability and Absence. An absence for maternity is treated like an absence for illness.

**Eligibility for STD Coverage**

Short-term disability coverage is available to all full-time and most part-time employees eligible for The Flexible Benefits Plan. The insert applicable to your business unit will indicate whether you are eligible for STD benefits. If you are eligible, STD coverage is effective the date you become eligible for coverage under the Plan.

Your eligibility for STD coverage under the Plan automatically ends when one of the following occurs, whichever is earliest:

- Your employment with UPS terminates (see Your Employment Status in this section for additional information);
- Your eligibility for coverage under The Flexible Benefits Plan ends; or
- You retire.

**STD Benefits**

The Plan pays a percentage of your base pay for any one continuous period of disability, up to the maximum STD benefit period in accordance with the insert for your business unit. Benefits may vary by business unit. Please refer to the insert applicable to your business unit for a definition of base pay.

Aetna will administer your STD payment beginning the first day of the pay cycle following your last day worked. Approved benefits will be paid by Aetna on a weekly schedule. If you are a management employee, you must contact Aetna on the first day of your disability to ensure that there is no interruption in receiving your paycheck from Aetna.

If you are a management or specialist employee, you should contact Aetna to open your short-term disability claim after you’ve been absent from work due to your illness injury for two weeks. However, if you know your confinement period will extend beyond two weeks (for example you are having a major surgery) you should contact Aetna one week prior to your confinement period to open your claim. Failure to timely report a leave of absence to Aetna may result in an interruption of your pay.
In any case, your claim must be received (via phone or Web) within 60 days of the initial date of your disability in order for you to receive STD benefits. STD benefits are taxed when paid to you. Aetna will issue W-2 forms for any benefits you receive under the STD Plan. You will be billed by the Benefits Resource Center for your share of the cost of your Flexible Benefits Plan coverage. If you fail to make timely payments of this bill, your coverage will be terminated.

Qualifications for Receiving STD Benefits
For STD purposes, you are considered disabled if the claims administrator, Aetna, determines that you are unable to perform the material and substantial duties of your regular occupation because of an illness or injury. In some cases, STD benefits will be reduced if you refuse to participate in the residual disability return-to-work program. Your date of disability (as determined by the claims administrator) must occur while you are covered under The Flexible Benefits Plan and prior to your termination date.

The fact that UPS has approved a leave of absence, made an accommodation (in keeping with Americans With Disabilities Act rules), or does not allow you to return to work in another position as a result of an injury or illness does not mean that you are “disabled” as defined by the Income Protection Plan.

Qualification for STD benefits is subject to you (or your physician at your request) providing objective clinical medical information to Aetna that supports your disability. You also may need medical approval prior to returning to work. See State-Mandated Benefits in this section for more information regarding the interaction of Plan benefits and state-mandated disability benefits.

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

- Intentionally self-inflicted injuries;
- Participation in a felony as defined by state or federal law;
- War, or act of war (whether such is declared or not), insurrection, rebellion, or participation in a riot or civil commotion;
- Any vague or indefinable condition that cannot be described by a standard medical nomenclature diagnosis.

Receiving vacation pay does not preclude you from receiving STD benefits or extend your disability period.

When STD Benefits Begin
For administrative and technical employees, benefits begin on the first work day of an absence due to an injury, and the fourth work day of an absence due to an illness. The period of time prior to when your benefits begin is considered your “waiting period.” Any unused discretionary days up to three will be used first before STD benefits are paid for an illness. For management or specialist employees, benefits begin on the first work day of an absence due to an injury or an illness.
If you are on an approved disability and subsequently return to work (other than as a participant in a residual disability/return-to-work program), you are subject to the following return-to-work provisions:

- If you are absent and receiving STD benefits and return to work for less than 30 consecutive calendar days (other than as a participant in a residual disability/return-to-work program), your second absence will be considered a continuation of the first disability period and both periods of absence count toward the 26-week period of STD benefits.

- If you are absent and receiving STD benefits and return to work for at least 30 consecutive calendar days (other than as a participant in a residual disability/return-to-work program), you are eligible for a new 26-week period of STD benefits. You must have returned to work for at least 30 consecutive calendar days to be eligible for a new 26 weeks of STD. Otherwise, your second absence will be considered a continuation of the first disability period and both periods of absence count toward the 26-week period of STD benefits. This provision applies regardless of whether the subsequent disability is due to the same or a different cause. Vacation or discretionary days are not counted in determining whether you have returned to work for 30 consecutive calendar days.

- If you return to work from an LTD leave of absence (other than as a participant in a residual disability/return-to-work program), and go back out of work again within the first 30 consecutive calendar days of your return due to a disability that is not same or related to your prior LTD claim, you will be eligible for a new 26 weeks of STD benefits. If however your second disability is determined by Aetna to be a continuation of the first disability for which you were receiving long-term disability benefits under the LTD Plan, then you are not eligible for a new 26 weeks of STD.

- If you return to active employment following retirement, and are receiving a retirement benefit under the UPS Retirement Plan, you are eligible to participate in the Short-Term Disability Plan; however, your STD benefits will be reduced in full by any benefits you are receiving under the UPS Retirement Plan.

**Residual Disability/Return to Work Program While Receiving STD Benefits**

The Plan will pay a residual benefit if you return to work, at UPS or another employer, while recovering from a disability. You will be considered residually disabled if you perform any work for wage or profit while disabled as defined by the Plan. The benefit you receive from STD will be calculated as follows: your STD benefit minus 75 percent of any earnings you receive while you are disabled.

Your residual earnings from all sources, combined with your STD payment, may not exceed 100 percent of your pre-disability base pay and any earnings (including earnings from other employers). Your STD payment will be reduced by any amounts in excess of your predisability earnings.

If Aetna and UPS determine that you can return to work for UPS under a residual disability program, and you fail to do so, your STD benefit payment will be offset by the amount you would have received as a residual disability benefit.

For purposes of this return-to-work program, you may be asked to return in any position for which you are reasonably qualified based on your education, training, or experience. If you return to work under a residual disability program, that time at work counts as part of your overall disability period. This means that your time at work under a residual disability program will not extend your disability period maximum.
**Health Care Coverage and STD**

For information about continuation of your health care coverage when you are on an approved disability, see Health Care Coverage and the Income Protection Plan in this section.

**State-Mandated Benefits**

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

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

If you work in California, Hawaii, New Jersey, New York, or Rhode Island and you do not satisfy the income protection plan’s definition of disability (see Qualifications for Receiving STD Benefits in this section), you may still qualify for the applicable state’s mandated benefit. Depending on the state, state-mandated benefits may be paid under the income protection plan or by a state-administered program.

In addition, the fact that you are entitled to state-mandated benefits in California, Hawaii, New Jersey, New York, or Rhode Island does not mean that you are “disabled” as defined by the income protection plan. If the Plan determines that you do not satisfy its definition of disability, but you are deemed disabled under the applicable state standard in:

- California or Rhode Island: You will not receive benefits from the Plan.
- Hawaii, New Jersey or New York: You will receive only the state-mandated benefit from the Plan. In addition, there may be other remedies available to you through the applicable state’s Department of Labor or other agency. You will be notified of your additional rights under state law in your claim denial letter.

**STD Benefit Offsets**

Your STD benefit will be reduced in full by other earnings (subject to the residual disability provisions) or disability income you may receive, or be eligible to receive, including:

- Any residual disability/return-to-work amounts that you may be eligible to earn. If you return to work after the first 13 weeks of STD benefits, your STD benefit will not be offset by any residual disability/return-to-work amounts that you earn until your return-to-work earnings exceed 20 percent of your pre-disability base pay.
- Any Workers’ Compensation payment from UPS (not including those received from another employer).
- Any amount you receive from another group insurance plan (individual insurance plans are not offset, nor are short-term disability benefits that you receive from another employer)
- Any no-fault or third-party benefit or settlement.
- Any amount you receive from a governmental or private disability plan, program or policy that is paid due to a disability that resulted from serving on active duty in any armed forces of any government.
- Any primary benefits received under the Social Security Act.
- Any incorrectly paid STD or LTD benefits.
- State-mandated benefits as described in this SPD.
• If you return to active employment following retirement, and are receiving a retirement benefit under the UPS Retirement Plan your STD benefits will be reduced in full by any benefits you are receiving under the UPS Retirement Plan.

• Discretionary days (such as sick pay or optional holiday pay, if applicable), holiday pay, and vacation pay*.

* Employees can elect to receive vacation pay with no offset between weeks 14–26 of STD leave if the sum of STD benefits and vacation pay does not exceed 100 percent of pre-disability weekly earnings. Management and specialist employees can use one day of vacation per week, between weeks 14–26, with no offset. Administrative and technical employees can use two days of vacation per week, between weeks 14–26, with no offset. Discretionary, holiday, or vacation days taken during STD leave do not extend the maximum 26-week STD period.

It is a requirement of the Plan that you apply for the Social Security disability insurance benefit as well as any state-provided disability benefits to which you may be entitled. You are also required to appeal any denials.

If you do not apply, or appeal denials, the claims administrator, Aetna, will estimate the Social Security amount and/or state-provided disability benefit that you could have received and offset your benefit by that amount. Additionally, it is a requirement of the Plan that you apply for Workers’ Compensation if your disability is work-related. Should you receive a lump sum payment (for example, from Social Security, or a no-fault or third-party settlement related to your injury or illness), the portion of that total payment (less any attorney fees) that represents disability benefits will be offset over the period for which the sum is given. If no period is given, the sum will be prorated as an offset over the 26-week STD period.

As an example, if you receive a $100,000 settlement (that represents disability benefits) and your STD benefit is $1,000 per month after all other offsets have been taken, you would receive no disability benefit from The Flexible Benefits Plan for 100 months, until the full $100,000 has been offset. At that time, your disability benefit would begin again (to the extent you were still eligible). This example assumes qualification for LTD coverage after the STD benefit period ends. If Aetna is unable to determine the exact amount of the award that represents disability benefits, 50 percent of the award will be considered disability benefits. This includes retroactive awards. Prorated offsets will begin when the lump sum payment is made.

In the event that you receive STD benefits for an illness or injury that is later determined to be an occupational illness or injury, you will be required to reimburse the Plan for any STD benefits you have received to date for that condition. Additionally, if your remaining STD benefit period is not sufficient to repay amounts that would not have been paid to you (for example, if your Workers’ Compensation claim had been determined earlier):

• Either your Workers’ Compensation benefits will be reduced by the amount owed to the Income Protection Plan (to the extent allowed by law); or

• You will be required to reimburse the Plan for excess STD benefit payments.

