The UPS Retired Employees’ Health Care Plan
Summary Plan Description

Effective January 1, 2018
About This Summary Plan Description

This Summary Plan Description (SPD) summarizes the main provisions of the The Retired Employees’ Health Care Plan (REHCP or 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 that 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—such as insurance policies issued by insurance carriers that fully insure the Benefit Options (collectively, the Plan Document) that are available to you upon request. The SPD (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 by calling 1-844-877-8588.

UPS is referred 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 by calling 1-844-877-8588.
About Your Participation

This section includes important information about your eligibility for The Retired Employees’ Health Care 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

Who Is Eligible

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

You are eligible to participate in the Plan if you are a full- or part-time union-free employee when you retire from UPS and you satisfy one of the following requirements:

- Be at least age 55, have 10 or more years of vesting service (at least one of which was as a participant in the UPS Retirement Plan);
- Be age 65, have five or more years of vesting service (at least one of which was as a participant in the UPS Retirement Plan); or
- Be a participant in The Flexible Benefits Plan on Long-Term Disability (LTD) who has been administratively terminated from UPS after 12 consecutive months of leave and still on an approved LTD period;
- You are eligible for coverage under the Flexible Benefits Plan at the time you gain eligibility for coverage under REHCP.

“Vesting Service” is defined by the UPS Retirement Plan. Your eligible dependents also may be covered under this Plan. See the Eligible Dependents section below for additional information.

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

- You must have been otherwise eligible for coverage under this Plan (age 55 with 10 or more years of vesting service or age 65 with five years of vesting service); or
- You must have at least one year of vesting service as a participant in the UPS Retirement Plan and worked for UPS at least 25 years.

If you meet either of the above requirements at the time of your death, and your dependents meet the dependent eligibility requirements for coverage under REHCP, they will receive coverage under REHCP in lieu of the Flexible Benefits 13 month extension provided to survivors under the Flexible Benefits Plan. Coverage under REHCP will begin the first day of the month following 30 days from date of death.

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

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

You may enroll your dependents for coverage in the UPS Retired Employees’ Health Care Plan if the dependent is any of the following at the time you retire from UPS:

- Your legal spouse;
- Your child who is under age 19 and financially dependent on you, or up to age 25 if a full-time student and still unmarried and financially dependent on you or;
- Your incapacitated Child who 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 guardian as determined by a court or applicable administrative agency.

**Full-Time Student Eligibility**

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

**Incapacitated Child Eligibility**

A covered child who becomes incapacitated while covered under the Plan before he or she reaches the limiting age identified above (i.e. before age 19 or, if a full-time student, age 25) is eligible to continue coverage after reaching the limiting age 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 reaching the limiting age. 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.

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

Additional eligibility requirements may apply with respect to a Benefit Option. See the Benefit Option sections of this SPD for more information.
When Coverage Starts
The REHCP coverage effective date will begin the first day of the month following your Retirement Date plus 30 days.

For example, if your Retirement Date is October 15,
- Retirement Date plus 30 days = November 14
- Flexible Benefits Plan coverage ends = November 30
- Retired Employees’ Health Care Plan coverage begins = December 1

If you are eligible for the Retired Employees’ Health Care Plan as a result of being on an approved long-term disability (LTD), your coverage effective date will be the first of the month following the end of your coverage under The Flexible Benefits Plan. Your medical, vision, and dental coverage will be extended at no cost to you based on the Benefit Options you had as a participant in The Flexible Benefits Plan for up to 18 months. Following your first 18 months of coverage, you will have the opportunity to make elections in the REHCP Plan.

Initial Enrollment Period
You will have 45 days from your Retirement Date to make your Initial Enrollment elections. Once your Initial Enrollment period ends, you will not be allowed to change your elections unless you experience a qualified Life Event.

If you do not actively enroll during your Initial Enrollment period, you (and your eligible dependents who are covered under The Flexible Benefits Plan at the time of your Initial Enrollment) will receive default coverage according to the table below.

