UPS Health and Welfare Package

For Retired Employees — IBT

Summary Plan Description

Summary of Material Modifications

UPS Health and Welfare Package for Retired Employees IBT/IAM
September 2019

This notice details plan improvements, changes, clarifications and required notifications effective January 1, 2020, unless otherwise noted below. You should keep this with your UPS Health and Welfare Package for Retired Employees IBT/IAM Summary Plan Description (SPD) for reference. The terms of the plan are not changing and remain in full force and effect, except as specifically described in this summary.

Appeals Management

The following provides a change to existing Plan language regarding the address to which eligibility claims and second level appeals are submitted. All other provisions of the *Appeals Procedures* section remain unchanged.

Eligibility Claims Claim and Appeals Management P.O. Box 7105 Rantoul, IL 61866-7105
Second Level Appeals Claim Appeal Fiduciary Services Attn: UPS Appeals 2475 Northwinds Parkway, Suite 200 Alpharetta, GA 30009 Fax number: 404-452-6824

HIPAA Privacy Notice

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

If you are a former employee or dependent of a former employee, you can request a copy of the notice by calling the UPS Benefits Service Center at 1-800-UPS-1508.

This notice is intended to fulfill UPS's legal obligation to notify employees of material changes to the UPS Health and Welfare Package for Retired Employees IBT/IAM Plan. This notice formally amends the coverage available under the plan.

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Behavioral Health Claims

The following provides a change to existing Plan language regarding the address to which behavioral health claims are submitted. All other provisions of the Claims section remain unchanged.

Claims Beacon Health Options P.O. Box 1850 Hicksville, NY 11802-1850
Appeals Beacon Health Options P.O. Box 1851 Hicksville, NY 11802 – 1851

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Solutions - Your EAP and Work/Life Benefits

Effective January 1, 2018, Aetna's Resources For Living® (RFL) will replace Beacon Health Options as the Employee Assistance Program's administrator. Starting January 1, 2018, you may contact RFL by calling 1-877-374-2779, or you can visit www.resourcesforliving.com. Username enter UPS and Password enter RFL.

Effective January 1, 2018 your Mental Health and Substance Use Disorder benefits will be provided through the medical vendor that you select during Annual Enrollment. Beacon Health Services will no longer provide these services effective January 1.

Life Insurance

The following are changes that are being made to your Basic and Supplemental Life Insurance coverage under the Life Insurance and AD&D Plan. All other provisions of the Life Insurance and AD&D Plan remain unchanged.

Life Insurance and AD&D

Effective January 1, 2018, Securian Life Insurance, a Securian Financial Group affiliate, will replace the Prudential Insurance Company of America as the new life insurance and AD&D benefits administrator and insurer for The Flexible Benefits Plan. All benefits insured by Securian will be provided in accordance with insurance documents provided by Securian.

Under the new plan you will make elections in multiples of your base annual salary, as opposed to the current $1,000 increments. All of your current coverage amounts, for you and your dependents, will be transitioned to Securian without changing the amount. If you wish to increase or decrease your coverage in the future you will be required to select an amount that fits within the new Securian plan design. If you currently have more coverage than the new plan allows, you may keep the coverage, however, if you decrease your coverage, you will not be allowed to return to your old coverage amount.

Special Enrollment Opportunity

With the transition to Securian, you will have a one-time opportunity to elect guaranteed coverage, meaning no health questions asked. What guaranteed coverage is available?

During this fall's enrollment period, you may elect the following guaranteed coverage for supplemental life insurance: the lesser of 2X your base annual salary or $250,000 as long as the resulting total does not exceed 5X your base annual earnings or $500,000. This offer is available to you if you're currently enrolled in life coverage or enrolling for the first time.

If you decide to take advantage of this opportunity, your current coverage will be round to the next salary multiple. For example:

- If your annual salary is $80,000 and your current coverage is $100,000 you will be rounded up to 2X salary ($160,000). Then, you may elect an additional 2X Salary ($160,000) on a guarantee issue basis for a total of 4X salary ($320,000)
- If your annual salary is $80,000 and your current coverage is $50,000 you

will be rounded up to 1X salary ($80,000). Then, you may elect an additional 2X Salary ($160,000) on a guarantee issue basis for a total of 3X salary ($240,000)

- If your annual salary is $80,000 and you currently have $350,000 in coverage you will be rounded up to 5X salary ($400,000) any additional elections will require evidence of insurability (EOI)
- If your annual salary is $125,000 and your current coverage is $300,000 you will be rounded up to have 3X salary ($375,000) you may elect an additional 1X Salary ($125,000) on a guarantee issue basis for a total of 4X salary ($500,000)

Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Coverage
Effective January 1, 2018, the Company provided basic life insurance and AD&D coverage for all employees is equal to 1 times your annual base salary, with a maximum benefit of $1 million, and will be subject to an aged based reduction as follows:

- The value of your basic life insurance coverage will be reduced by 35% when you attain age 65.
- The value of your basic life insurance coverage will be reduced by an additional 50% when you attain age 70.

So for example, if you have $50,000 in basic life insurance, it will be reduced to $32,500 when you attain age 65, and to $16,250 when you attain age 70.

Supplemental Life Insurance
Effective January 1, 2018, if you want more insurance for yourself than your basic coverage, you can purchase supplemental term life insurance in multiples of your base annual salary from 1 to 8 times your base annual salary, with a maximum benefit of $2 million. Any employee that has more than 8 times their base annual salary in supplemental life insurance coverage as of December 31, 2017 will be permitted to keep the higher coverage amount, but they may not increase their supplemental life insurance coverage above the amount in effect on December 31, 2017.

Spouse's Supplemental Life Insurance
You may purchase supplemental term life insurance for your spouse in $25,000 increments up to the combined amount of the employee's insurance coverage (basic and supplemental), with a maximum benefit of $250,000. A spouse that has more than the maximum amount of supplemental life insurance coverage described above as of December 31, 2017, will be will be permitted to keep the higher coverage amount, but cannot increase the spouse supplemental life insurance coverage above the amount in effect on December 31, 2017.

Children's Supplemental Life Insurance
Supplemental child life insurance will now be available in amounts of $10,000, $20,000, or $30,000.

Supplemental AD&D Coverage
Effective January 1, 2018, you can purchase supplemental AD&D insurance in multiples of your base annual salary from 1 to 8 times your base annual salary, with a maximum benefit of $2 million. Any employee that has more than 8 times their base annual salary in supplemental life insurance coverage as of December 31, 2017 will be permitted to keep the higher coverage amount, but they may not increase their supplemental AD&D insurance coverage above the amount in effect on December 31, 2017.