**Taxes and Your STD Benefit**

STD benefits are taxed when paid to you. Aetna Disability will issue W-2 forms for any benefits received under the STD Plan.
When STD Benefits End
You should contact your manager to keep him or her informed of your return-to-work status. If you qualify for long-term disability benefits, Aetna will automatically refer your case for LTD coverage. Certain conditions, as listed below, could cause your STD benefits to be terminated:

• You cease to have a "disability" that qualifies you for benefits under the Plan, as determined by the claims administrator.
• Terminate employment due to a pre disability scheduled termination date (for example, because of resignation, a facility closing, or a reduction in workforce).
• You fail to provide objective clinical medical documentation requested by the Claims Administrator. Aetna can request additional medical documentation of an ongoing disability as often as it deems reasonably necessary.
• You fail to comply with a reasonable course of medical treatment and care necessary and appropriate to treat and/or resolve the condition for which you’re receiving disability benefits, including, but not limited to, receiving treatment from a health care or mental health professional who does not have appropriate training and experience in the field of medicine related to your particular disability.
• You fail to comply with an independent medical examination, functional capacity evaluation or other evaluation as may be required by the claims administrator.
• You begin receiving benefits from the UPS Retirement Plan.
• You have been paid the maximum disability period of 26 weeks for STD benefits.

If you can't return to work when your benefits end, and you are a part-time employee not eligible to apply for LTD, you may be eligible for a Total and Permanent Disability benefit. See Total and Permanent Disability benefit for Part-Time Employees in the Life Insurance and AD&D section of this SPD.

Appeals
If your request for benefits is denied in whole or part, you have a right to file an appeal. See the Appeals section of this SPD for more information.

Long-term Disability
Long-term disability (LTD) coverage provides protection from disabilities caused by an occupational or non-occupational illness or injury that last longer than the STD benefit period. The Long-Term Disability benefits are provided pursuant to an insurance contract issued to the Company by Aetna. Refer to the Benefit Plan Documents prepared by Aetna for more details on LTD benefits. Notwithstanding anything to the contrary in the Benefit Plan Documents prepared by Aetna, the following terms and conditions also apply.

When You Become Covered for LTD
The effective date of LTD coverage could be delayed under certain circumstances. If you increase your coverage for any reason and are ill or injured and absent from work on the date the increased coverage would otherwise start, the newly elected coverage will not be effective until after you return to work for at least one full day. You are considered “absent from work” for these purposes even if you perform limited work from home while you are ill or injured. If the increased coverage never becomes effective because you do not return to work, you will continue to be covered at the option level that was in effect prior to the requested increase. Once you are eligible for LTD benefits, your LTD contributions will not be charged.
**LTD Benefits**
If you are determined to be disabled by Aetna, you will receive a percentage of your predisability base pay (as described in the Benefit Plan Documents). “Base pay” is defined the same as it is for short term disability benefits. See insert applicable to your business unit for details regarding “base pay”.

**Claims and Appeals**
See the Filing a Claim for details on how and when to file a claim. See the Appeals section of this SPD for details regarding your rights and obligations if your claim for benefits is denied in whole or part.

**Health Care Coverage and the Income Protection Plan**
You and your covered dependents will continue to receive Flexible Benefits Plan coverage for up to 12 months following the date of your disability, as long as you continue to be approved for disability benefits under the Plan. You continue to be responsible for your share, if any, of the cost of coverage either through billing statements or payroll deductions (if you are receiving a paycheck from UPS). At the latest, coverage will end on the last day of the 12th full month of continuous disability, as long as you continue to pay your share of the cost. You cannot change your elections for life or AD&D insurance while you are absent due to disability. When your 12-month extension of health care coverage ends, you and your dependents may elect COBRA continuation for 18 months, for a total of 30 months of continued coverage. (See the Continuation of Coverage Under COBRA section for more information). Or, if you are eligible and approved for LTD benefits, you and your eligible dependents may be eligible for coverage under the Retired Employees’ Health Care Plan.

The Flexible Benefits Plan does not cover any expenses related to an occupational disability. You must submit claims directly related to your occupational disabilities to the Workers’ Compensation Administrator.

Short-term disability benefits are offset by the Workers’ Compensation payments received.

**Your Employment Status**
Except as limited below, if you are absent from your regular occupation for 12 months, you will be administratively separated from employment, regardless of your status on STD or LTD. You must return to your regular occupation or any position provided as a reasonable accommodation under the Americans With Disabilities Act (ADA) (or state equivalent) for at least 30 calendar days before a new 12-month period will begin.

Time spent performing modified work under the Residual Disability Program is not provided as a reasonable accommodation under the ADA (or state equivalent); thus such time is considered an absence and does not extend this 12-month period. For example, if your disability begins July 15, 2017, you will be administratively separated July 14, 2018. If your disability should end after your separation and you are able to return to work, you will be considered for employment based on your experience and skills, as would any other applicant.
Reasonable Accommodation Assessment
If, during your 12-month absence, you have requested an accommodation (or UPS has enough information to already know that an accommodation may be necessary) under the ADA (or state equivalent), you will be referred to a Human Resources representative responsible for ADA (or state equivalent) compliance to determine whether you are eligible for an accommodation under applicable law and, if so, whether a reasonable accommodation is available (refer to the UPS Equal Opportunity Statement, available at UPSers.com).

If an accommodation request is being processed at the 12 month date, an administrative termination will not occur, and health care coverage under The Flexible Benefits Plan will continue, until a decision has been made regarding the accommodation request. Once the 12 month date has passed, you will be administratively separated if (a) you fail to participate in the interactive process, (b) or at such time as you have participated in the interactive process, and UPS has determined that no reasonable accommodation is available and the six month job search has been completed, or (c) that providing an accommodation would be an undue burden.

Flexible Spending Accounts
Health Care and Limited Purpose Flexible Spending Account
Before the start of each Plan Year, you will be able to elect to contribute some of your upcoming pay to a Health Care Flexible Spending Account or Limited Purpose FSA (collectively "FSA"). The portion of your pay that is contributed to the Plan is not subject to federal income or Social Security taxes, and in some cases state income taxes. Your Social Security benefits may be slightly reduced because your income is reduced by the amount you elect to contribute to an FSA during the year. Contributing to these accounts and reducing your taxable income reduces the Social Security (FICA) taxes you pay as well as the company’s contribution to Social Security on your behalf.

Using an FSA allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under an FSA, you cannot claim a federal income tax credit or deduction on your return. When you incur an eligible expense, you may use your FSA debit card to deduct the expense directly from your account up to the amount of your total FSA election or pay the expense, then submit the appropriate claim form along with a receipt for the expense to the claims administrator, Via Benefits Accounts. Be sure to save your receipts regardless of which payment method you use.

Benefits
There are two types of health care FSAs depending on your medical plan enrollment: the Health Care FSA and the Limited Purpose FSA. Regardless of which type you're eligible for, you can contribute from $200 to $2,600 to your FSA. When you enroll in an FSA, you decide how much to contribute to your account through payroll deductions. Your contributions can be used to reimburse you for eligible health care expenses that you, your spouse, or your dependents incur while you are contributing to your account.

The Health Care FSA is available to employees who do not enroll in a High Deductible Health Plan (HDHP) or who waive medical coverage. If you enroll in an HDHP, you may be eligible to open a Health Savings Account (HSA) which is different from a Health Care FSA. You can use an HSA to pay for current and future eligible health care expenses. If you participate in an
HSA, you are not permitted to also participate in a Health Care FSA. Therefore, for employees who enroll in an HDHP, we offer a Limited Purpose FSA.

The Limited Purpose FSA is available only to employees enrolled in an HDHP through the company. It works like the Health Care FSA, but is only available for dental, orthodontic and vision expenses. You cannot use the Limited Purpose FSA for any medical or prescription drug expenses, even after you meet the HDHP deductible. Although the IRS restricts the types of expenses that can be paid from your Limited Purpose FSA, there could still be good reasons to open one. If you plan to open an HSA, you also should consider contributing to a Limited Purpose Health Care FSA if you expect to have out-of-pocket vision, dental, and orthodontia expenses you can reasonably predict and do not want to spend the funds in your HSA, which can accumulate and be used in later years.

**Contributions**

You will have an opportunity to enroll each year in a Health Care FSA. As part of Annual Enrollment, you will be asked to indicate the amount of pretax pay you want to contribute, over the course of the plan year, to a Health Care FSA for the following Plan Year. You also may choose not to contribute to an FSA.

These contributions are held in a notional account, not a bank account. No interest accrues on your contributed amounts to an FSA. Later, you can use your contributions to pay for eligible health care expenses that you have incurred and claimed during the Plan Year.

**Annual Enrollment**

Each Plan Year you may update your elections during the Annual Enrollment period. You may also choose not to participate in the FSAs for the upcoming Plan Year. If you fail to make new elections during the Annual Enrollment period before a new Plan Year begins, you will be considered to have elected not to participate in the Health Care or Limited Purpose FSA for the upcoming Plan Year.

**Mid-Year Election Changes**

Generally, you are not permitted to change your FSA elections after the beginning of the Plan Year. However, there are certain limited situations in which you may change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. See the *Life Events* section in this SPD for more information.

**Grace Period**

Any unused FSA funds may be used to reimburse eligible expenses incurred during the "grace period" that follows the end of the plan year in which you allocated your FSA funds. The grace period begins on the first day of the next Plan year and ends two months and fifteen days later. For example, if the Plan year ends December 31, 2018, the grace period begins January 1, 2019 and ends March 15, 2019. The following rules apply to the grace period:

- To take advantage of the grace period, you must be either a participant in the Health Care FSA or Limited Purpose FSA on the last day of the Plan year to which the grace period relates, or a qualified beneficiary who is receiving COBRA coverage under the Health Care FSA on the last day of the Plan year to which the grace period relates.
• Eligible expenses incurred during a grace period and approved for reimbursement are paid first from available amounts that were remaining at the end of the plan year to which the grace period relates, and then from any amounts that are available to reimburse expenses incurred during the current plan year.

• Claims are paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the plan year to which the grace period relates, if those expenses have not yet been submitted for reimbursement.

• Previous claims are not reprocessed or re-characterized so as to change the order in which they were received. For example, suppose $200 remains in your FSA at the end of the 2018 Plan year and you elected to contribute $2,400 to your FSA for the 2018 plan year. If you submit for reimbursement an eligible medical expense of $500 that was incurred on January 15, 2019, $200 of your claim is paid out of the unused FSA balance from the 2018 Plan year, and the remaining $300 is paid out of your FSA balance for 2019.

• You may not use Health Care FSA or Limited Purpose FSA amounts to reimburse eligible child or elder care expenses.

Reimbursements for Health Care and Limited Purpose FSAs
In order to be reimbursed for a health care expense, you must submit an itemized bill or an explanation of benefits (EOB) from the service provider to Via Benefits Accounts prior to the end of the Run Out Period described below. You may only be reimbursed from your spending account for eligible expenses incurred during the Plan Year or the Grace period (described above).

The Plan also provides you with a debit card to use to pay for eligible health care expenses. Via Benefits Accounts will provide you with further details about using the debit card, filing manual, or online claims and managing your account.

Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the account will be paid at least once a month. Expenses under this Plan are treated as being incurred when you receive the care related to the expenses, not when you are formally billed or charged, or when you pay for the health care.

You may be reimbursed for eligible expenses for an amount that is more than the current balance in your FSA, but no reimbursement (either alone or in combination with other reimbursements incurred during the same Plan Year) may be more than the total amount you have elected to contribute to the account for the year. For example, let’s say you elect to set aside $1,200 in your Health Care FSA for the year. In March, you incur $1,000 in expenses. You can receive reimbursement for the full $1,000 — even though only about $300 has been contributed to the account. Later in the year, you incur $1,000 more in expenses. You can only be reimbursed for $200 of the $1,000, because you cannot be reimbursed for more than the $1,200 you elected to contribute to your account for the year.