<table>
<thead>
<tr>
<th>Default Coverage at Initial Enrollment</th>
<th>New REHCP Participants (excluding LTD)</th>
<th>REHCP LTD Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td>Lowest cost plan and carrier option, excluding Kaiser</td>
<td>Same plan and carrier option as enrolled under The Flexible Benefits Plan</td>
</tr>
<tr>
<td>Dental Plan</td>
<td>No coverage</td>
<td>Same plan option as enrolled under The Flexible Benefits Plan</td>
</tr>
<tr>
<td>Vision Plan</td>
<td>No coverage</td>
<td>Same plan option as enrolled under The Flexible Benefits Plan</td>
</tr>
</tbody>
</table>

Waiving Coverage
In certain circumstances, you may wish to waive coverage for yourself or your dependents — for instance if you have coverage through a spouse’s employer. You may not waive coverage for yourself and continue coverage for your spouse and dependents. If you waive coverage and want to re-enroll in REHCP, you must provide written proof of continuous other coverage during the time you waived coverage under REHCP or you will not be allowed to reinstate coverage in the future. To reinstate coverage in the future, you must provide written proof of continuous other coverage to the Benefits Resource Center within 60 days from the date of the loss of coverage. Remember, you cannot add dependents to coverage unless they were eligible dependents at the time of retirement. For more information about waiving and reinstating coverage, call the Benefits Resource Center at 1-844-877-8588.
Address Changes
It is important to keep the Benefits Resource Center informed about your current address. To change your address, call the Benefits Resource Center at 1-844-877-8588. It is not necessary to contact your insurance carrier. The Benefits Resource Center will forward your new address to the appropriate insurance companies. (Address changes may affect which network is available to you based on ZIP code). If you maintain two residences, you must change your address each time you move.

Annual Enrollment Period
Each year, UPS will conduct an Annual Enrollment period during which You may make changes to your current Benefit Option elections. 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. If your current Medical Plan Benefit Option is not available, then you will be defaulted into coverage with the lowest cost option excluding all Kaiser options. 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.

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.

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 participant under the health plan. Federal law—ERISA Section 609—provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected retiree 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 must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected retiree 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 applied to your UPS credits or your next bill.

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 QMSCO 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.

**Coverage Provided by the Plan**

**Participants Age 65 and Over**

UPS offers medical coverage to retirees and/or dependents who are age 65 and over and Medicare-eligible through a Retiree Reimbursement Account (RRA). Under the REHCP, you will have an RRA into which you will be credited an amount that you may use for reimbursement of certain insurance premiums and other expenses. The amount contributed to your RRA each year is determined by UPS, which reserves the right to change the details of your RRA at any time. The amount in your RRA is the lesser of your Defined Dollar Benefit (DDB) credits earned in the UPS Retirement Plan or the maximum subsidy set by UPS each year. You will receive an annual RRA notification of the amount credited to your RRA account.

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

UPS provides access to individual Medicare supplemental medical plans through the Aon Retiree Health Exchange. This program allows you to select individually-owned coverage through a Medicare Supplement, Medicare Advantage, and/or a Medicare Prescription Drug plan (known as “eligible Medicare policies”). Enrolling in a plan through the Aon Retiree Health Exchange is optional. You may purchase an individual plan directly from an insurance carrier and still receive reimbursement from your RRA. However, the advisor and advocacy services provided by Aon will not be available to you. Additionally, you will have to file your own claims to receive reimbursement from your RRA. For more information, contact the Aon Retiree Health Exchange at 1-800-505-8515 or visit their Web site at https://retiree.aon.com/ups.

Whichever policy you choose, it is owned by you. UPS does not sponsor or maintain policies on the individual Medicare market.