New Guarantee Issue Guidelines
The following opportunities exist to elect coverage without Evidence of Insurability (EOI).

Supplemental Employee Term Life

- Within 45 days of initial eligibility you may elect up to the lesser of 4X base annual earnings or $500,000.

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Spouse Term Life

- Within 45 days of employee's initial eligibility or 60 days for marriage you may elect up to $50,000.

Any elections outside of these time periods or above these amounts will require EOI.

HIPAA Privacy Notice

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Non-Discrimination Language

UPS, as plan sponsor of the Health and Welfare Package for Retired Employees-IBT/IAM (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex with respect to the Plan. UPS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. UPS also:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator at:
Civil Rights Coordinator
c/o Corporate Compliance
55 Glenlake Pkwy
Atlanta, GA 30328
404-828-6000

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If you believe that UPS has failed to provide these services or discriminated against you, you can file a grievance with the Coordinator. You can file a grievance in person or by mail. You also can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil available at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW.,
Room 509F, HHH Building, Washington, DC 20201,
1–800–868–1019, 800–537–7697 (TDD).
File complaint electronically at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-UPS-1508	注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電1-800-UPS-1508	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-UPS-1508
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-UPS-1508	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-UPS-1508	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-UPS-1508
مقرب لصتا .ناجملاب كل رفاوتت 1-800-UPS-1508 ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ :ةظوحلم	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-UPS-1508	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-UPS-1508
UWAGA: Jezeli mówisz po polsku, mozesz skorzystac z bezplatnej pomocy jezykowej. Zadzwon pod Numer 1-800-UPS-1508	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-UPS-1508	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-UPS-1508
注意事項:日本語を話される場合、無料の言語支援をご利用いただけます1-800-UPS-1508	امش یارب ناگیار تروصب ینابز تلایهست توجه: اگر به زبان فارسی گفتگو می کنید، 1-800-UPS-1508 تماس بگیرید.	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-UPS-1508

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Transgender Benefits

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

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c/o Corporate Compliance
55 Glenlake Pkwy
Atlanta, GA 30328
404-828-6000

If you believe that UPS has failed to provide these services or discriminated against you, you can file a grievance with the Coordinator. You can file a grievance in person or by mail. You also can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil available at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW.,
Room 509F, HHH Building, Washington, DC 20201,
1–800–868–1019, 800–537–7697 (TDD).
File complaint electronically at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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September 2014

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Eligibility

As of January 1, 2015, this plan will also cover IAM bargaining unit retirees of UPS and retirees who were represented by other non-IBT union organization(s), and the name of this schedule will be amended to the UPS Health and Welfare Package for Retired Employees–IBT/IAM.

Eligible Dependents

As clarification of current plan administration, your legal spouse as defined by the IRS, same-sex domestic partner or civil union partner are eligible for coverage only if he/she was your spouse, same-sex domestic partner or civil union partner on the date of your retirement from UPS.

Minimum Essential Coverage

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

Privacy Notice

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

Application of the Affordable Care Act and Other Federal Laws

As noted in the September 2010 SMM, this Plan is not subject to any of the health care reforms added by the Affordable Care Act to Section 27 of the Public Health Service Act (and also ERISA and the Internal Revenue Code). For purposes of clarification, those reforms include but are not limited to the following:

- Prohibitions against annual and lifetime dollar limits on essential health benefits;
- Coverage for dependent children up to age 26
- Coverage for otherwise covered expenses incurred in connection with an approved clinical trial;
- External claim review requirements;
- No cost coverage for recommended preventive care services.

In addition, this Plan is not subject to the following laws:

- The Mental Health Parity and Addiction Equity Act
- The Women's Health and Cancer Rights Act
- HIPAA's portability and non-discrimination requirements (other than the Genetic Information Nondiscrimination requirements).

If you have any questions about the impact of the Affordable Care Act on this plan, please contact the plan administrator identified in your SPD.

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UPS Health and Welfare Package for Retired Employees – IBT

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Overview of the Plan

Concern for the security and well-being of you and your family is the cornerstone of our benefits philosophy. We regard our benefits expenditures as an investment in your health and security. This book describes provisions of the UPS Health and Welfare Package for Retired Employees – IBT (for eligible retired employees). The Plan is designed to ensure that you receive value for the benefit dollars spent.

You have one medical option that has in-network and out-of-network benefits. The Traditional Out-of-Area Program is available if you live outside the boundaries of the medical network.

Comprehensive benefits include:

- Medical, including prescription drug and behavioral health benefits
- Dental
- Vision

How the Plan Works

You can change your benefit choices each year during the annual enrollment period, usually in the fall. The benefits you select at that time will be effective for the following calendar year. The only time that you can change your benefits elections during the year is if you have a family status change, such as marriage, divorce, birth of a baby or adoption. See the *Life Events* section for more information on status changes.

Levels of Coverage

When you enroll for medical coverage, you'll be asked to choose one of the following levels of coverage:

- You only
- You plus family (spouse and/or children)

Eligibility

As a retired IBT bargaining unit employee of UPS, you're eligible to participate in the UPS Health and Welfare Package for Retired Employees – IBT per the terms of your collectively bargained agreement. You may also have a Summary Plan Description (SPD) insert that describes additional details of your group's coverage. Keep your insert with this booklet for reference.

Eligible Dependents

It's important that you know exactly what "dependent" means. The term has the same meaning for all coverage described in this book.

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

- Your legal spouse as defined by the Internal Revenue Service
- Your same-sex domestic partner or civil union partner
- An unmarried child who is:
  - A natural child; an adopted child (or a child placed for adoption); a stepchild living with you at least half of the time; a stepchild who is a full-time student away from home, provided that the stepchild lived with you at least one half of the time in the year immediately prior to the year
  - The stepchild became a full-time student away from home; or a child living with you for whom you are a court-appointed legal guardian or custodian, and

– Under age 19 and financially dependent on you, or up to age 25 if a full-time student and still financially dependent on you; or an incapacitated child

Proof of Dependent Status

The Plan Administrator may periodically request proof of dependent status. Failure to provide proof may result in termination of dependent coverage. In addition, you may be required to provide certain information deemed necessary by the Plan Administrator as a condition of eligibility for you and/or you dependents. For example, you must provide a Social Security number (SSN) to the UPS Benefits Service Center for each dependent you wish to enroll in the Plan to satisfy federal reporting requirements. This condition allows UPS to comply with a law requiring health plan administrators to electronically report data for covered plan participants to the Centers for Medicare and Medicaid Services (CMS).