Eligible Expenses under the Health Care FSA
When you have an eligible health care expense that is not paid by your medical, dental, or vision plan, you should submit a claim for reimbursement from your Health Care FSA. Your account may be used to pay for any health care expenses considered tax deductible by the IRS, except for health insurance premiums. Generally, eligible health care expenses include
deductibles and copayments for yourself and your dependents under a medical, dental, and vision plan, as well as certain other expenses.

The following is a partial list of eligible health care expenses under the Health Care FSA when they are incurred by you or your dependents and neither you nor your dependents are reimbursed for the expenses from another health plan:

- Acupuncture services related to the diagnosis, cure, mitigation, treatment, or prevention of disease
- Ambulance expenses
- Chiropractors’ fees
- Cosmetic surgery — only if directly related to a congenital abnormality, a personal injury from an accident or trauma or a disfiguring disease
- Dental care
- Diagnostic services, including laboratory and X-ray services
- Eyeglasses and contact lenses
- Hospital bills
- Insulin
- Medical appliances, such as artificial teeth or limbs, crutches, elastic stockings, and hearing aids
- Nonprescription, or over-the-counter, drugs or supplies that are legally purchased, such as antacids, allergy medicine, pain relievers and cold medicine, but only if prescribed for you by a doctor
- Nurses’ fees
- Operations
- Oxygen equipment and oxygen
- Physicians’ fees
- Prescription drugs
- Psychiatric care
- Psychologists’ fees
- Surgical fees

**Eligible Expenses under the Limited Purpose FSA**

The following is a partial list of eligible health care expenses under the Limited Purpose FSA when they are incurred by you or your dependents and neither you nor your dependents are reimbursed for the expenses from another health plan:

- Dental, orthodontic, or vision care copayments, deductibles, or coinsurance amounts
- Charges for services over the limits of your dental or vision coverage (for example, charges exceeding the limits on orthodontic care)
- Dental expenses that exceed reasonable and customary charges
- Eyeglasses, frames, and contact lenses
- Prescription sunglasses
- LASIK laser eye surgery and similar procedures to improve visual acuity in myopic individuals

**Ineligible Expenses for Reimbursement from any FSA**

Expenses that are not eligible for the health care tax deduction under the Internal Revenue Code (IRC) are not eligible for reimbursement through the Health Care or Limited Purpose FSA. Examples of ineligible expenses are:
• The cost of most types of cosmetic surgery, including breast augmentation, face-lifts, hair
  transplants, hair removal (electrolysis), and liposuction;
• Premiums for a health care plan;
• Vitamins (unless prescribed by a physician);
• Over-the-counter medicine or drugs, except insulin, purchased without a doctor’s
  prescription;
• Health spas, health club dues, and exercise classes; however, if a letter from a physician
  is provided stating the medical condition this exercise program would be treating, it may
  be reimbursable;
• Weight-reduction classes, except as part of the treatment of a specific disease diagnosed
  by a physician, such as obesity, hypertension, or heart disease;
• Telephone and television charges for hospital inpatients;
• Babysitting expenses to enable you to get to a doctor’s appointment.

For a complete list of eligible medical expenses (with the exception of premiums), refer to
IRS Publication #502, “Medical and Dental Expenses,” available on the IRS website at
www.irs.gov, by calling 1-800-TAX-FORM (1-800-829-3676) or by visiting your local IRS
office.

**Ineligible Expenses under the Limited Purpose FSA**

Any medical expenses that are not related to dental (including orthodontic) or vision care are
not reimbursable under the Limited Purpose FSA.

**Dependent Care Flexible Spending Account**

You can be reimbursed through a Dependent Care Flexible Spending Account (FSA) for
eligible dependent care expenses that are incurred for the custodial care of an eligible
dependent or for related household services, and to enable you (and your spouse, if
applicable) to be gainfully employed or look for work.

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

**Eligible Dependents**

You may receive reimbursements for eligible expenses incurred to care for your “qualifying
dependents”. A qualifying dependent is any of the following:
• Your “qualifying child” (as defined by IRC Sec. 152) who is under age 13. Generally
  speaking, a “qualifying child” is child (including a brother, sister, step sibling) of the
  employee or a descendant of such child (e.g. a niece, nephew, grandchild) who shares the
  same principal place of abode with you for more than half the year and does not provide
  over half of his/her support; and/or
• Your spouse or “dependent” who is physically or mentally unable to care for him/herself.
  A “dependent” means any individual whom you can claim under IRC Sec. 152 as a
dependent on your federal income tax return, or anyone for whom you could otherwise
claim as a dependent on your federal income tax return, but for the fact that they are
married, have income in excess of the applicable exemption amount or are a dependent
of a dependent. In addition, a child to whom IRC Section 152(e) applies, which is
generally a child of divorced or separated parents, is considered a dependent only of the custodial parent, without regard to whom actually claims the child as a dependent.

**Eligible Expenses**
- Amounts paid to a care provider (whether inside or outside your home) except as noted below.
- FICA and other taxes you pay on behalf of the care/service provider.
- Nursery schools, day camps and day care and elder care centers that meet state or local regulations, provide care for more than six non-residents and receive fees for services provided (per IRS rulings, pre-kindergarten is an eligible expense).

*Based on Internal Revenue Service Publication 503, "Child and Dependent Care Expenses."

**Ineligible Expenses**
- Dependent care provided by a spouse, parent of the child, child under age 19, or by anyone you claim as a dependent on your federal income tax return.
- Dependent care that isn’t necessary to enable you (and your spouse, if applicable) to be gainfully employed.
- Dependent care provided if your spouse does not work.
- Any expense you plan to take as a credit on your income tax return.
- Transportation to and from a dependent care location, except those charged by the day care provider to pick up and/or take the child to and from the day care center.
- Care provided in a full-time residential institution.
- Late payment fees.
- Expenses for a provider’s food, clothing and entertainment.
- Expenses to care for dependents that do not live with you at least eight hours per day.
- Expenses for overnight camp are not eligible day care expenses even if the expenses are itemized to show the daytime portion of the expense.
- Overnight care expenses (unless the parents work nights).
- Expenses that are primarily for education, food and/or clothing are not considered to be for custodial care. Therefore, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, day camps are considered to be for custodial care even if they also provide educational activities such as soccer and computer skills.
- Summer school and summer tutoring programs are considered to be “education,” and therefore do not qualify as custodial care.

*Based on Internal Revenue Service Publication 503, "Child and Dependent Care Expenses."

**Tax Credit vs. Dependent Care FSA**
For every dollar of reimbursement you receive through the Dependent Care FSA, your dependent care tax credit is reduced by a dollar. So if you elect to participate in the Dependent Care FSA, you are making a decision not to take the federal dependent care tax credit for those expenses.

In most cases, the Dependent Care FSA will offer you the greater tax savings. However, it is important to note that in some cases, your tax savings may be greater if you use the dependent care tax credit rather than the spending account for part or all of your dependent care expenses. Refer to IRS Publication 503 for a complete discussion of the tax credit. The following table compares the Dependent Care FSA and the federal income tax credit. You may want to consult your personal tax advisor to see which method makes the most sense for you.
<table>
<thead>
<tr>
<th><strong>Using the Dependent Care FSA</strong></th>
<th><strong>Using the Federal Income Tax Credit</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum annual contribution is $50</td>
<td>No minimum annual expenses for using the tax credit</td>
</tr>
<tr>
<td>Maximum annual contribution is $5,000 ($2,500 each if married filing separately)</td>
<td>Maximum annual expense applicable toward tax credit is $3,000 for one qualifying child; $6,000 for two or more qualifying children</td>
</tr>
<tr>
<td>Contributions are excluded from taxable income</td>
<td>A percentage of expense is applied as credit against taxes owed</td>
</tr>
<tr>
<td>Contributions are free from Social Security taxes</td>
<td>Tax credit doesn't affect Social Security taxes</td>
</tr>
<tr>
<td>You must decide contribution amount before expenses are incurred and you forfeit the unused amount</td>
<td>You determine tax credit at the end of the year after all expenses are incurred; there’s no risk of forfeiture</td>
</tr>
</tbody>
</table>

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

**Reimbursements of Dependent Care FSA Claims**

Expenses are treated as being incurred when you receive the care related to the expenses, not when you are formally billed or charged, or when you pay the dependent care provider.

In order to be reimbursed for a dependent care expense, you must submit an itemized bill from the service provider to Via Benefits Accounts prior to the end of the Run Out Period described below. Receipts must include:

- The caregiver’s name and taxpayer ID number or Social Security number. No taxpayer identification number is required for tax-exempt organizations, such as the YMCA, a church or similar organization;
- Date the service was provided;
- Name and date of birth of the dependent receiving services; and Amount paid.

The Plan also provides you with a debit card to use to pay for eligible dependent care expenses. Via Benefits Accounts will provide you with further details about using the debit card, filing manual or online claims, and managing your account.

The maximum reimbursement you may receive is equal to the current account balance in your Dependent Care FSA. If your reimbursement request is more than your available balance, the remaining amount will be placed in a pending status. The pended amount will be paid when additional funds are posted to your account.

**Run Out Period for Flexible Spending Accounts**

Except as otherwise described above for the Health Care and Limited Purpose FSA grace period, you’ll forfeit any spending account contributions you haven’t used by the end of the plan year. This is known as the “use it or lose it” rule. Claims for expenses incurred during the prior year must be received by the end of the run-out period, which is May 31 following the end of the Plan Year. After that date, any amount left in your account(s) will be forfeited. This money will be used to offset future costs of administering the accounts, and then
according to applicable rules and regulations. Reimbursement requests must be postmarked by May 31 following the end of the Plan Year.

**Appeals**
If your request for reimbursement is denied in whole or part, you have the right to appeal the denial. See the *Appeals* section of this SPD for more information.

**Highly Compensated and Key Employees**
The IRC contains rules prohibiting discrimination in favor of highly compensated employees (as defined in the IRC). Generally, highly compensated employees are those whose annual earnings are greater than the IRS limit. If the operation of the Plan violates any nondiscrimination rule under the IRC, the Administrator or Company will have the right to unilaterally terminate and/or modify elections, place limitations on participants’ pretax contributions, and modify benefit selection, availability and/or method of allocating employee pretax contributions with respect to highly compensated employees, in order for the Plan to meet the nondiscrimination requirements. Any changes in the rate of employees’ pretax pay by highly compensated employees will be applied in a fair and consistent manner. The Company will notify you if these limits apply to you.

**Adoption Assistance**
To help UPS employees realize the dream of having a family, UPS offers eligible employees financial assistance through its Adoption Assistance Program. You are eligible for this benefit as part of the comprehensive basic coverage under The Flexible Benefits Plan.

**Eligibility**
Employees are eligible for this benefit as part of the basic coverage under The Flexible Benefits Plan. You do not need to enroll separately in the Adoption Assistance Program benefit and there is no cost to you to take advantage of this program.