**Retiree Reimbursement Account**

Your Retiree Reimbursement Account (RRA) can be used for reimbursement of eligible premiums for Medicare Supplement, Medicare Advantage, and/or Medicare Part D prescription drug plan coverage. In addition, your RRA can be used to reimburse you for eligible out-of-pocket medical care expenses, as defined by Internal Code Section 213(d), such as deductibles, coinsurance, and copayments.
Note: Certain insurance premium expenses that otherwise qualify as “medical care” are not eligible for reimbursement, such as dental and/or vision insurance premiums, and premiums for health insurance policies (other than the premium for an eligible Medicare Policy). Also, qualified long-term care expenses are not eligible for reimbursement.

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

**Participants Under Age 65**

The Plan provides a variety of medical, dental, and vision 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.

**Split-Family Coverage**

A covered individual who is under age 65 is still eligible for the benefits provided to those under age 65 even though a covered family member (in other words, the retiree or spouse) has turned age 65 and is no longer eligible for benefits provided to those under age 65. The participant(s) under age 65 will receive new health care ID cards upon eligibility for split-family coverage. The retiree’s eligible credits (if any) will be applied to the RRA for the individual who is age 65 or older and will be used to offset premiums for the coverage under the UPS Plan for the individual who is under age 65. For more information about your credits, contact the Benefits Resource Center at 1-844-877-8588.

**Paying for Coverage**

**Required Contributions**

Depending on the annual cost of providing Plan benefits, you or your dependents may be required to contribute to the cost of coverage (“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. You are not required to enroll in the same coverage you had as an active employee. For retiree coverage, you may enroll in different medical, dental, or vision plans, and you may change your coverage tier.

You can view your monthly contribution amounts for the Benefit Options available to you on the UPS Benefits Resource Center website as well as the amount of credits you will receive, if any, towards the cost of the Plan. As a retired employee, UPS may provide you, and your spouse, a dollar amount of credits toward the cost of coverage. These credits, also called Defined Dollar Benefit or DDB, represent UPS’s commitment to the cost of your benefits. Separate credits are established for you and your spouse. Your dependent children are included in the credits of the youngest covered parent.

Different rules apply to each business unit with respect to earning credits.
If You Are Required to Pay for Coverage

The Plan, through the UPS Benefits Resource Center, will notify you each year of the premium cost of your coverage for the following year and your share of that premium, if any. If the cost of your coverage exceeds the amount of UPS-provided credits, you will be billed directly for the difference in monthly installments by the Benefits Resource Center. You pay for retiree health coverage with after-tax dollars by mailing in a check or using Auto Pay.

The initial invoice will include details on how to enroll in Auto Pay, or pay by check, and information about when payment is due. You can create a Billing Account online by clicking on View My Billing Information link on the home page.

With Auto Pay, your monthly contribution amounts for retiree health coverage are automatically deducted from your designated bank account each month. Here is how it works:

- When you enroll for retiree benefits, you enter your banking information on the UPS Benefits Resource Center website. This enables the electronic funds transfer.
- Once your Auto Pay account is established, your contribution deduction for coverage each month is taken from your designated account on the 4th of each month.
- There are no fees for Auto Pay. You will, however, be charged for overdrafts, if applicable, according to the terms of your bank account.
- If you do not set up Auto Pay now, you can begin Auto Pay at any time in the future by enrolling online or calling the UPS Benefits Resource Center. A representative can help you set up or stop Auto Pay or change your designated bank account.
- If you fail to make timely payments, your coverage will terminate.

When Benefit Option Coverage Ends

Retirees

In general, your UPS Retired Employees’ Health Care Plan coverage continues as long as you meet the Plan’s eligibility requirements. 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 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 any required contributions for that Benefit Option. If you fail to make a required contribution, 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 continue coverage under the Plan as long as they continue to qualify as eligible dependents. See the What If section 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 year in which your dependent Child turns 19 years of age unless he/she is a full-time student. Coverage for dependent Children who are full-time students will end on the last day of the year in which the Child turns 25. 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 any required contributions. The date that your dependent dies.

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

Life Events
Generally, you cannot change your elections during the year unless you experience a life event identified below.