Spouses, same-sex domestic partners and/or civil union partners are not eligible to begin coverage until an SSN has been provided as part of enrollment. Coverage for dependent children will begin upon enrollment. However, if a child's SSN is not received by the due date indicated on the enrollment form, coverage for the child will be terminated retroactive to the date coverage began.

If you fail to provide the requested information or proof, coverage may be terminated or delayed for you and/or your dependents, and you may be required to reimburse the Plan for any expenses for which benefits were paid on behalf of an otherwise ineligible dependent. See the *Right of Recovery Provision* section of this SPD for more information on the Plan's right to reimbursement.

Placed for Adoption

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

Full-Time Student

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

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

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

Incapacitated Children

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

The child must have a mental or physical incapacitation that renders the child unable to care for him- or herself, as determined by the claims administrator. For this purpose, the incapacitation must be verified before coverage can be continued. In addition, periodic medical documentation of the continuing incapacitation is required as determined by the claims administrator. Your incapacitated dependents' coverage can continue as long as you or your spouse or partner remain eligible for the Plan and your dependents meet the eligibility requirements. If you or your spouse or partner are no longer eligible for

the Plan, your dependent can only continue coverage until the normal limiting age, the end of the calendar year in which they turn age 25.

When Spouses or Children Are UPSers

If you and your spouse or child both worked for UPS and are both eligible for the UPS Health and Welfare Package for Retired Employees – IBT, the following conditions apply:

- Each of you may elect retiree coverage under the Plan. Only one spouse may elect coverage for your eligible children.
- Each of you can be covered only once; you may not be covered as both a retiree and a spouse or child of a retiree. You may elect coverage for your spouse or child as your dependent and your spouse or child may elect no coverage. Your spouse or child should then be listed as a dependent whom you want to cover.

If you are eligible for the UPS Health and Welfare Package for Retired Employees – IBT and your spouse or child is covered by another UPS-sponsored plan (for example, The Flexible Benefits Plan, or a multi-employer health care plan to which UPS contributes), you have the following options:

- You may elect any available family level of coverage option (you only or you plus family) in the UPS Health and Welfare Package for Retired Employees – IBT.
- You may enroll your spouse or child in the UPS Health and Welfare Package for Retired Employees – IBT and your spouse or child can continue coverage through the multi-employer plan; UPS will continue to contribute to that plan on your spouse's or child's behalf.
- You may elect not to participate in the UPS Health and Welfare Package for Retired Employees – IBT. Your coverage may be provided by your spouse's or child's plan based on that plan's eligibility provisions. (Parents are not covered by most health care plans.)

Refer to the *Maintenance of Benefits* section of this booklet for information about how the Plan pays benefits when you have coverage from two plans.

QMCSO

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

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

If you wish to submit a medical child support order, or you wish to request a copy of the Plan's policies and procedures for determining whether such order is "qualified" in accordance with ERISA, the address is as follows:

UPS Benefits Service Center
Attention: Qualified Order Team
PO Box 1542
Lincolnshire IL 60069-1542

When Coverage Ends

In general, your coverage continues as long as you meet the Plan's eligibility requirements. Coverage ends when you become eligible for Medicare (except as a result of a disability, see below).

You become eligible for Medicare at the beginning of the month in which you reach age 65 unless your birthday falls on the first day of the month, in which case you're eligible for Medicare at the beginning of the month prior to your birthday.

Your dependents coverage will continue as long as you or your eligible spouse or partner remain eligible for the Plan and your dependents meet the eligibility requirements.

Coverage for your spouse ends at the earlier of either your divorce or legal separation or your spouse becoming eligible for Medicare, except as a result of a disability. (See *Disability in Retirement* below.)

Your children's (and eligible stepchildren's) eligibility for coverage ends on December 31 of the calendar year in which they reach age 19 (or age 25 if full-time students). You must certify your child's student status each year during annual enrollment or he or she will lose coverage for the following year. If your child graduates from or leaves school before the age limit is reached, coverage continues through December 31 of the year in which he or she graduates or leaves school; or until he or she becomes covered through another plan, if earlier. If your dependent loses eligibility for any other reason, for example marriage, coverage ends on the date of the event.

If you or your spouse or partner ceases to be eligible prior to your dependent children, your dependent children can continue coverage only through the limiting age of 19, or if a full-time student, age 25.

If you divorce or become legally separated, your spouse's health care coverage may be continued under COBRA provisions. If your children reach the age limit or are otherwise no longer eligible for coverage from this Plan, their health care coverage may be continued under the Plan's COBRA provisions. (Please see the *Continuation of Coverage Under COBRA* section for more information).

UPS reserves the right to amend or terminate the Plan at any time.

If You Die

Your eligible spouse and dependents continue coverage for as long as they remain eligible and make required payments. (See *When Coverage Ends* section for coverage end dates.)

Disability in Retirement

For a disabled individual entitled to Medicare as a result of a disability, the Plan will continue to provide coverage, supplemental to Medicare (in other words, Medicare is primary), until the individual reaches his or her normal coverage end date (see *When Coverage Ends* above). You must notify the Benefits Service Center immediately after becoming Medicare eligible as a result of a disability.

Contribution

All retired employees are responsible for a monthly contribution toward their medical coverage. The contribution amount differs depending on the level of coverage you choose: coverage for yourself ("You Only"), or for you and your spouse and/or any eligible dependents ("You + Family"). The monthly rates for each calendar year is shown in the table below:

	2014	*2015*	*2016*	*2017*	*2018*
You Only	$50	$100	$150	$150	$150
You + Family	$100	$200	$300	$300	$300

Enrollment

Annual enrollment happens every year during the fall. You can choose to keep coverage or waive coverage each year during the annual enrollment period. Dental and vision are automatic features if you elect medical coverage.

If you choose to waive coverage, you must verbally certify by phone to the Benefits Service Center that you're waiving coverage under the Plan because you have other coverage available.

Before you are able to later reinstate coverage in the Plan, you must provide the following:

- Proof of other coverage within 60 days of losing other coverage
- Copy of HIPAA Certificate from other plan, or
- Confirmation of Coverage or Coverage Termination notice from other plan, or
- Letter on company letterhead documenting termination of other coverage

At future annual enrollments, if you do not make new benefits elections, you'll receive the same coverage for yourself and your dependents that you currently have; except in the following situation: If your dependent child is a full-time student age 19 or older, you must certify full-time student status each year during annual enrollment to maintain the child's coverage. If you do not certify student status, your child's coverage will end on December 31 of the current Plan year.