**Benefit Amount**
UPS will reimburse 100 percent of eligible costs, up to $3,500 per child, associated with the adoption of a child less than age 18 as long as the child is not related by marriage or blood. If both parents are UPS employees, expenses are reimbursed only one time per child, up to $3,500.

**Children with Special Needs**
If you adopt a child with a special need, the program will reimburse an additional $1,500 ($5,000 total) in eligible expenses. A child with special needs often has a physical or emotional disability. For the Adoption Assistance Program, documentation is required from the state in which the child is adopted certifying that the child qualifies for a special needs adoption in that state. Check with the applicable state social services division for information on that state’s definition of special needs. International adoptions cannot be considered for the special needs benefit.
What is Covered by Your Adoption Assistance Benefit
The Adoption Assistance Program covers the following adoption-related expenses:

- Legal/court fees
- Adoption agency fees (public or private, foreign or domestic)
- Medical expenses (when not covered by another source), including the following:
  - Newborn expenses
  - Maternity expenses for the birth mother
  - Charges for temporary foster care before placement
  - State-required home study program and other required adoptive parental counseling
  - Expenses to transport the child to the home

Call the UPS Benefits Resource Center at 1-844-877-8588 to request a UPS Adoption Assistance Program claim form.

What is Not Covered by Your Adoption Assistance Benefit
The following expenses are not covered by the UPS Adoption Assistance Program:

- Expenses incurred prior to the effective date of this plan or your eligibility for this plan
- Any costs when an adopting parent is related to (by blood or marriage) or a stepparent of the child being adopted
- Adoptions that are not legally recognized
- Personal items for the parents or child (food, clothing, etc.)
- Charges associated with legal guardianship
- Expenses related to the adoption of a person 18 years of age or older
- Donations or contributions
- Any costs when an adopting parent is the domestic partner of the parent of the child being adopted
- Consultant fee
- Any costs for or expenses of a surrogate mother (woman who is acting solely as a host of a fertilized egg)

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

Certain amounts of your reimbursement may be subject to income tax if your income is over a certain level, as defined by the federal government. You may want to consult a tax advisor. Taxable amounts are not grossed up to offset the tax liability.

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

Appeals
If your request for adoption assistance is denied, you have a right to file an appeal. See the Claims and Appeals section for more details.
Supplemental Insurance
You are eligible to participate in supplemental insurance offered through Allstate. The following supplemental medical plans are available on a voluntary basis to active employees in The Flexible Benefits Plan and their eligible dependents. You may enroll in the supplemental medical insurance plans at initial enrollment or during annual enrollment periods. Payment is made through payroll deductions.

If there is any conflict between the Allstate group contract certificates and these descriptions, the contract certificate provisions apply. You can obtain a copy of the contract certificate(s) by calling Allstate at 1-866-709-3909.

The Supplemental Insurance policies are not sponsored or maintained by UPS and are not subject to ERISA.

Accident Insurance
Accident insurance provides benefits in the event of a covered accident to help you pay for costs such as deductibles, treatment, transportation to/from medical centers, childcare and house payments. The cash benefit is provided in the form of a lump-sum payment.

Critical Illness Insurance
Critical illness insurance provides you the power to take control of your health when faced with a covered critical illness such as cancer, heart attack, or stroke. It pays benefits that can be used for medical and non-medical expenses that health insurance might not cover. The cash benefit is in the form of a lump-sum payment, which is paid to you after a covered diagnosis.

Hospital Indemnity Insurance
Hospital indemnity insurance can complement your medical coverage by easing the financial impact of a hospitalization. It provides a lump-sum payment when you are admitted into the hospital. The cash benefit is paid in a lump sum that can be used for both medical and nonmedical expenses that may arise due to a hospital admission. Neither Benefit Option insured by Allstate coordinates with the Medical Benefit Option. In other words, both benefit options provided by Allstate will pay benefits in accordance with the insurance contract without regard to whether the Medical Benefit Option pays for the same events. You may end up with benefits from both the Medical Benefit Option and the Allstate benefits that exceed your actual medical expenses. In that case, you may have to include the excess in your gross income for federal tax purposes.

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

You and your covered family members will have access to the Hyatt Legal Plans network, a nationwide network of plan attorneys. You will receive full coverage for covered services from a Hyatt network attorney. You also may use any attorney of your choice; Hyatt will provide a fee reimbursement schedule that shows the maximum amount payable for specific services under the plan.
The legal benefits are provided according to an insurance contract issued to UPS by Hyatt Legal Plans. If there is any conflict between the summary of benefits provided in this SPD and the benefits described in the contract or on the Hyatt Legal Plans website, the description in the contract and/or on the website controls.

The supplemental Hyatt Legal Plan is a voluntary benefit available to individuals and their dependents who are eligible for The Flexible Benefits Plan. You may enroll in the supplemental Hyatt Legal Plan benefit at Initial Enrollment, during Annual Enrollment, or following a qualified life event change.

**How the Legal Benefits Work**

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

- **Telephone Service** — You have access to advice, consultation, and direction regarding personal legal matters that are not specifically excluded under the Plan. There’s no cost for this service.
- **Hyatt Legal Plans attorneys** — If you need an attorney, you can choose one from Hyatt’s national network of attorneys throughout the United States who have agreed to provide covered services to Hyatt Legal Plan participants. If you use a Hyatt Legal Plans network attorney, you will receive benefits for most covered matters.
- **Non-Participating Attorneys** — You also can receive legal counsel from an attorney who does not participate in the Hyatt Legal Plans attorney network. When you use a nonparticipating attorney, you are reimbursed for covered legal services up to a scheduled maximum amount. You’ll be responsible to pay the difference, if any, between the plan’s payment and the non-network attorney’s charge for services.

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

**Legal Services Covered and Excluded**

Listed below are examples of legal services that are provided according to the contract with Hyatt Legal Plans. If you’re thinking about enrolling, visit their website at www.legalplans.com. Enter password 5530010 for the single plan or 5540010 for the family plan to access Hyatt Legal Plans’ legal plan resource center. Or, call Hyatt Legal Plans at 1-800-821-6400.

**Covered Legal Services**

Examples of covered services include:

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

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

**How to Use the Plan**
Once you are enrolled, log on to www.legalplans.com or call Hyatt Legal Plans’ Client Service center at 1-800-821-6400 Monday through Friday from 8 a.m. to 8 p.m., ET. A Client Service representative will confirm that you are eligible to use the plan, and will give you the address and telephone number of the attorney(s) located most conveniently to you, as well as a case number.

Once you have this information, you may contact the attorney yourself to schedule an appointment. The Client Services representative also can help you understand coverage, offer information about using an out-of-network attorney, and answer any other questions.

**Cost of Coverage**
To determine how much the coverage will cost, call Hyatt Legal Plans at 1-800-821-6400.

**Paying for Coverage**
Payment for legal plan coverage is made through after-tax payroll deductions.

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

**Portability**
You are eligible to convert your Hyatt Legal Plan coverage to an individual policy upon leaving UPS. If you choose to continue legal coverage, you will be billed directly for the cost. Contact Hyatt Legal Plans’ Client Service Center at 1-800-821-6400 for more information.
How to File a Claim
If you choose to receive services from one from Hyatt’s national network of attorneys, all covered services are paid in full – there is no need to submit a claim form. If you use a non-network attorney, you will be reimbursed for covered services according to a set fee schedule. You are responsible to pay the difference, if any, between the plan’s payment and the non-network attorney’s charge for services. To request a claim form, contact Hyatt Legal Plans’ Client Service center at 1-800-821-6400 or go online at www.legalplans.com.

Continuation of Your Plan Coverage
You may be able to continue coverage under the UPS Medical, Dental, and Vision Plans under certain conditions. Limited continuation rights may also be available with a Health Care FSA.

Continuation Coverage Rights under COBRA
This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the UPS Medical, Dental, and Vision Plans and the Health Care FSA. This notice generally explains COBRA continuation coverage, when it may become available to you and your covered dependents, and what you need to do to protect the right to receive it. Refer to the section Continuing Your Health Care Flexible Spending Account under COBRA for the special rules that apply to continuing participation in that account under COBRA.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under a group health plan because of a qualifying event. It also can become available to your spouse and dependent children who are covered under a plan when they would otherwise lose such coverage because of a qualifying event. The plan provides no greater COBRA rights than what COBRA requires (other than allowing domestic partners to elect continuation coverage) – nothing in this section is intended to expand your rights beyond COBRA’s requirements.

What Is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of group health plan (medical, dental, vision and Health Care FSA) coverage when you would otherwise lose such coverage because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if covered under the plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Additionally, a child who is born to or adopted or placed for adoption with you (the covered employee) during the COBRA continuation coverage period is also considered a qualified beneficiary. Under the plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the Paying for COBRA Continuation Coverage section.

COBRA Qualifying Events
If you are an employee, you will become a qualified beneficiary if you lose coverage under the plans because either one of the following qualifying events happens:
• Your hours of employment are reduced; or
• Your employment ends for any reason other than your gross misconduct.
If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose coverage under a plan because any of the following qualifying events happens:

- The covered employee dies;
- The covered employee’s hours of employment are reduced;
- The covered employee’s employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from the covered employee; or the covered employee becomes entitled to Medicare.

Your dependent children will become qualified beneficiaries if they lose coverage under a plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated;
- The child stops being eligible for coverage under the plan as a “dependent child”; or
- The parent-employee becomes entitled to Medicare.

For this purpose, “lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event (as defined by COBRA).

**Giving Notice That a COBRA Qualifying Event (or Second Qualifying Event) Has Occurred**

The plans will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Service Center has been timely notified that a qualifying event has occurred. When the qualifying event is the employee’s termination of employment (other than for gross misconduct) or reduction of work hours, or death of the employee, the employer must notify the COBRA Service Center of the qualifying event.

Important Note: For the other qualifying events (divorce or legal separation of the employee and spouse/domestic partner or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the COBRA Service Center within 60 days after the later of: 1) the date of qualifying event (or second qualifying event) or 2) the date the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event (or second qualifying event). You must provide this notice by calling the COBRA Service Center at 1-877-29-COBRA (1-877-292-6272) or you may send written notice to:

COBRA Service Center  
P.O. Box 1185  
Pittsburgh, PA 15230

**How COBRA Continuation Coverage Is Provided**

Once COBRA Service Center receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a COBRA Continuation Coverage Election Notice) to qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children.
If coverage under a plan is changed for similarly situated active employees, the same changes will be provided to individuals receiving COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods, if a qualified life event occurs or at other times under a plan to the same extent that active employees may do so.

**Duration of COBRA Continuation Coverage**

COBRA continuation coverage is a temporary continuation of group health coverage. When the qualifying event is the employee’s termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage for the employee and the employee’s covered spouse/domestic partner and dependent children generally lasts for up to a total of 18 months from the date of the qualifying event or loss of coverage, whichever is later. For information on the different rules that apply to continuation of Health Care FSA participation, refer to the section *Continuing your Health Care Flexible Spending Account under COBRA*.