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>Legal</th>
<th>Supplemental Medical (Accident, Critical Illness, Hospital Indemnity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorce; Legal Separation; Annulment</td>
<td>If covered, change family status and coverage option. If opted out, start coverage if lost under spouse’s plan with proof of continuous other coverage.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage if lost under spouse’s plan with proof of continuous other coverage.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage if lost under spouse’s plan with proof of continuous other coverage.</td>
<td>Change family status. Change coverage option.</td>
<td>Change family status. Change coverage option.</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 with proof of continuous other coverage.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage if lost under spouse’s plan with proof of continuous other coverage.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage if lost under spouse’s plan with proof of continuous other coverage.</td>
<td>Change family status. Change coverage option.</td>
<td>Change family status. Change coverage option.</td>
</tr>
<tr>
<td>Death of Child or Loss of Child’s Eligibility</td>
<td>Change in coverage tier</td>
<td>Change in coverage tier</td>
<td>Change in coverage tier</td>
<td>No changes</td>
<td>Change in coverage tier</td>
</tr>
<tr>
<td>Event</td>
<td>Medical</td>
<td>Dental</td>
<td>Vision</td>
<td>Legal</td>
<td>Supplemental Medical (Accident, Critical Illness, Hospital Indemnity)</td>
</tr>
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<td>----------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</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 with proof of other continuous coverage. If now have outside coverage, can opt out.</td>
<td>If covered, change family status and coverage option. If opted out, start coverage with proof of other continuous coverage. If now have outside coverage, can opt out.</td>
<td>Change family status</td>
<td>Start, stop or change coverage</td>
<td>No changes</td>
</tr>
<tr>
<td>Loss of Outside Medical Coverage Eligibility with Other Employment</td>
<td>If opted out, start coverage if lost under spouse’s plan with proof of continuous other coverage.</td>
<td>If opted out, start coverage if lost under spouse’s plan with proof of continuous other coverage.</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 Diffs from Retiree'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>No changes</td>
<td>Start, stop or change coverage</td>
<td>No change for AE at different time. Change family status if spouse gains coverage.</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>
</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>
</tr>
</tbody>
</table>

*In accordance with age-based eligibility for retiree benefit plan options.  
**Must comply with QMCSO requirements in ERISA.

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.

If you die while you’re covered by The Retired Employees’ Health Care Plan, your dependents may continue health care coverage in the Plan as long as they continue to qualify as eligible dependents.
Long-Term Disability Participants
If you die while covered under the REHCP and you were eligible for the Plan due solely to your receipt of long-term disability benefits under The Flexible Benefits Plan, your surviving, covered dependents will be eligible to continue their coverage under COBRA for a maximum period of 36 months. If you were in your 18 month no cost coverage period at the time of your death, your surviving dependents will be eligible to receive coverage under COBRA for no cost for the remainder of the 18 month period. After the remainder of the 18 month period has expired, your surviving dependents must pay the entire COBRA premium. However, if, at the time of your death, you also satisfied the requirements to participate in the Plan as a retiree, then your surviving, covered dependents will continue to be eligible for coverage under the REHCP as if you were participating in the Plan as a retiree and as long as they continue to meet the dependent eligibility requirements as described in the REHCP SPD.

Generally, you cannot add new dependents to coverage unless they were eligible at the time of your retirement, or you became eligible for LTD. In addition, you can defer your UPS coverage if you are eligible for the Plan as an LTD participant or as a retiree if you can show proof of other coverage. Contact the Benefits Resource Center at 1-844-877-8588 for detailed information.

Your Plan Options
As an eligible participant under age 65, 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 for Participants Under Age 65
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 Plan constitutes minimum essential coverage for purposes of the individual mandate applicable to you beginning on January 1, 2015, as required by the Affordable Care Act (ACA). The dental and vision options are not minimum essential coverage.