If your child's coverage ends 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 (not retroactively to January 1). In this situation, you must call the UPS Benefits Service Center within 60 days of the return-to-school date in order to add your dependent to your coverage.

Opting Into the Network

If you live outside the network area, you will receive out-of-area benefits. However, if you feel the providers in the network are convenient to you, you may elect to participate in the network. For details, see *A Guide to Network-Based Health Care* in the *Medical Benefits* section of this booklet.

Life Events

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

You are allowed to change certain benefit elections during the year depending on the type of change in your family status that occurs — as long as the change in selection is consistent with the change in status. As a general rule, you will be allowed to make coverage changes only if the event results in you, your spouse, or your dependents gaining or losing coverage eligibility under an employer-sponsored plan. For example, if you have a baby, you can change your level of medical coverage from you only to you plus family.

If you experience any of the following events, you may choose to waive medical, dental and vision coverage under the Plan in addition to other changes you are permitted to make as indicated in the *Allowable Coverage Changes* chart:

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

Additionally, you can choose to waive coverage if a life event occurs. If you choose to waive coverage, you must verbally certify by phone to the Benefits Service Center that you're waiving coverage under the Plan because you have other coverage available.

Before you are able to later reinstate coverage in the Plan, you must provide the following:

- Proof of other coverage within 60 days of losing other coverage
- Copy of HIPAA Certificate from other plan, or
- Confirmation of Coverage or Coverage Termination notice from other plan, or
- Letter on company letterhead documenting termination of other coverage

60-Day Time Limit

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

Effective Date of Revised Coverage

Revised coverage is effective retroactive to the date of the event.

Allowable Coverage Changes

Only the changes listed are allowed.

Event	*Medical, Dental and Vision*
Marriage	Start dependent coverage
Divorce; legal separation; annulment	Start or stop dependent coverage
Birth; adoption or placement for adoption; child gain eligibility	Start dependent coverage
Death of spouse	Start or stop dependent coverage
Death of child; loss of child's eligibility; termination of Adoption Proceedings	Stop dependent coverage
Loss of outside medical coverage eligibility with other employment	Start dependent coverage
Change in spouse's employment or coverage; open enrollment period differs from employee's	Start or stop dependent coverage
Court-ordered coverage for child*	As dictated by court order
Gain or loss of eligibility from Medicaid	If covered, change family status. If opted out, start coverage. If now have outside coverage, can opt-out.

**Must comply with QMCSO*

Summary of Benefits

The tables on these pages represent a summary of the actual benefits described in your Summary Plan Description (SPD). All benefits are subject to additional Plan limits, such as medical necessity determination by the claims administrator, as described in the specific sections of the SPD. If this summary conflicts with the specific sections of the SPD, the specific sections of the SPD control. You should contact the claims administrator with any questions prior to services being received or obtained.

Medical Benefits

Your medical benefits are administered by Aetna. You can choose to see any provider you wish, but the highest benefit from the Plan will be received when you use in-network providers for your care. If you live outside of Aetna's network area, then you will receive out-of-area benefits. If you have any questions about providers or covered services, please contact Aetna's Concierge Member Services at 1-800-435-7324.

	In-Network	***Out-of-Network****	***Traditional Out-of-Area****
Medical Basic Provisions			
Annual deductible (applies to medical, behavioral health and prescription drug benefits)	$200 individual $400 family	$200 individual $400 family	$200 individual $400 family
Annual out-of-pocket maximum	$1,000 individual	$1,000 individual	$1,000 individual
Lifetime maximum – including any claims from another UPS-sponsored retiree plan	$500,000 per person		
Preventive Medical Care			
Routine physical exams	80%	Not covered	80%
Routine OB/GYN exam	80%	Not covered	80%
Routine mammogram	80%	Not covered	80%
Well-child care	80%	Not covered	80%
Physician Charges – Non-Preventive Care			
Office visit	80%	70%	80%
Inpatient surgery	80%	70%	80%
Outpatient surgery	80%	70%	80%
Hospital Facility Charges			
Inpatient services	80%	70%	80%
Outpatient services	80%	70%	80%
Emergency room	80%	70%	80%
Other Covered Charges			
Diagnostic x-ray and lab (includes pre-admission testing)	80%	70%	80%
Hospice care – inpatient	80%	70%	80%
Hospice care – outpatient	80%	70%	80%
Skilled nursing facility	80%	70%; limit 60 days/year	80%; limit 60 days/year

Medical Benefits (Cont.)			
Other Covered Charges			
Outpatient private duty nursing – private duty nursing provided by an RN or LPN.	80%	70%; limit 560 hours/year	80%; limit 560 hours/year
Home health care—Care by an RN, LPN or therapist to provide physical, occupational or speech therapy or services from a home health aide.	80%	70%; limit 120 four-hour visits/year	80%; limit 120 four-hour visits/year
Ambulance	80%	70%	80%
Durable medical equipment	80%	70%	80%
Chiropractor—$1,000 annual maximum per person	80%; maximum $40/visit	70%; maximum $40/visit	80%; maximum $40/visit
Rehabilitation—Services consisting of physical, occupational or speech therapy that are expected to improve a body function lost or impaired due to an injury, disease or congenital defect.	80%	70%; limit 60 visits/year combined inpatient and outpatient	80%; limit 60 visits/year combined inpatient and outpatient

**All out-of-network and out-of-area medically necessary services are subject to reasonable and customary limits.*

Behavioral Health Benefits

Your behavioral health benefits are administered by ValueOptions. You can choose to see any provider you wish, but the highest benefit from the Plan will be received when you use in-network providers for your care. ValueOptions network providers are available in all areas. No out-of-area benefits are available. All treatment must be determined by ValueOptions to be medically necessary. If you have any questions about providers or covered services, please contact ValueOptions Member Services at 1-800-336-9117.

	In-Network	Out-of-Network
Mental health – inpatient	80%	70%
Mental health – outpatient	80%	70%
Substance abuse treatment	80%	70%

Prescription Drug Benefits

Your prescription drug benefits are administered by Express Scripts (formerly known as Medco). You can choose to get your prescriptions from any prescription provider you wish, but the highest benefit from the Plan will be received when you use in-network providers. If you have any questions about your prescription drug benefits, please contact Express Scripts Member Services at 1-800-346-1327.