When the qualifying event is the death of the employee, or your divorce or legal separation, COBRA continuation coverage for the employee’s qualified beneficiary spouse and/or dependent children (but not the employee) lasts for up to a total of 36 months from the date of the qualifying event or loss of coverage, whichever is later. Also, the employee’s qualified beneficiary dependent children are entitled to COBRA continuation coverage for up to 36 months after losing eligibility as a dependent child under the terms of the plans.

There are three ways in which the 18-month period of COBRA continuation coverage due to the employee’s termination of employment or reduction of work hours can be extended.

- **Employee’s Medicare Entitlement Occurs Before a Qualifying Event That Is Employee’s Termination of Employment or Reduction of Work Hours:** When the qualifying event is the employee’s termination of employment (other than for gross misconduct) or reduction of work hours, and the employee became entitled to (i.e., enrolled in) Medicare benefits less than 18 months before the qualifying event (even if Medicare entitlement was not a qualifying event for the employee’s spouse or dependent children because their coverage was not lost), COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee’s Medicare entitlement. For example, if the employee becomes entitled to Medicare eight months before the date on which employment terminates and coverage is lost, COBRA continuation coverage for the employee’s qualified beneficiary spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

- **Disability Extension:** If any qualified beneficiary covered under the plan are determined by the Social Security Administration (SSA) to be disabled on the date of the employee’s termination of employment or reduction of work hours, or at any time during the first 60 days of COBRA continuation coverage due to such qualifying event, each qualified beneficiary covered under the Plan (whether or not disabled) may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this disability extension, you must notify the COBRA Service Center in writing of the person’s disability status BOTH: 1) within 60 days after the latest of: i) the date of the disability determination by the SSA, ii) the date on which the qualifying event occurs, iii) the date on which you lose (or would lose) coverage under a plan, or iv) the date on which you are informed of both the responsibility to
provide this notice and the plan’s procedures for providing such notice to the COBRA Service Center, AND 2) before the original 18-month COBRA continuation coverage period ends. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the COBRA Service Center in writing within 30 days after this determination. Any notice of disability that you provide must include: i) the name and address of the disabled qualified beneficiary, ii) the date that the qualified beneficiary became disabled, iii) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage, iv) the date that the Social Security Administration made its determination, v) a copy of the Social Security Administration’s determination, and vi) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled. Send your written notice to:

COBRA Service Center
P.O. Box 1185
Pittsburgh, PA 15230

If these procedures are not followed or if the notice is not provided in writing to the COBRA Service Center within the required period, you will not receive a disability extension of COBRA continuation coverage.

• **Second Qualifying Event Extension:** If a qualified beneficiary spouse and/or dependent children experience a second qualifying event while receiving the initial 18 or 29 months of COBRA continuation coverage, qualified beneficiaries (other than the employee) can get up to a total of 36 months of COBRA continuation coverage if timely notice of the second qualifying event is given to the COBRA Service Center.

• This extension may be available to the employee’s spouse/domestic partner and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under the plan had the first qualifying event not occurred. If a second qualifying event occurs at any time during the 29-month disability continuation period (as described above), then each qualified beneficiary who is the employee’s spouse/domestic partner or dependent child (whether or not disabled) may further extend COBRA continuation coverage for seven more months, for a total of up to 36 months from the employee’s termination of employment or reduction of work hours (or the date coverage is lost, if later). (See the “Giving Notice That a COBRA Qualifying Event (or Second Qualifying Event) Has Occurred” section for important details on the proper procedures and timeframes for giving this notice to the COBRA Service Center.) If these procedures are not followed or if the notice is not provided in writing to the COBRA Service Center within the required 60-day period, you will not receive an extension of COBRA continuation coverage due to a second qualifying event.
The table below provides a summary of the COBRA provisions outlined in this section.

<table>
<thead>
<tr>
<th>Qualifying Events That Result in Loss of Coverage</th>
<th>Employee</th>
<th>Spouse/ Domestic Partner</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s reduction of work hours (e.g., full-time to part-time)</td>
<td>18 months</td>
<td>18 months</td>
<td>18 months</td>
</tr>
<tr>
<td>Employee’s termination of employment for any reason (other than gross misconduct)</td>
<td>18 months</td>
<td>18 months</td>
<td>18 months</td>
</tr>
<tr>
<td>Employee or employee’s spouse or dependent child is disabled (as determined by the Social Security Administration) who is covered at the time of the qualifying event is determined by the Social Security Administration to have been disabled on or before the 60th day of COBRA continuation coverage that begins as a result of termination of employment or reduction of work hours</td>
<td>29 months</td>
<td>29 months</td>
<td>29 months</td>
</tr>
<tr>
<td>Employee dies</td>
<td>N/A</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Employee and spouse legally separate or divorce</td>
<td>N/A</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Employee becomes entitled to Medicare within 18 months before termination of employment or reduction in work hours (even if such Medicare entitlement was not a qualifying event for the covered spouse/domestic partner or dependent child because their coverage was not lost)</td>
<td>N/A</td>
<td>36 months(^1)</td>
<td>36 months(^1)</td>
</tr>
<tr>
<td>Child no longer qualifies as a dependent child under the terms of the plan</td>
<td>N/A</td>
<td>N/A</td>
<td>36 months</td>
</tr>
</tbody>
</table>

\(^1\) 36-month period is counted from the date the employee becomes entitled to Medicare.

**Electing COBRA Continuation Coverage**
You and/or your covered spouse and dependent children must choose to continue coverage within 60 days after the later of the following dates:
- The date coverage is lost under a plan as a result of the qualifying event; or
- The date the COBRA Service Center notifies you of your right to choose to continue coverage as a result of the qualifying event.

**Paying for COBRA Continuation Coverage**
**Cost:** Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. With respect to the 11-month disability extension of COBRA continuation coverage, the cost of coverage for the 19th through 29th months of coverage will increase to 150% of the cost of group health plan coverage for the disabled individual.
**Premium Due Dates:** If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Form is postmarked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under a plan. Payment is considered made on the date it is sent to a plan (the postmark date, or the date entered on the check if the postmark is unreadable).

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The premium due date and exact amount due for each coverage period will be shown on the COBRA payment coupons you receive. Although periodic payments are due on the dates shown on the COBRA payment coupons, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you elect COBRA continuation coverage, but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under the plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

**When COBRA Continuation Coverage Ends**

COBRA continuation coverage for any person will end when the first of the following occurs:

- The applicable 18-, 29- or 36-month COBRA continuation coverage period ends, except as provided herein.
- If you fail to timely and completely pay the premium, the last day of the month for which a timely and complete payment was made.
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan not offered by UPS.
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (i.e., enrolled in) Medicare benefits (under Part A, Part B or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare.
- In the case of extended COBRA continuation coverage due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA continuation coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.
- For newborns and children adopted by or placed for adoption with you (the covered employee) during your COBRA continuation coverage, the date your COBRA continuation coverage period ends unless a second qualifying event has occurred.
- UPS ceases to provide any group health plan for its employees and retirees.

COBRA continuation coverage also may be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).
Continuing Your Flexible Spending Account under COBRA
Generally, if the benefit still available to you from a Health Care or Limited Purpose Flexible Spending Account (FSA) as of the date of a qualifying event is greater than the COBRA premium for the rest of the plan year, you may continue your participation in the FSA under COBRA. Continuing contributions will be made on an after-tax basis for the remainder of the plan year in which a qualifying event occurs.

You will not be able to continue your participation in a FSA under COBRA if, for the plan year in which the qualifying event occurs, the COBRA premium for the rest of the plan year is greater than the benefit still available to you under a FSA as of the date of the qualifying event.

In no event will you be able to elect FSA participation for the plan year following the year in which the qualifying event occurs, even if your COBRA continuation period is still in effect for your medical, dental and/or vision coverage. You will be required to follow all of the notice, election, payment and termination provisions applicable to the Medical, Dental, and Vision Plans above.

If You Have Questions
Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes
In order to protect your rights, as well as the rights of your spouse/domestic partner and dependent children, you should keep the COBRA Service Center informed of any changes in the addresses of your spouse/domestic partner and/or dependent children. You also should keep a copy for your records of any notices you send to the COBRA Service Center.

Plan Contact Information
For more information on your continuation rights under COBRA, please contact:
   COBRA Service Center
   P.O. Box 1185
   Pittsburgh, PA 15230
   1-877-29-COBRA (1-877-292-6272)
   https://cobra.ehr.com

Continuation of Coverage for Employees in the Uniformed Services
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible associates who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.
Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights, and benefits that would have been attained if employment had not been interrupted.

Under USERRA, the maximum period of continuation coverage available to you and your eligible dependents is the lesser of 24-months after the leave begins or the day the leave ends. When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

**Military Absence of 30-Days or Less**
Coverage for employees on military absence and their dependents who are covered under the Plan will remain in effect for the duration of any leave of 30 days or less. The employee will continue to pay the employee portion of the premium from his or her regular pay. If the employee elects not to continue to pay the premium, coverage terminates 30-days after the effective date of the leave of absence.

**Military Absence of More Than 30-Days**
Coverage for employees on military absence and their dependents who are covered under the Plan may continue for up to 24-months. The employee is required to continue to pay the employee portion of the premium from his or her regular pay while receiving differential pay (applies to emergency call-ups only). If the employee elects not to continue to pay the premium, coverage terminates at the end of the pay period in which the leave of absence is effective. Upon return from leave, coverage will be reinstated without a waiting period.

For all inquiries relating to military leave, please refer to the Military Leave of Absence policy and your Human Resources representative. In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days.
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days.
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

**Right of Recovery and Subrogation**
This section describes the Plan’s right to seek reimbursement of expenses that are paid by the Plan on behalf of you or your covered dependents (referred to in this section as a “covered individual”) if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident). The Plan may seek reimbursement of these expenses from any recovery you may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. The terms of the Plan's reimbursement rights are described below.

NOTE: This section applies with respect to a Benefit Option only to the extent Right of Recovery and/or subrogation provisions are not described in the applicable Benefit Plan Documents.
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 receives any recovery 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:

- Execute an agreement provided by UPS (“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;
- Provide such information as UPS or claims administrator may request;
- Notify UPS and/or the 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;
- Agree to notify UPS and/or the claims administrator of any recovery.

The Plan’s right to recover the benefits it has paid is subject to reduction for attorney’s fees and other expenses of recovery to the extent that the Covered Individual fully cooperates with the Plan and does not interfere with or impede the Plan’s rights to reimbursement or subrogation. The reduction is limited to the lesser of actual attorney fees and other expenses or one-third of the Plan’s lien. The Plan’s right to recover benefits shall apply to the entire proceeds of any recovery by the covered individual. This includes any recovery by judgment, settlement, arbitration award, or otherwise.

The Plan’s right to recover shall not be limited by application of any statutory or common law "make whole" doctrine (in other words, the Plan has a right of first reimbursement out of any recovery, even if the covered individual is not fully compensated), or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained.