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 also can find additional information in IRS Publication 969.
**HSA Contributions**

If you open an HSA administered by Optum Bank, you are eligible to make contributions to your HSA. 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 also can 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 also can 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 for Participants Under Age 65**

If you are a participant in a UPS Medical Plan with coverage through Aetna, Anthem, or UnitedHealthcare 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% (or are subject to applicable copay/coinsurance. 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><strong>In-Network Only</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></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><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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>
</tbody>
</table>

**Preventive Drugs**

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.

**Retail Rx**

Patient pays (deductible does not apply):

- Generic $10
- Preferred Brand-Name 30%, $25 min/$75 max
- Non-Preferred Brand-Name 40%, $50 min/$100 max

Patient pays after deductible:

- Generic $10
- Preferred Brand-Name 30%, $25 min/$75 max
- Non-Preferred Brand-Name 40%, $50 min/$100 max

Patient pays after deductible:

- Generic $10
- Preferred Brand-Name 30%, $25 min/$75 max
- Non-Preferred Brand-Name 40%, $50 min/$100 max

**Mail Rx**

Patient pays (deductible does not apply):

- Generic $25
- Preferred Brand-Name 30%, $62.50 min / $187.50 max
- Non-Preferred Brand-Name 40%, $125 min / $250 max

Patient pays after deductible:

- Generic $25
- Preferred Brand-Name 30%, $62.50 min / $187.50 max
- Non-Preferred Brand-Name 40%, $125 min / $250 max

Patient pays after deductible:

- Generic $25
- Preferred Brand-Name 30%, $62.50 min / $187.50 max
- Non-Preferred Brand-Name 40%, $125 min / $250 max

*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**

| **Lifetime maximum benefit** | All medical plan options for retirees under age 65 include a lifetime maximum benefit of $1,000,000 per person. This maximum benefit applies to the combination of medical and prescription drug benefits paid by the plan. |
| **For short-term medications (up to a 30-day supply)** | To view participating in-network retail pharmacies near you, sign in at www.caremark.com, and then Log In, or call Customer Care 1-855-282-8412. |
| **For long-term medications (up to a 90-day supply)** | Visit www.caremark.com, 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. |
| **If you choose a brand-name drug that has an available generic equivalent** | 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. |
| **Specialty Drugs** | 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. |
| **To access CVS Caremark from your mobile device** | To view participating in-network retail pharmacies near you, sign in at www.caremark.com, and then log in or call Customer Care 1-855-282-8412. |

**Your 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.

**Lifetime Benefit Maximum**
There is a combined lifetime benefit maximum for your medical and prescription drug coverage. The lifetime limit for all plans is $1,000,000 per person based on the combined benefits paid by the plan.

**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%
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 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 Prior Authorization section 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 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, 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 newly diagnosed individuals to 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 a UPS 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 UPS Retired Employees’ Health Care 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 Retired Employees’ Health Care Plan offers you a choice of two vision plan options. The Plan options are entitled 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 UnitedHealthcare 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.

**Quit For Life® Tobacco Cessation Program**

Quit For Life® is available to all retirees who otherwise satisfy the eligibility requirements for The Retired Employees’ Health Care Plan. Individuals who otherwise satisfy the requirements to be a dependent age 18 or older also are 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.

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

**Supplemental Insurance Plans**
You are eligible to participate in supplemental insurance offered through Allstate. The following supplemental medical plans are available on a voluntary basis to retirees in The Retired Employees’ Health Care Plan and their eligible dependents. You may enroll in the supplemental medical insurance plans at initial enrollment or during Annual Enrollment periods. Payment for coverage is made through direct billing from Allstate.

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.

**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 non-medical 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 booklet 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 Retired Employees’ Health Care Plan. You may enroll in the supplemental Hyatt Legal Plan benefit at Initial Enrollment, during Annual Enrollment periods, 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 non-participating attorney, you are reimbursed for covered legal services up to a scheduled maximum amount. You will 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 utilize the plan, if you use a Hyatt network attorney, your cost of coverage 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 are thinking about enrolling, visit the 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 retiree 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 Thursday from 8 a.m. to 7 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 coverage is made through direct billing from Hyatt Legal.