	Retail Pharmacy (30-day supply)		Mail Order (90-day supply)
	In-Network	Out-of-Network	In-Network
Generics	80%	70%	80%
Brands	80%	70%	80%

Dental Benefits

Your dental benefits are administered by Aetna. You can choose to see any provider you wish, but the highest benefit from the Plan will be received when you use in-network providers for your care. If you live outside of Aetna's network area, then you will receive out-of-area benefits. If you have any questions about providers or covered services, please contact Aetna's Concierge Member Services at 1-800-435-7324.

	In-Network and Traditional Out-of-Area*	***Out-of-Network****
Deductible	None	None
Preventive services	Covered at 100%	Covered at 80% R&C
Basic services	Covered at 100%	Covered at 80% R&C
Major services	Covered at 80%	Covered at 50% R&C
Annual maximum benefit (orthodontia not included)	None	$2,500
Child orthodontia	Covered at 50%	Covered at 50% R&C
Lifetime maximum orthodontia benefit	$1,500 in- and out-of-network combined	
Lifetime maximum TMJ coverage		

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

Vision Benefits

Your vision benefits are administered by Vision Service Plan (VSP). You can choose to see any provider you wish, but the highest benefit from the Plan when you use in-network providers for your care. If you have any questions about providers or covered services, please contact VSP Member Services at 1-800-877-7195.

	Vision Frames and Lenses	
	VSP Provider	***Non-VSP Provider*****
Eye exam	100%	Up to $40
Single-vision lenses	100%*	Up to $30
Bifocal lenses	100%*	Up to $40
Trifocal lenses	100%*	Up to $50
Frames	100%*	Up to $30
Standard daily-wear contact lenses in lieu of glasses	100%	Up to $60

**For VSP standard frames and corrective lenses. For cosmetic frames and lenses, you will be responsible for additional charges, but at reduced VSP pricing.*

***Services provided by a non-VSP vision provider are subject to reasonable and customary (R&C) limits.*

Medical Benefits

The medical coverage is network based coverage, referred to as a Preferred Provider Organization (PPO) network. Your costs are less when you choose your care from a network of primary and specialty care physicians, but you don't have to select a primary care physician (PCP) or receive referrals.

See *A Guide to Network-Based Health Care* later in this section for more information about the network.

The network offers many advantages to you:

- Participating doctors and hospitals go through a stringent credentialing process and background check by the claims administrator before they're allowed to participate in the network.
- The network doctors and hospitals have agreed to treat network participants for set fees that are usually lower than you would be billed without these arrangements.

If you live in a ZIP Code outside the network area, but you feel you have adequate access to the doctors in the network or consider them close or convenient enough, you may choose the in-network option by "opting in." If you live in a ZIP Code that falls outside the network and you do not "opt in" to the network, you're considered "out of area" and will receive your coverage from the Traditional Out-of-Area Program.

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

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

- How the network-based option works
- How the Traditional Out-of-Area benefits work
- Your expenses
- Expenses covered by the Plan
- Prescription drug benefits
- Behavioral health benefits

A Guide to Network-Based Health Care

What Is Network-Based Health Care?

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

The current medical claims administrator is Aetna. Although UPS has a long relationship with this administrator, over time the composition of a network or the administrator in your area may change.

Medical Network

UPS has worked with the claims administrator to establish a nationwide PPO medical network based on the medical resources available in your community. You and eligible family members will enjoy the highest benefit level when you receive care provided by the network offered in your area. This is known as receiving "in-network" care. In the PPO, you always have the flexibility to use any health care provider you wish to use—even out-of-network providers. However, you will receive the lower level of benefits if you go "out-of-network."

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

Claims administrator means the company that establishes and maintains the network for the network-based health care option. The claims administrator is also responsible for processing claims for in- and out-of-network treatment.

Preferred Provider Organization

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

Participants in the PPO network are not required to select a PCP, but it is a good idea to see the same physician on a regular basis.

The Traditional Out-of-Area Program

If you live outside the PPO network area (usually UPSers who live in rural areas or outlying communities), you will be covered by the Traditional Out-of-Area Program. The Traditional Out-of-Area Program allows you to receive reimbursement for eligible expenses provided by the physician of your choice. You will also receive the following preventive care benefit features:

- Well-child care
- Immunizations
- Routine mammograms
- Routine gynecological examinations
- Routine physical examinations

If you live close to a network area, you may join the network and receive in-network benefits. See *A Guide to Network-Based Health Care* in the *Medical Benefits* section of this booklet for more details, or contact the UPS Benefits Service Center at 1-800-UPS-1508.

Choosing your Health Care Provider

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

There are two ways to find out which doctors are in the network:

- Network website (log onto *www.aetna.com*)
- Member Services (call the number on the back of your ID card)

If you want more information before selecting a PCP, go online or call Member Services. You can find out which medical school the doctor attended, the year he or she graduated, his or her hospital of residency, what hours they are available, and at which hospitals the doctor has admitting privileges.

If You Participate in the Traditional Out-of-Area Program

If health care for you and your family is provided by the Traditional Out-of-Area Program, you may receive your health care from any qualified health care provider. You pay for health care services as they

are rendered and may have to later submit a claim for reimbursement after you have met your annual deductible.

> If you live outside the network area, you may choose to participate in the network-based option. If after joining the network you use out-of-network health care providers, you'll receive the benefits shown under the out-of-network column of the *Summary of Medical Benefits*.

Special Situations

Preferred Provider Organization Network

- If you're traveling and need emergency medical care when you're away from home, get the care your treating physician recommends. Your benefit will be paid at the in-network level (if otherwise covered by the Plan).
- If you have eligible dependent children or an eligible spouse who lives permanently outside your area (non-resident dependents) or is away at school, they should use in-network providers in their area for covered expenses to be paid as in-network benefits. The PPO network is comprised of providers nationwide and can be found online or by calling the claims administrator.
- In the rare instance that you need to see a specialist who is not in the network, your treatment will be covered on an out-of-network basis unless you have prior approval from the network.

Member Services

Member Services is your link to network care. You can call a Member Services representative to:

- Ask questions about a network physician's credentials
- Ask questions about claims
- Ask questions about your benefits
- Change your PCP
- Get a new ID card
- Obtain information about a network provider or service
- Precertify

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

Precertification

Precertification is a process that takes a closer look at:

- A hospital stay recommended by your doctor
- A convalescent facility stay
- Home health care services
- Hospice services

The idea behind precertification is to make sure the confinement or services are medically necessary and appropriate for your care. Precertification starts with a call to Member Services. Here are the guidelines to remember:

- In the PPO network, if your care is provided or coordinated by your PCP or another in-network physician, he or she will start the precertification process. You don't need to do anything.
- If you use an out-of-network physician, or if you participate in the Traditional Out-of-Area Program, you are responsible for starting the precertification process yourself.