The Plan shall have a lien against the proceeds of any recovery by the covered individual and against future benefits due under the Plan in the amount of any claims paid. The lien shall attach as soon as any person or entity agrees to pay any money to or on behalf of any covered individual that could be subject to the Plan’s right of recovery if and when received by the covered individual. If the covered individual fails to repay the Plan from the proceeds of any recovery, the Plan Administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

If the covered individual fails to take action against a responsible third party to recover damages within one year or within 30 days after the Plan requests, the Plan shall be deemed to have acquired, by assignment or subrogation, a portion of the covered individual’s claim equal to the amounts the Plan has paid on the covered individual’s behalf. The Plan may thereafter commence proceedings directly against any responsible third party. The Plan shall not be deemed to waive its rights to commence action against a third party if it fails to act after the expiration of one year, nor shall the Plan’s failure to act be deemed a waiver or discharge of the lien described above.
The Plan has the greater of six (6) years or the time period under any applicable law to enforce its lien or to otherwise seek reimbursement from any recovery received by or on behalf of the Covered Individual. The time period referenced above begins to run on the date the Plan discovers that a lien attached as described herein.

The covered individual shall cooperate fully with the Plan in asserting claims against a responsible third party and such cooperation shall include, where requested, the filing of suit by the covered individual against a responsible third party and the giving of testimony in any action filed by the Plan. If a covered individual fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator may deny payment of claims and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator.

In addition, the Plan has a right to recover benefits that were paid in error (for example, income protection plan benefits paid to a person who does not qualify for benefits) or benefits that were obtained through fraudulence, 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.

**Claims**
The requirements for filing claims for benefits, including the manner in which claims are filed and the time period for filing claims, are described below. All claims for benefits must be filed in accordance with the Benefit Plan Documents within 12 months of the date the event giving rise to the claim occurred except as otherwise described in specific Benefit Option section of this SPD or the Benefit Plan Documents.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>File Claims with...</th>
<th>How you file claims...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit Option Claims</td>
<td>See the Benefit Plan Documents for details</td>
<td>See the Benefit Plan Documents for details</td>
</tr>
<tr>
<td>Dental Benefit Options</td>
<td>Aetna Dental</td>
<td>See the Benefit Plan Documents for details</td>
</tr>
<tr>
<td>Vision Benefit Options</td>
<td>United Healthcare Vision</td>
<td>See the Benefit Plan Documents for details</td>
</tr>
<tr>
<td>CVS Prescription Drug Claims</td>
<td>CVS/caremark</td>
<td>See the “Prescription Drug Section of this SPD for details</td>
</tr>
<tr>
<td>Life Insurance/AD&amp;D</td>
<td>Securian</td>
<td>Contact the Benefits Resource Center for assistance.</td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>Aetna</td>
<td><a href="http://www.aetnadisability.com">www.aetnadisability.com</a>, or call 1-866-825-0186</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>Aetna</td>
<td><a href="http://www.aetnadisability.com">www.aetnadisability.com</a>, or call 1-866-825-0186</td>
</tr>
<tr>
<td>Spending Accounts</td>
<td>Via Benefits Accounts</td>
<td>See the Spending Accounts section of this SPD for details</td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>UPS</td>
<td>Contact the Benefits Resource Center to request an Adoption Assistance Program claim form</td>
</tr>
</tbody>
</table>
You have the right to have an authorized representative file a claim for benefits on your behalf. Whether a representative is authorized to act on your behalf will be determined in accordance with the Claims Administrator’s or Carrier’s reasonable procedures.

**Appeals**
If your claim for benefits under the Plan with respect to any Benefit Option is denied, you are entitled to a full and fair review procedure in accordance with ERISA Section 503. This section of the SPD describes the appeals procedures for the following Benefit Options:
- Prescription drug claims administered by CVS/caremark
- Health Care FSA and Limited Purpose FSA
- Dependent Care FSA (not subject to ERISA)
- Short-Term Disability
- Adoption Assistance (not subject to ERISA)

**Appeals Procedures**
Generally, the following steps describe your appeal procedures for the above mentioned Benefit Options.

**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. The time frame in which you will receive this notice is described in the *Claims and Appeals Procedure Chart* below and will vary depending on the type of Benefit Option for which the claim is filed. The contact information for the Claims Administrator is provided in the *Claims Administrator and Claims Fiduciary Chart* below. In addition, the claims administrator may request 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, at a minimum, the following information:
- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan’s appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your appeal;
- A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request; and
- 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.
**Step 3: If you disagree with the decision, file a 1st Level Appeal with the claims administrator.** If you do not agree with the decision of the claims administrator and you wish to appeal, you must file a written appeal with the claims administrator within 180 days of receipt of the claims administrator’s letter (or oral notice if an urgent care claim) referenced in Step 1. 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. You have the right to have an authorized representative file an appeal on your behalf. Whether a representative is authorized to act on your behalf will be determined in accordance with the Claims Administrator’s or Carrier’s reasonable procedures.

**Step 4: 1st Level Appeal notice is received from claims administrator.** If the claim is again denied, you will be notified by the claims administrator within the time period described in the Claims and Appeals Procedure 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, at a minimum, that is provided in the first notice of denial provided by the claims administrator.

**Step 6: If you still disagree with the claims administrator’s decision, file a 2nd Level Appeal with the applicable Claims Fiduciary.** If you still do not agree with the claims administrator’s decision and you wish to appeal, you must file a written appeal with the Claims Fiduciary for that Benefit Option within 60 days after receiving the 1st Level Appeal denial notice from the claims administrator. See the Claims Administrator and Claims Fiduciary Chart below for the Claims Fiduciary’s contact information. 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.

If the Claims Fiduciary denies your 2nd Level Appeal, you will receive notice within the time period described in the Claims and Appeals Procedure Chart, depending on the type of claim. The notice will contain the same type of information that was referenced in Step 2 above.

A claim is not deemed “filed” for purposes of these claims review procedures until it is filed in accordance with the Filing a Claim section of this SPD and it is received by the claims administrator or, where applicable, the Claims Fiduciary.

**Additional Rules**
There are additional rules that apply to the appeals procedures for the above mentioned Benefit Options:

**All of the Above Mentioned Benefit Options**
- 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 a right to request documents or other records relevant (as defined by ERISA) to your claim.

You cannot file suit in federal court until you have exhausted these appeals procedures.
**CVS/caremark administered prescription drug claims, Health Care FSA, Limited Purpose FSA, and Short Term Disability Claims**

- If a claim involves medical judgment, then the claims administrator and the Claims Fiduciary will consult with an independent health care professional during the 1st and 2nd Level Appeal who has expertise in the specific area involving medical judgment.
- If an internal, rule, guideline, or protocol was relied upon in making the Denial, the Plan will either provide the specific rule, guideline or protocol or provide a statement that a copy will be provided free of charge upon request.

**CVS/caremark administered prescription drug claims only**

- If your claim involves “urgent care”, you may first file your claim or appeal orally and the Claims Administrator or Claims Fiduciary may initially respond orally (followed by a written notice). See the *Claims and Appeals Procedures Chart* below for the definition of “urgent care.”
- If the claim was an Urgent Care Claim, the notice will include a description of the expedited appeal process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you not later than three days after the oral notification. The Claims Administrator/claim Fiduciary will automatically provide the claimant free of charge, with any new or additional evidence considered, relied upon or generated by the plan or issuer in connection with the claim that is being appealed. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Denial is required to be provided, without request from the claimant for such evidence. Before issuance of a final internal Denial, if the determination is based on a new or additional rationale, the plan will provide the claimant with the additional rationale free of charge. Such rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final denial is required to be provided, without a request from the claimant for such rational.
- Notification of an Denial of a claim for major medical Benefits will including the following information:
  - A statement that you may request the applicable diagnosis and/or treatment codes and their corresponding meanings;
  - Any denial code and its corresponding meaning as well as the applicable standard applied in making the determination; and
  - The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist you with the claim.
- You also may have the right to request an external review of any final Denial in accordance with the information below.

**External Review for CVS/caremark administered claims and appeals**

- You may make a written request for an external review with an independent review organization within four (4) months of the date you receive a 2nd level denial from the Claims Fiduciary. Also, you may request an external review for a denial of an Urgent Care Claim or 1st level Appeal based on medical judgement provided that the time frames for completion of an urgent care appeal will seriously jeopardize your life or health or would seriously jeopardize your ability to regain maximum function.
- Within five (5) business days of receiving your request for an external review, the Claims Review Committee or its designated representative will complete a preliminary review of the request to determine whether you were covered under the Plan at the time the expense was incurred and whether you have exhausted the internal appeal process where required. Within one (1) business day of making the determination, you will be notified if
the external review request is denied and you will be provided with (i) the reasons why
the claim is initially ineligible for external review, or (ii) the information or materials
needed for a complete request. In the event your request is denied due to lack of
information or materials, you must present your claim by the later of the end of the
4-month period following the final internal Adverse Benefit Determination or 48 hours
following notification that your request for external review was denied.

• If initially eligible for an external review, your request will be assigned to an Independent
Review Organization. The Independent Review Organization will make a determination of
eligibility for external review, and provide you and the Plan with notice of its
determination within 45 days of receiving the review request. Generally, only claims
involving medical judgment are eligible for external review. Medical judgment for this
purpose means a decision based on the Plan’s medical necessity requirements,
appropriateness of care, level of care or effectiveness of a covered benefit, or as
otherwise contemplated by 29 C.F.R. § 2590.715-2719(d)(1)(ii)(A), as determined by the
Independent Review Organization.

• If, due to your medical condition, the timeframe for completion of the standard external
review process would seriously jeopardize your life or health or your ability to regain
maximum function, you may request an expedited external review. Under an expedited
external review, the preliminary review will be completed immediately. If determined to
be initially eligible, the Claims Administrator will assign the request to an Independent
Review Organization and the Independent Review Organization will complete the review
as expeditiously as your medical condition requires, but in no event more than 72 hours
after receiving the request.

### Claims Administrator and Claims Fiduciary Chart

The following table provides a summary of the claims administrator and claims fiduciary for
each Benefit Option.

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Claims Administrator</th>
<th>Claims Fiduciary</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVS/caremark administered prescription drug claims</td>
<td>CVS/caremark Appeals Department, MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax number: 1-866-689-3092</td>
<td>UPS Claims Review Committee 55 Glenlake Parkway, N.E. Atlanta, GA 30328</td>
</tr>
<tr>
<td>Health Care FSA and Limited Purpose FSA</td>
<td>Via Benefits Accounts Reimbursement Center P.O. Box 25172, Lehigh Valley, PA 180025172 1-844-877-8588 <a href="http://www.viabenefitsaccounts.com">www.viabenefitsaccounts.com</a></td>
<td>Same as Claims Administrator</td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td>Via Benefits Accounts Reimbursement Center P.O. Box 25172, Lehigh Valley, PA 180025172 1-844-877-8588 <a href="http://www.viabenefitsaccounts.com">www.viabenefitsaccounts.com</a></td>
<td>Same as Claims Administrator</td>
</tr>
</tbody>
</table>
### Benefit Options and Claims Administrators

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Claims Administrator</th>
<th>Claims Fiduciary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Disability</td>
<td>Aetna Disability-Workability Appeals Attn: UPS Appeals P.O. Box 14578 Lexington, KY 40512-4578 Fax: 855-733-1262</td>
<td>UPS Claims Review Committee 55 Glenlake Parkway, N.E. Atlanta, GA 30328</td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>UPS Corporate Benefits</td>
<td>UPS Claims Review Committee 55 Glenlake Parkway, N.E. Atlanta, GA 30328</td>
</tr>
</tbody>
</table>

UPS, as plan administrator, delegates to the Claims Fiduciary all authority and discretion to interpret the terms of the Plan (including the applicable Benefit Plan Documents) and to decide questions of fact as is necessary to make a determination of benefits. Except as noted above with respect to an external review, the decision of the claims fiduciary is final and binding on the Plan.