**Benefit Termination**
Generally, your coverage under this benefit ends when you cease to be eligible for The Retired Employees’ Health Care Plan. However, you have the option to continue coverage through an individual policy. See Portability below.
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.

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 options. 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 Continuing Your Health Care Flexible Spending Account under COBRA section 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. 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
Eligibility for COBRA is triggered by a “qualifying event.” The following table describes the types of qualifying events and the maximum length of coverage available for each event. The maximum coverage period is measured from the date of the qualifying event, except as otherwise stated in this SPD. If you decide to continue coverage, you must pay the full cost of that coverage, plus a two percent administrative cost. The monthly premium amount will be provided to you at the time a qualifying event occurs. The initial premium must be paid within 45 days of your enrollment date (no grace period). Subsequent premiums are due on the first of each month. Failure to make subsequent payments within 30 days of the due date will cause your coverage to terminate retroactive to the end of the last month for which full payment was received.
### Qualifying Event

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Continuation of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your dependent Spouse</td>
<td>Your dependent Child</td>
</tr>
<tr>
<td>You become divorced or legally separated</td>
<td>36 months</td>
</tr>
<tr>
<td>Your child ceases to be a qualified dependent</td>
<td>N/A</td>
</tr>
<tr>
<td>Death of LTD Participant (eligible only as LTD Participant)</td>
<td>36 months</td>
</tr>
</tbody>
</table>

### Giving Notice That a COBRA 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. You must notify the COBRA Service Center within 60 days after the date of qualifying. 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. Qualified beneficiaries also may change their coverage elections during the Annual Enrollment periods.

### Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of group health coverage. When the qualifying event is your divorce or legal separation, COBRA continuation coverage for the retiree’s spouse and/or dependent children lasts for up to a total of 36 months from the date of the qualifying event or loss of coverage.

Also, the retiree’s 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. When your qualifying event is the death of an LTD Participant covered under the plan (and the LTD participant was ONLY eligible as an LTD Participant), then the covered spouse and covered children are entitled to elect up to 36 months of continuation coverage.

### Electing COBRA Continuation Coverage

You and/or your covered spouse/domestic partner 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 retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.
**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 COBRA continuation coverage period ends;
- 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;
- 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).

**If You Have Questions**
Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the 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

**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 the 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 &quot;Prescription Drug Section of this SPD for details</td>
</tr>
<tr>
<td>RRA</td>
<td>See the Benefit Plan Documents for details</td>
<td>See the Benefit Plan Documents for details</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
- Medical expense reimbursements under the RRA

**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* 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*. 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* 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**
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 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.

**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>RRA</td>
<td>Aetna Claims Department P.O. Box 4000 Richmond, KY 40476-4000</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

## Claims and Appeals Procedures

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Initial Claims</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You’ll be notified of determination as soon as possible, but no later than...</strong></td>
<td><strong>Extension allowed for circumstances beyond claims administrator’s control...</strong></td>
<td><strong>If additional information is needed, you must provide within...</strong></td>
<td><strong>You must file your appeal within...</strong></td>
</tr>
<tr>
<td>CVS/caremark Administered Prescription Drug Claims</td>
<td></td>
<td></td>
<td></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>
<tr>
<td>Concurrent: To deny your request to extend treatment</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>
</tbody>
</table>

**Note:** Additional information may be needed within specific timeframes. If extension allowed for circumstances beyond claims administrator’s control, you must file your appeal within 15 days from receipt of appeal.
Claims and Appeals Procedures

<table>
<thead>
<tr>
<th></th>
<th>Initial Claims</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Service</td>
<td>30 days</td>
<td>One extension</td>
<td>180 days</td>
</tr>
<tr>
<td></td>
<td>from receipt</td>
<td>of 15 days</td>
<td>of claim</td>
</tr>
<tr>
<td></td>
<td>of claim</td>
<td>45 days of</td>
<td>denial</td>
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<td></td>
<td></td>
<td>date of claim</td>
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<td></td>
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<td>extension</td>
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<td></td>
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<td>notice</td>
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<td></td>
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<td>180 days</td>
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<td></td>
<td></td>
<td>of claim denial</td>
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<td></td>
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<td>30 days from</td>
<td>60 days of 1st</td>
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<td></td>
<td>receipt of appeal</td>
<td>Level Appeal</td>
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<tr>
<td></td>
<td></td>
<td>30 days from</td>
<td>denial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>receipt of appeal</td>
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</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.