When to Precertify

If you are responsible for calling Member Services to precertify, you must call:

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

What Happens When You Call to Precertify

When you call to precertify, a nurse consultant will ask for some information, including:

- Your name and the patient's name (if the patient is a dependent)
- The condition that is being treated
- Your doctor's name, address and phone number
- The hospital's name, address and phone number
- The scheduled date of admission

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

If You Don't Call to Precertify

If you don't call Member Services to precertify a hospital stay when it is required, you will pay a $250 fee for failure to precertify. The $250 fee will not apply toward your out-of- pocket maximum. You may also be subject to the full cost of any charges for services not precertified.

What Medical Expenses You Have to Pay

The medical coverage pays a significant portion of the medical expenses you and your family may incur each year. You'll generally also pay a portion of the costs incurred. Here is a description of the types of charges for which you'll be responsible. For information about the amount of these charges, please refer to the *Summary of Benefits* section of this SPD.

Deductible

The deductible is the amount you must pay before certain benefits begin each year.

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

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

Expenses credited towards the in-network deductible do not apply towards the out-of-network deductible. And any expenses credited towards the out-of-network deductible do not apply towards the in-network deductible.

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

Enrolled Family Members	***Example #1***	***Example #2***
You	$200	$100
Your Spouse	$200	$75
Son	—	$75
Daughter	—	$150
TOTAL	**$400**	**$400**

Coinsurance

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

Hospital Admission Fee

A $250 hospital admission fee applies each time you're admitted as a hospital inpatient if the admission is at an out-of-network hospital without prior approval from the claims administrator.

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

Out-of-Pocket Maximum

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

In calculating your out-of-pocket expenses subject to the out-of-pocket maximum, the dollar amounts included are the deductible, coinsurance amounts for medical, behavioral health and prescription drug expenses and the hospital admission fee.

Dollar amounts not included in determining the out-of-pocket maximum are the additional hospital admission fee (for failure to precertify), any amounts over reasonable and customary and expenses that are not covered by the Plan.

If you live within the PPO network, there are two out-of-pocket maximums — one for in-network care and one for out-of-network care. Only in-network expenses are applied to the in-network out-of-pocket maximum, and only out-of-network expenses are applied to the out-of-network out-of-pocket maximum.

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

Lifetime Benefit Maximum

Up to $500,000 in lifetime medical benefits can be paid for each person participating in the UPS Health and Welfare Package for Retired Employees – IBT. The maximum is a combined amount of the total benefits paid by the Plan, including any benefits paid from another UPS-sponsored retiree plan. The

lifetime maximum includes all of your medical benefits, including benefits you receive for behavioral health services and prescription drug benefits.

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

Preventive Care

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

For more information on covered preventive care services, see *What is Covered by Your Medical Benefits* in this section.

In an Emergency

Regardless of your option, in case of an emergency, seek medical care as quickly as possible.

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

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

If you receive medically necessary care for a non-emergency at an emergency facility, you pay the first $100 of expenses, in addition to your deductible and coinsurance, then the Plan pays its portion of the remaining covered expenses.

Ambulance Coverage (Ground or Air)

Emergency use of an ambulance is covered as an emergency benefit. Non-emergency use of an ambulance is covered, if it's medically necessary.

What is Covered by Your Medical Benefits

Your medical benefits cover the following types of medical services and supplies, but the amount you pay for each covered expense may vary. Regardless of the option you select, the care must be:

- Medically necessary, as determined by the claims administrator
- Neither investigational nor experimental, as determined by the claims administrator
- Within the reasonable and customary limit, as determined by the claims administrator, and
- Not excluded by the Plan

Medically Necessary Services and Supplies

Except as specifically noted under the *Preventive Care* section, only medically necessary services, as determined by the claims administrator, are covered by the UPS Health and Welfare Package for Retired Employees – IBT.

Medically necessary is a criteria established by the claims administrator and includes, but is not limited to, their determination of required or necessary services, supplies and/or standards of care by using currently available clinical information. This information includes clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in clinical areas, and other relevant factors for the diagnosis, care or treatment of a disease, injury or illness (including pregnancy) within generally accepted medical practice.

Investigational or Experimental

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

Reasonable and Customary Charges

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

Hospital Services

Inpatient

The Plan covers hospital charges for semiprivate room and board and related services and supplies. Other covered hospital services include:

- The use of operating, recovery and treatment rooms and their equipment
- The use of intensive care and cardiac care units
- Dressings, splints and plaster casts
- Inpatient laboratory and X-ray examinations
- Physical therapy
- Electrocardiograms
- Oxygen and anesthesia and their administration
- The cost and administration of blood and blood plasma
- Intravenous injections and solutions
- X-ray and radium therapy
- Prescribed drugs

Outpatient

The Plan covers the following outpatient hospital services provided on an outpatient basis or by a licensed free-standing emergency care center, surgical center or birthing center:

- Preadmission testing within seven days of a scheduled admission for non-emergency surgery
- Chemotherapy infusion
- Kidney dialysis performed either in the hospital or in your home
- Hospital charges connected with outpatient surgery
- Hospital emergency room care of an accidental injury or for emergency treatment of a life-threatening sudden and serious illness

Surgical Services

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

- Surgeon's services
- Anesthesiologist's services
- Assistant surgeon or surgical assistant's services, when medically necessary or when required by the hospital's established policy

Professional Services

The Plan covers the following professional services:

- Doctor's and osteopath's services
- Second surgical opinions
- Chiropractor's services
- Podiatrist's services
- Services by a registered graduate nurse, licensed practical nurse or licensed vocational nurse
- Examinations and other services for the treatment of an illness or injury, including radiation therapy and chemotherapy
- Medical consultations when requested by the physician in charge of the patient
- Diagnostic examinations, X-rays and laboratory tests, including their reading and interpretation
- Charges for hearing exams and an initial hearing aid per ear per lifetime age 19 or older or one hearing aid per ear every three years for children up to age 19 (must be prescribed by an otolaryngologist)
- Ambulance service to the nearest appropriate facility to treat a patient's medical condition
- Hemodialysis

Maternity and Obstetrical Services

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

If you use an in-network obstetrician, or you participate in the Traditional Out-of-Area program, your cost for maternity care for pregnancy will be paid like any other covered in-network services.