### Claims and Appeals Procedure Chart

<table>
<thead>
<tr>
<th>Claims and Appeals Procedures</th>
<th>Initial Claims</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Claim</strong></td>
<td><strong>You’ll be notified of determination as soon as possible but no later than...</strong></td>
<td><strong>If additional information is needed, you must provide within...</strong></td>
<td><strong>You’ll be notified of determination as soon as possible but no later than...</strong></td>
</tr>
<tr>
<td>Pre-Service</td>
<td>15 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>180 days of claim denial</td>
</tr>
<tr>
<td>Pre-Service involving Urgent Care</td>
<td>72 hours (24 hours if additional information is needed from you)</td>
<td>None</td>
<td>180 days of claim denial</td>
</tr>
<tr>
<td>Concurrent: To end or reduce treatment prematurely</td>
<td>Notification to end or reduce will allow time to finalize appeal before end of treatment</td>
<td>N/A</td>
<td>(Denial letter will specify filing limit)</td>
</tr>
</tbody>
</table>

**CVS/caremark Administered Prescription Drug Claims**

| Pre-Service                   | 15 days from receipt of claim | 45 days of date of extension notice | 180 days of claim denial | 15 days from receipt of appeal | 60 days of 1st Level appeal denial | 15 days from receipt of appeal |
| Pre-Service involving Urgent Care | 72 hours (24 hours if additional information is needed from you) | None | 180 days of claim denial | 72 hours from receipt of appeal | N/A | N/A |

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UPS – The Flexible Benefits Plan
### Claims and Appeals Procedures

<table>
<thead>
<tr>
<th>Concurrent: To deny your request to extend treatment</th>
<th>Initial Claims</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treated as any other pre-service or post-service claim</td>
<td>Treated as any other pre-service or post-service claim</td>
<td>Treated as any other pre-service or post-service claim</td>
</tr>
<tr>
<td></td>
<td>Treated as any other pre-service or post-service claim</td>
<td>Treated as any other pre-service or post-service claim</td>
<td>Treated as any other pre-service or post-service claim</td>
</tr>
<tr>
<td>Concurrent: Involving Urgent Care</td>
<td>24 hours, if claim submitted at least 24 hours before the scheduled end date of treatment. Otherwise, treated as Pre-Service Urgent Care: 30 days from receipt of appeal</td>
<td>None</td>
<td>(Denial letter will specify filing limit)</td>
</tr>
<tr>
<td></td>
<td>Treated as any other pre-service or post-service claim</td>
<td>Treated as any other pre-service or post-service claim</td>
<td>Treated as any other pre-service or post-service claim</td>
</tr>
<tr>
<td>Post-Service</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>
<tr>
<td>Other Claims</td>
<td>FSA and Adoption Assistance</td>
<td>30 days from receipt of claim</td>
<td>One extension of 15 days</td>
</tr>
<tr>
<td></td>
<td>Short-Term Disability</td>
<td>45 days from receipt of claim</td>
<td>Two extensions of 30 days each</td>
</tr>
</tbody>
</table>

- **Pre-Service Claim.** A claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you precertify hospital admissions.
- **Concurrent Care Claim.** A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.
• **Post-Service Claim.** A claim for care that has already been received, any claim for which the Plan does not require pre-authorization and Health Care Spending Account claims (including Child/Elder Care Spending Accounts and Adoption Assistance Program claims).

• **Urgent Care Claims.** A Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:
  – Seriously jeopardize the life of the claimant (in the view of a prudent layperson 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).

**All Other Benefit Options**

If your claim for benefit from any other Benefit Option not described above ("Other Benefits") is denied in whole or part, you will have a right to appeal in accordance with the Claims Administrator’s or Carrier’s appeals procedures. Those procedures will be described in the Benefit Plan Documents or the denial notices provided to you by the Claims Administrator or Insurance Carrier. The following describes the minimum procedures that will apply:

• You have the right to have an authorized representative file a claim for Other Benefits on your behalf. Whether a representative is authorized to act on your behalf will be determined in accordance with the Plan’s or the Insurer’s reasonable procedures.

• UPS, as plan administrator, delegates to the Claims Administrator or the Carrier for the Other Benefits all authority and discretion to interpret the terms of the Plan (including the applicable Benefit Plan Documents) and to decide questions of fact as is necessary to make a determination of benefits.

• The Claims Administrator or Carrier may establish reasonable procedures for filing claims for Benefits and appeals. For example, the Plan may require that you file a claim on a particular form and/or send the claim to a particular address and in most cases, the Plan may require that you file your claim in writing. The specific claim filing procedures for a Benefit Plan will be described in the applicable Benefit Plan Documents or in the notice of denials.

• If your claim for Other Benefits is denied, you will receive a notice of the denial that contains the following information:
  – Reference to the specific plan provisions on which the denial is based;
  – Description of information necessary to perfect your claim;
  – A description of the Plan’s procedures for filing an appeal of the Adverse Benefit Determination;
  – A statement of your right to file suit under ERISA 502 (provided you exhaust the Plan’s claims and appeal procedures);
  – Notice regarding any voluntary level of appeals that may be available and a description of your rights with respect to such voluntary appeal;
  – You will have at least 180 days to file an appeal of a denial of long term disability benefits or a group health plan benefits (e.g. Medical Plan, Dental, Vision);
  – You will have at least 90 days to file an appeal of a denial of term life and AD&D insurance benefits;
  – You have the right during any appeal of a denial to submit written comments, documents, records, and other information related to the claim.

• You have the right to receive, upon request and free of charge, reasonable access to and copies of all documents and records that are "Relevant" to your claim for benefits. A document or record is Relevant for this purpose if it meets any of the following criteria:
  – It was relied upon in making the determination;
− It was submitted, considered or generated in the course of making the determination, without regard to whether it was relied upon in making the determination; or
− It demonstrates compliance with ERISA’s requirement for determinations that are consistent with the applicable Benefit Plan Document.

• A right to have all documents, records, and comments that you submit reviewed and considered by the appropriate claims reviewer;
• You generally may not file suit until you have exhausted the Plan’s internal claims and appeals process.

**Plan Administration**
As noted, this SPD provides information regarding the terms and conditions of the Plan and the Benefit Options offered by the Plan. The following chart provides general information about the Plan.

<table>
<thead>
<tr>
<th>Name of the Plan</th>
<th>The Flexible Benefits Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Number</td>
<td>501</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 through December 31</td>
</tr>
</tbody>
</table>
| Plan Sponsor              | United Parcel Service of America, Inc.  
                            | 55 Glenlake Parkway, NE 
                            | Atlanta, GA 30328 
                            | 1-800-UPS-1508 |
| Plan Administrator        | United Parcel Service of America, Inc.  
                            | 55 Glenlake Parkway, NE 
                            | Atlanta, GA 30328 
                            | 1-800-UPS-1508 |
| COBRA Administrator for the following Benefit Options: | COBRA Service Center  
                            | P.O. Box 1185 
                            | Pittsburgh, PA 15230 
                            | 1-877-29 COBRA (292-6272) 
                            | https://cobra.ehr.com |
| • Medical Benefit Options |                            |
| • Dental Benefit Options  |                            |
| • Vision Benefit Options  |                            |
| • Health Care FSA         |                            |
| See the Continuation of Coverage section of this SPD for more information regarding COBRA continuation coverage | |
| Employer Identification Number | 95-1732075 |
| VEB Association           | All required contributions and other “plan assets” for the self-funded medical and dental options are held in a VEB trust. See “Plan Benefits” below for more information. | Boston Safe Deposit and Trust Company  
                            | 135 Santilli Highway 
                            | Everett, MA 02149 |
**Benefit Options**
The following identifies the Benefit Options (i.e., the employer sponsored benefits) offered through this Plan, whether they are self-funded or fully insured, and the identity of the claims administrator or Insurance Carrier. NOTE: A claims administrator administers a self-funded Benefit Option, but does not guarantee or finance the benefits. An insurance carrier guarantees the benefits pursuant to an insurance policy in exchange for payment of a premium.