- **Urgent Care Claims.** A Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:
  - Seriously jeopardize the life of the claimant (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant's medical condition); or
  - Subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition).

**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. 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 group health plan benefits (e.g. Medical Plan, Dental, Vision);
– 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;
  ▪ 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 Retired Employees’ Health Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Number</td>
<td>001</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 through December 31</td>
</tr>
<tr>
<td>Plan Sponsor</td>
<td>United Parcel Service of America, Inc.</td>
</tr>
<tr>
<td></td>
<td>55 Glenlake Parkway, NE</td>
</tr>
<tr>
<td></td>
<td>Atlanta, GA 30328</td>
</tr>
<tr>
<td></td>
<td>1-800-UPS-1508</td>
</tr>
<tr>
<td>Plan Administrator</td>
<td>Administrative Committee of the UPS Retirement Plan</td>
</tr>
<tr>
<td></td>
<td>United Parcel Service of America, Inc.</td>
</tr>
<tr>
<td></td>
<td>55 Glenlake Parkway, NE</td>
</tr>
<tr>
<td></td>
<td>Atlanta, GA 30328</td>
</tr>
<tr>
<td></td>
<td>1-800-UPS-1508</td>
</tr>
<tr>
<td>COBRA Administrator for the following Benefit Options:</td>
<td>COBRA Service Center</td>
</tr>
<tr>
<td>• Medical Benefit Options</td>
<td>P.O. Box 1185</td>
</tr>
<tr>
<td>• Dental Benefit Options</td>
<td>Pittsburgh, PA 15230</td>
</tr>
<tr>
<td>• Vision Benefit Options</td>
<td>1-877-29 COBRA (292-6272)</td>
</tr>
<tr>
<td></td>
<td><a href="https://cobra.ehr.com">https://cobra.ehr.com</a></td>
</tr>
<tr>
<td>See the Continuation of Coverage section of this SPD for more information regarding COBRA continuation coverage</td>
<td></td>
</tr>
<tr>
<td>Employer Identification Number</td>
<td>95-1732075</td>
</tr>
</tbody>
</table>
**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>Self-funded</td>
<td>Aetna P.O. Box 981106 El Paso, TX 79998-1106 1-800-435-7324 <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anthem BCBS P.O. Box 105187 Atlanta, GA, 30348-5187 1-855-804-2073 <a href="http://www.anthem.com">www.anthem.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>UnitedHealthcare Services, Inc. P.O. Box 30555 Salt Lake City, UT 84130-0555 1-844-333-2618 <a href="http://www.myuhc.com">www.myuhc.com</a></td>
</tr>
<tr>
<td></td>
<td>Fully Insured</td>
<td>CVS/caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136 1-855-282-8412 <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></td>
<td>$500 Deductible Plan</td>
<td>For Northern California: Kaiser Permanente Northern California 1950 Franklin Street Oakland, CA 94612 1-800-464-4000</td>
</tr>
<tr>
<td></td>
<td>$1,500 Deductible Plan with HSA</td>
<td>For Southern California: Kaiser Permanente Southern California 393 East Walnut Street Pasadena, CA 91188 1-800-464-4000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For Colorado: Kaiser Permanente Colorado 10350 E. Dakota Avenue Denver, CO 80247 1-800-632-9700</td>
</tr>
<tr>
<td>Benefit Option</td>
<td>Self-funded or Fully Insured</td>
<td>Claims Administrator (self-funded) or Insurance Carriers (fully insured)</td>
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<tr>
<td></td>
<td></td>
<td>For Georgia:</td>
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<td></td>
<td></td>
<td>Kaiser Permanente Georgia</td>
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<tr>
<td></td>
<td></td>
<td>Nine Piedmont Center</td>
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<tr>
<td></td>
<td></td>
<td>3495 Piedmont Road, NE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Atlanta, GA 30305</td>
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<tr>
<td></td>
<td></td>
<td>1-888-865-5813</td>
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<tr>
<td></td>
<td></td>
<td>For MidAtlantic States:</td>
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<tr>
<td></td>
<td></td>
<td>Kaiser Permanente Mid-Atlantic States</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2101 East Jefferson Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rockville, MD 20852</td>
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<tr>
<td></td>
<td></td>
<td>1-800-777-7902</td>
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<tr>