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

Covered services include:

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

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

any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage for Reconstructive Surgery Following Mastectomies

The following services are covered by the Plan. Benefits are paid like any other covered services:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses; and
- Physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient

Transplants

Transplants are covered as any other medical procedure.

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

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

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

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

Medical Supplies

The Plan covers the following medical supplies:

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

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

Total Parenteral Nutrition and Enteral Nutrition

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

Enteral nutrition (EN) is considered necessary for a patient with a functioning gastrointestinal tract who, because of dysfunction of surrounding structures that are necessary to permit food to reach the gastrointestinal tract, cannot maintain weight or strength commensurate with his or her general condition. Examples of these conditions are head and neck cancer with reconstructive surgery, and central nervous system disease leading to interference with the neuromuscular mechanisms of ingestion. TPN and EN covered expenses are:

- Cost of nutrients/solutions, except baby food and other regular grocery items, including those that can be blended and used in enteral feeding systems
- Cost of the infusion pump and Heparin lock
- Supplies and equipment necessary for proper functioning and effective use of a TPN or EN system
- Home visits by a physician or nurse in conjunction with TPN or EN

In order to qualify for this coverage, the patient must:

- Require at least 75 percent of their total sustenance from EN or TPN
- Have a long-term need for EN or TPN
- Have a condition involving the GI tract which prevents adequate oral intake

Coverage under this provision excludes:

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

Allergy Treatment

Allergy testing and treatment (including injections) is covered after the appropriate deductible and/or coinsurance.

Infertility Treatment

The Plan covers the diagnosis of the cause of infertility and/or medical treatment to correct that cause (Erectile Dysfunction drugs, such as Viagra and Levitra, are not covered).

Both men and women are covered for infertility treatment. However, all procedures and services, including lab and X-ray, intended to induce pregnancy (rather than to treat an underlying medical cause) are not covered. See the *Prescription Drug Benefits* section for details on how infertility medications are covered.

The following procedures are not covered because they do not correct the underlying medical causes of infertility:

- Artificial insemination
- In vitro fertilization with embryo transfer
- Intrafallopian transfer
- Sperm banking/semen specimen storage
- Artificially assisted fertilization

- Infertility counseling for, or related to, artificially assisted fertilizations
- Services for and costs of a surrogate mother

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

Chiropractic Treatment

All medically necessary services performed or directed by a licensed chiropractor are covered like any other covered service, up to a maximum of $40 per visit (including diagnostic testing). There is an annual $1,000 maximum benefit per individual for chiropractic care.

Special Types of Therapy

The Plan covers short-term rehabilitation therapy and speech therapy. Here are the procedures for each type of coverage.

If you live in the network area and use an in-network provider, rehabilitation and speech therapy benefits are covered at the in-network deductible and/or coinsurance levels for each visit. There is no limit for medically necessary visits. If you choose out-of-network care, or are in the Traditional Out-of-Area Program, you are limited to 60 visits (combined rehabilitation and speech therapy) per Plan year. Any in-network visits will be counted toward your out-of-network limit.

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

Short-Term Rehabilitation Therapy

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

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

Charges are not covered for:

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

Speech Therapy

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

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

Certain speech problems, such as stuttering in children, may be covered by Public Law 94-142, The Education for All Handicapped Children Act of 1975. This law provides public schools with language and speech services for all children between the ages of three and 21, including help in identifying and

diagnosing speech and language disorders as well as rehabilitative and preventive treatment. As a result, treatment is not covered for these kinds of speech problems.

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

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

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

Individual Case Management

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

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

- Understanding treatment plans and alternatives, monitoring claims payments, and
- Evaluating alternative treatment facilities and options

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

- Quadriplegia, paraplegia
- AIDS and certain associated symptoms
- Newborn respiratory distress, newborn apnea
- Brain injury, including traumatic brain injury
- Spinal cord injury

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

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

Alternatives to a Hospital Stay

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

Skilled Nursing Facility

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

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

Outpatient Private Duty Nursing

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

To be covered, outpatient private duty nursing services must:

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

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

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

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

Home Health Care

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

Covered home health care expenses include:

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

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

The following expenses are not covered by home health care:

- Services or supplies not included in the home health care plan outlined by your physician
- Services of a person who ordinarily lives in your home or who is a member of your or your spouse's family
- Custodial care
- Transportation

Hospice Care

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

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

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

The following services and supplies are allowable when furnished to a person receiving outpatient hospice care coordinated by the hospice program administrator:

- Part-time intermittent nursing care by an RN or LPN for up to eight hours in any one day
- Medical social services under the direction of a physician, including:
  - Assessment of the person's social, emotional and medical needs and of the home and family situation
  - Identification of community resources needed to meet his or her assessed needs
  - Assisting the person to obtain the resources needed to meet his or her assessed needs
- Psychological and dietary counseling
- Consultation or case management services by a physician or nurse
- Physical and occupational therapy
- Medical supplies prescribed by a physician
- Part-time or intermittent home health aide services for up to eight hours in any one day. These consist mainly of caring for the person.

Benefits are not provided for the following hospice care services and supplies:

- Any charge for daily room and board in a private room in excess of the institution's semi-private room rate
- Charges made for the following services:
  - Bereavement counseling
  - Funeral arrangements
  - Pastoral counseling
  - Financial or legal counseling, including estate planning or the drafting of a will
  - Homemaker or caretaker services that are not solely related to care of the person (sitter or companion services for the patient or other members of the family, transportation, house cleaning and maintenance of the house)
  - Respite care (care furnished when the patient's family or usual caretaker cannot or will not attend to his or her needs)

What is Not Covered by Your Medical Benefits

Except as specifically noted otherwise in this booklet, benefits are not provided by the UPS Health and Welfare Package for Retired Employees – IBT for the services and supplies listed below. Excluded charges will not be taken into account in determining benefits. If you are not sure whether an expense is covered by your Plan, call Member Services.