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Self-funded or Fully Insured</th>
<th>Claims Administrator (self-funded) or Insurance Carrier (fully insured)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $500 Deductible Plan</td>
<td></td>
<td>Aetna</td>
</tr>
<tr>
<td>• $1,500 Deductible Plan with HSA</td>
<td></td>
<td>P.O. Box 981106</td>
</tr>
<tr>
<td>• $2,000 Deductible Plan with HSA</td>
<td></td>
<td>El Paso, TX 79998-1106</td>
</tr>
<tr>
<td>• Hawaii Traditional Medical Plan Option</td>
<td></td>
<td>1-800-435-7324</td>
</tr>
<tr>
<td>• Out-of-Area Plan</td>
<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Anthem BCBS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 105187</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Atlanta, GA, 30348-5187</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-855-804-2073</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.anthem.com">www.anthem.com</a></td>
</tr>
<tr>
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<tr>
<td></td>
<td></td>
<td>UnitedHealthcare Services, Inc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 30555</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Salt Lake City, UT 84130-0555</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-844-333-2618</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
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<tr>
<td></td>
<td></td>
<td>For prescription drug coverage:</td>
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<tr>
<td></td>
<td></td>
<td>CVS/caremark Claims Department</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 52136</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phoenix, AZ 85072-2136</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-855-282-8412</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.caremark.com">www.caremark.com</a></td>
</tr>
<tr>
<td>Medical Plan</td>
<td></td>
<td>Kaiser Permanente <a href="http://www.kp.org">www.kp.org</a></td>
</tr>
<tr>
<td>• $500 Deductible Plan</td>
<td></td>
<td>For Northern California:</td>
</tr>
<tr>
<td>• $1,500 Deductible Plan with HSA</td>
<td></td>
<td>Kaiser Permanente Northern California</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1950 Franklin Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oakland, CA 94612</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-464-4000</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>For Southern California:</td>
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<tr>
<td></td>
<td></td>
<td>Kaiser Permanente Southern California</td>
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<tr>
<td></td>
<td></td>
<td>393 East Walnut Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pasadena, CA 91188</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-464-4000</td>
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UPS – The Flexible Benefits Plan
<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Self-funded or Fully Insured</th>
<th>Claims Administrator (self-funded) or Insurance Carrier (fully insured)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Colorado: Kaiser Permanente Colorado</td>
<td>For Colorado:</td>
<td>Kaiser Permanente Colorado</td>
</tr>
<tr>
<td>10350 E. Dakota Avenue</td>
<td>10350 E. Dakota Avenue</td>
<td>Denver, CO 80247</td>
</tr>
<tr>
<td>1-800-632-9700</td>
<td>1-800-632-9700</td>
<td></td>
</tr>
<tr>
<td>For Georgia: Kaiser Permanente Georgia</td>
<td>For Georgia:</td>
<td>Kaiser Permanente Georgia</td>
</tr>
<tr>
<td>Nine Piedmont Center</td>
<td>Nine Piedmont Center</td>
<td>3495 Piedmont Road, NE</td>
</tr>
<tr>
<td>Atlanta, GA 30305</td>
<td>Atlanta, GA 30305</td>
<td>1-888-865-5813</td>
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<tr>
<td>For MidAtlantic States:</td>
<td>For MidAtlantic States:</td>
<td>Kaiser Permanente Mid-Atlantic States</td>
</tr>
<tr>
<td>Kaiser Permanente Mid-Atlantic States</td>
<td>Kaiser Permanente Mid-Atlantic States</td>
<td>2101 East Jefferson Street</td>
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<tr>
<td>2101 East Jefferson Street</td>
<td>2101 East Jefferson Street</td>
<td>Rockville, MD 20852</td>
</tr>
<tr>
<td>1-800-777-7902</td>
<td>1-800-777-7902</td>
<td></td>
</tr>
<tr>
<td>For Northwest: Kaiser Permanente</td>
<td>For Northwest:</td>
<td>Kaiser Permanente Northwest</td>
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<tr>
<td>Northwest</td>
<td>Northwest</td>
<td>500 N.E. Multnomah Street, Suite 100</td>
</tr>
<tr>
<td>Portland, OR 97232</td>
<td>Portland, OR 97232</td>
<td>1-800-813-2000</td>
</tr>
<tr>
<td>For Hawaii:</td>
<td>For Hawaii:</td>
<td>Kaiser Permanente Appeals Department</td>
</tr>
<tr>
<td>Kaiser Permanente Appeals Department</td>
<td>Kaiser Permanente Appeals Department</td>
<td>2828 Pa’a Street, Suite 3080</td>
</tr>
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<td>2828 Pa’a Street, Suite 3080</td>
<td>2828 Pa’a Street, Suite 3080</td>
<td>Honolulu, HI 96819</td>
</tr>
<tr>
<td>1-808-432-7535</td>
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<tr>
<td>Medical Plan - International</td>
<td>Medical Plan - International</td>
<td>Fully Insured Aetna</td>
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<td>Fully Insured Aetna</td>
<td><a href="http://www.aetnainternational.com">www.aetnainternational.com</a></td>
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<td>Dental Plan</td>
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<td>Self-funded Aetna</td>
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<tr>
<td>• $2,500 Max Plan with Orthodontia</td>
<td>$2,500 Max Plan with Orthodontia</td>
<td>P.O. Box 14094 Lexington, KY 40512</td>
</tr>
<tr>
<td>• $1,500 Max Plan with Orthodontia</td>
<td>$1,500 Max Plan with Orthodontia</td>
<td>1-800-435-7324 <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Dental Plan – DHMO with Orthodontia</td>
<td>Dental Plan – DHMO with Orthodontia</td>
<td>P.O. Box 14094 Lexington, KY 40512</td>
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<tr>
<td></td>
<td>Fully Insured Aetna</td>
<td>1-800-435-7324 <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Vision Plan</td>
<td>Vision Plan</td>
<td>Fully Insured UnitedHealthcare</td>
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<td>• High</td>
<td>High</td>
<td>UnitedHealthcare</td>
</tr>
<tr>
<td>• Low</td>
<td>Low</td>
<td>6220 Old Dobbin Lane</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Columbia, MD 21045</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-844-851-7822</td>
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<td></td>
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<td><a href="http://www.myuhcvision.com">www.myuhcvision.com</a></td>
</tr>
<tr>
<td>Benefit Option</td>
<td>Self-funded or Fully Insured</td>
<td>Claims Administrator (self-funded) or Insurance Carrier (fully insured)</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Health Care Spending Accounts</td>
<td>Self-funded</td>
<td>Via Benefits Accounts Reimbursement Center P.O. Box 25172, Lehigh Valley, PA 18002-5172 1-844-877-8588 <a href="http://www.viabenefitsaccounts.com">www.viabenefitsaccounts.com</a></td>
</tr>
<tr>
<td>• Health Care FSA</td>
<td></td>
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<tr>
<td>• Limited Purpose FSA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Cessation Program</td>
<td>Self-funded</td>
<td>Free &amp; Clear®, Inc. <a href="http://www.quitnow.net/ups">www.quitnow.net/ups</a> 1-866-QUIT-4-LIFE (1-866-784-8454)</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Self-funded</td>
<td>Aetna Resources for Living® <a href="http://www.resourcesforliving.com">www.resourcesforliving.com</a> 1-877-374-2779</td>
</tr>
<tr>
<td>Group Term Life Insurance</td>
<td>Fully insured</td>
<td>Securian Life Insurance Company 400 Robert Street St. Paul, MN 55101-2098 1-866-365-3230</td>
</tr>
<tr>
<td>• Basic Term Life Insurance for Employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Basic Term Life Insurance for Dependents</td>
<td></td>
<td></td>
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<tr>
<td>• Supplemental Life Insurance for Employees</td>
<td></td>
<td></td>
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<tr>
<td>• Supplemental Spouse Life Insurance</td>
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<td>• Supplemental Child Life Insurance</td>
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<td>• Employee</td>
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<tr>
<td>• Dependent</td>
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<tr>
<td>Short Term Disability Program</td>
<td>Self-funded</td>
<td>Aetna Disability 1601 SW 80th Terrace Plantation, FL 33324 1-866-825-0186 <a href="http://www.aetnadisability.com">www.aetnadisability.com</a></td>
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<tr>
<td>Long Term Disability Program</td>
<td>Fully Insured</td>
<td>Aetna Disability 1601 SW 80th Terrace Plantation, FL 33324</td>
</tr>
<tr>
<td>Legal Protection Plan</td>
<td>Fully Insured</td>
<td>Hyatt Legal Plans 1111 Superior Avenue Cleveland, OH 44114 1-800-821-6400 <a href="https://www.legalplans.com">https://www.legalplans.com</a></td>
</tr>
<tr>
<td>Benefit Option</td>
<td>Self-funded or Fully Insured</td>
<td>Claims Administrator (self-funded) or Insurance Carrier (fully insured)</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
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<tr>
<td>Dependent Care Flexible Spending Account (Not subject to ERISA)</td>
<td>Self-funded</td>
<td>Via Benefits Accounts Reimbursement Center P.O. Box 25172, Lehigh Valley, PA 18002-5172 1-844-877-8588 <a href="http://www.viabenefitsaccounts.com">www.viabenefitsaccounts.com</a></td>
</tr>
<tr>
<td>Adoption Assistance (Not subject to ERISA)</td>
<td>Self-funded</td>
<td>UPS Adoption Assistance Program United Parcel Service of America, Inc. 55 Glenlake Parkway, NE Atlanta, GA 30328</td>
</tr>
</tbody>
</table>

**Plan Administrator Rights and Obligations**

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 except as otherwise delegated herein. Any such interpretation or decision shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plan’s terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents. The Plan Administrator may delegate certain discretionary authority to one or more persons, entities, and/or committees.

Additional rights and duties of the Plan Administrator also may be set forth in the Plan Document.

**Plan Administration Expenses and Benefits**

Benefits provided by self-funded Benefit Options will be paid first with any available plan assets. If Benefits payable exceed plan assets, the Company may, in its sole discretion, contribute the difference.

The Plan is responsible for payment of all plan administration expenses unless and to the extent responsibility for such expenses is shifted to the Covered Individuals. If the Company pays a plan administration expense for which the Plan is responsible, the Plan will reimburse the Company upon request with any plan assets that may be available.

**The Company’s Right to Amend or Terminate the Plan**

It is UPS’s intent that The Flexible Benefits Plan and its component plans will continue indefinitely. However, the Company reserves the right to amend, modify, suspend, or terminate the plan, in whole or in part, by action of the Company. Any such action would be taken in writing and maintained with the records of the plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the plan to the extent permitted by law.
UPS’s rights include the right to obtain coverage and/or administrative services from additional or different insurance vendors, third-party administrators, etc., at any time, and the right to revise the amount of employee contributions. Employees will be notified of any material modification to the plan. If the plan is terminated, there will not be any plan assets that would need to be distributed.

**Limitation on Assignment**

Except as otherwise set forth in the Benefit Plan Documents, your rights under the plan cannot be assigned, sold or transferred to your creditors or anyone else.

**Your Employment**

The Summary Plan Description does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under The Flexible Benefits Plan or any of the Benefit Options should not be interpreted as an implied or express contract or guarantee of employment. UPS’s employment decisions are made without regard to benefits to which you are entitled upon employment.

**Limitation on Legal Action**

In no event will a claimant or any other person be entitled to challenge a decision of the Plan Administrator or Claims Fiduciary in court or in any other administrative proceeding unless and until the claim and appeal procedures described herein have been complied with and exhausted. In no event may a claimant challenge the Plan Administrator’s or Claim Fiduciary’s decision (including a deemed decision) upon appeal in any court or governmental proceeding after 12 months from the date of the Plan Administrator’s decision (included a deemed decision) of the appeal.

In no event may an employee bring any other claim for relief against the Plan Administrator, the Plan and/or the Company with respect to the Plan in court or in any other administrative proceeding more than 12 months after the claim arose.

**Forum for Legal Action**

All claims in connection with the Plan must be brought in the United States District Court for the Northern District of Georgia.

**Additional Rules that Apply to the Plan**

**HIPAA Privacy Notice**

The Medical Benefit Options, the EAP, the Dental Benefit Options, the Vision Benefit Options, the Medical Supplemental Benefit Options, and the Health Care Flexible Spending Accounts are all subject to HIPAA Privacy rules. The Plan maintains on behalf of these Benefit Options 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 received a copy of the notice when you first enrolled in the plan. The notice also is posted on UPSers.com. If you do not have access to UPSers.com, call the UPS Benefits Resource Center at 1-844-877-8588 to request a copy of the notice.

**Your Rights under ERISA**

The Flexible Benefits 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 under ERISA. ERISA provides that, as a Plan participant, you are entitled to the following provisions.
Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator’s office and at other specified locations such as work sites, 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.
- Obtain, upon written request to the plan administrator, copies of 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 administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue group health coverage for yourself, your spouse/domestic partner or your dependents if there is loss of coverage under the plan as a result of a qualifying event. You (or your dependents) may have to pay for such coverage. Review this Summary Plan Description (this SPD and the vendor-prepared materials listed in the section "For More Information") and the documents governing the component plans for the rules governing your COBRA continuation coverage rights.

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 you and other 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 plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court, but only after you have exhausted the plan’s claims and appeals procedure as described in the claim and appeals sections in the materials prepared by your plan vendor. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. Any action at law or in equity must begin within three years after the denial of any appeal from an initial adverse benefit determination, regardless of any state or federal statutes establishing procedures relating to limitations of actions.
If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and 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 your 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 in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-EBSA (1-866-444-3272), logging on to www.dol.gov or contacting the EBSA field office nearest you.