<td></td>
<td></td>
<td>For Northwest:</td>
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<tr>
<td></td>
<td></td>
<td>Kaiser Permanente Northwest</td>
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<tr>
<td></td>
<td></td>
<td>500 N.E. Multnomah Street, Suite 100</td>
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<tr>
<td></td>
<td></td>
<td>Portland, OR 97232</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-813-2000</td>
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<td></td>
<td></td>
<td>For Hawaii:</td>
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<tr>
<td></td>
<td></td>
<td>Kaiser Permanente</td>
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<tr>
<td></td>
<td></td>
<td>Appeals Department</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2828 Pa'a Street, Suite 3080</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Honolulu, HI 96819</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-808-432-7535</td>
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<tr>
<td>Dental Plan</td>
<td>Self-funded</td>
<td>Aetna</td>
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<tr>
<td>$2,500 Max Plan with</td>
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<td>P.O. Box 14094</td>
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<tr>
<td>Orthodontia</td>
<td></td>
<td>Lexington, KY 40512</td>
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<tr>
<td>$1,500 Max Plan with</td>
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<td>1-800-435-7324</td>
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<tr>
<td>Orthodontia</td>
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<td><a href="http://www.aetna.com">www.aetna.com</a></td>
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<tr>
<td>Dental Plan – DHMO with</td>
<td>Fully Insured</td>
<td>Aetna</td>
</tr>
<tr>
<td>Orthodontia</td>
<td></td>
<td>P.O. Box 14094</td>
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<tr>
<td></td>
<td></td>
<td>Lexington, KY 40512</td>
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<tr>
<td></td>
<td></td>
<td>1-800-435-7324</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Vision Plan</td>
<td>Fully Insured</td>
<td>UnitedHealthcare</td>
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<tr>
<td>High</td>
<td></td>
<td>6220 Old Dobbin Lane</td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td>Columbia, MD 21045</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-844-851-7822</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.myuhcvision.com">www.myuhcvision.com</a></td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>Self-funded</td>
<td>Free &amp; Clear®, Inc.</td>
</tr>
<tr>
<td>Program</td>
<td></td>
<td><a href="http://www.quitnow.net/ups">www.quitnow.net/ups</a></td>
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<tr>
<td></td>
<td></td>
<td>1-866-QUIT-4-LIFE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1-866-784-8454)</td>
</tr>
<tr>
<td>Legal Protection Plan</td>
<td>Fully Insured</td>
<td>Hyatt Legal Plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1111 Superior Avenue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cleveland, OH 44114</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1-800-821-6400</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://www.legalplans.com">https://www.legalplans.com</a></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 may also 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 Retired Employees’ Health Care 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 retiree contributions. Retirees 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.

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 or Claims Fiduciary’s decision (including 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.
Additional Rules that Apply to the Plan

HIPAA Privacy Notice
The Medical Benefit Options, the Dental Benefit Options, the Vision Benefit Options, and the Medical Supplemental Benefit Options 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 Retired Employees’ Health Care Plan is an employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA). As a participant in the Plan, you have certain rights and protection 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](http://www.dol.gov) or contacting the EBSA field office nearest you.