- Charges that exceed the reasonable and customary limit, as determined by the claims administrator
- Services and supplies that are not medically necessary, as determined by the claims administrator, even if prescribed, recommended or approved by the attending physician or dentist
- Services and supplies the benefits administrator determines to be unnecessary for the diagnosis, care or treatment of the condition involved
- Care, treatment, services or supplies not prescribed, recommended and approved by the attending physician
- Hospital care for diagnostic purposes unless the covered person's condition or type of test requires hospitalization
- Services or supplies not provided in accordance with medical or professional standards and practice
- Treatments or procedures and related materials that are investigational or experimental in nature, as determined by the claims administrator
- Occupational conditions, ailments or injuries for which coverage is provided by Workers' Compensation or a similar law
- Additional expenses for a private room in a hospital, unless medically necessary
- Private duty nursing while confined
- Custodial care, rest centers, nursing homes or assisted living centers
- Treatment of a condition caused by war (declared or undeclared) or any act of war
- Treatment for conditions caused by committing an unlawful act of aggression, including a misdemeanor or a felony
- Services or supplies that are provided under any government law
- Services or supplies that are provided because of past or present service in any armed forces of any government
- Services provided before coverage becomes effective or after coverage ends
- Dietary supplements, including any supplement for newborn infants except as described in *Total Parenteral Nutrition and Enteral Nutrition* section in this booklet and PKU supplements
- Services or supplies related to any eye surgery performed mainly to correct refractive errors (for example, radial keratotomy) unless vision acuity cannot be corrected to 20/50 with corrective lenses
- Services or supplies for or related to sex change surgery or any treatment of gender identity disorders
- Services or supplies intended to induce pregnancy, such as artificial insemination, in vitro fertilization or embryo transfer procedures, including surrogate parenting
- Reversal of voluntary sterilization
- Expenses related to the purchase of orthopedic shoes or related corrective devices and appliances, except where the shoes or devices are permanently fastened to an orthopedic brace and are medically necessary or used in the place of surgery
- Personal hygiene, comfort or convenience items, such as air conditioners, humidifiers, whirlpools, waterbeds, home blood pressure monitor, televisions and physical fitness equipment
- Items to accommodate your home, office or vehicle as a result of an injury or illness, such as wheelchair lifts, hand rails or stair risers
- Acupuncture therapy, except when performed by a physician as a form of anesthesia in connection with surgery covered by this Plan
- Weight reduction programs, unless preapproved by the claims administrator
- Plastic surgery, reconstructive surgery or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons. However, benefits are paid if cosmetic/plastic surgery is needed to:
  - Improve the function of a body part that is not a tooth or structure that supports the teeth, or

  - Correct a severe birth defect, including harelip or webbed fingers or toes, provided the surgery is necessary to improve the functionality of the body part, or
  - Correct a malformation as a direct result of disease, surgery performed to treat a disease (including reconstructive surgery following a mastectomy), or an accidental injury. The injury must occur while the person is covered by the Plan, and surgery must be performed in the same calendar year as the accident causing the injury, or in the next calendar year
- Charges for a missed or broken appointment
- Charges for the doctor's travel
- Administrative or office service fees, such as copying and mailing expenses and state and local taxes
- Claims received more than 12 months past the date of service
- Charges for or related to services, treatment, educational testing or training related to learning disabilities or developmental delays
- Services and supplies for which you are not legally obligated to pay
- Services and supplies provided by a personal injury protection or compulsory medical payments provision of any motor vehicle insurance contract required by federal or state law, whether or not the participant properly asserts his or her rights under the motor vehicle insurance contract
- Charges made only because coverage exists
- Charges for care furnished mainly to provide surroundings free from exposure to conditions that can worsen a person's disease or injury
- Services of a physician who is still a resident or intern, when services are billed in that capacity
- Items listed in the following sections as not covered expenses:
  - Enteral Nutrition and Total Parenteral Nutrition
  - Infertility Treatment
  - Special Types of Therapy
  - Home Health Care
  - Hospice Care
  - Prescription Drug Benefits
  - Behavioral Health Benefits

How to File a Claim

See the *Filing a Claim* section of this booklet.

Prescription Drug Benefits

Prescription drug benefits for participants of the Plan are administered by Express Scripts. The program gives you and your family three ways to obtain your prescription medications:

- You may have your prescriptions filled at pharmacies that participate in the Express Scripts network (called participating pharmacies). When you do, you'll pay your deductible and/or coinsurance for your medication. There are no claim forms to worry about.
- You may have your prescriptions filled at non-participating pharmacies, but you'll need to pay the full amount of the prescription, then file a claim for reimbursement.
- You may order maintenance medications through Express Scripts mail order program.

See the *Summary of Benefits* section of this booklet for coverage provided for each level of drug.

Using Participating Pharmacies

Express Scripts maintains an extensive network of pharmacies nationwide, including many major pharmacy chains and independent pharmacies. When you enroll you'll receive a prescription ID card. To find a participating pharmacy near you, call Express Scripts at 1-800-346-1327.

Simply present your ID card to the pharmacist along with your doctor's prescription. You don't have to file any claims. You'll pay:

- 20% coinsurance after meeting the in-network annual deductible for any generic or brand name medications filled at an in-network pharmacy
- 30% coinsurance after meeting the out-of-network deductible for any generic or brand name medications filled at an out-of-network pharmacy

Your benefits cover up to a 30-day supply of medication with each prescription. If you need more than a 30-day supply, you may be required to order your medication through the mail order service offered by Express Scripts.

Using Non-Participating Pharmacies

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

Mail Order Pharmacy Service

The mail order pharmacy services give you and your family a convenient, money-saving way to purchase maintenance medications. Maintenance medications are those prescribed for long-term or ongoing conditions, such as high blood pressure, allergies or diabetes. When you use the mail order services:

- You can order up to a 90-day supply of medication*
- You won't need to file a claim or wait for reimbursement.
- Ordering is easy. This is what you do:
  - Ask your physician to prescribe up to a 90-day supply, plus refills, of your medication.
  - Provide that prescription to Express Scripts. You can call Express Scripts at 1-800-346-1327 with any questions or for further details.
- Medication is delivered to your home.
- Prescriptions are filled by registered pharmacists who check your prescription against your personal medical profile to safeguard you against adverse reactions.

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

Refill Prescriptions Online

You may also order mail order prescription refills over the internet by using the Express Scripts website at *www.express-scripts.com* anytime 24 hours a day, seven days a week.

Prior Authorization Program

Express Scripts has a prior authorization program that evaluates the medical necessity of using certain drugs in certain situations.

Your pharmacist will tell you if your prescription requires prior authorization. Then you or your physician must call Express Scripts to request authorization for coverage of these drugs. The list of drugs requiring

prior authorization may change from time to time. Contact Express Scripts at 1-800-346-1327 for more information.

Specialty Drug Program

Certain specialty drugs must be obtained through Express Scripts' specialty care pharmacy, Accredo Health Group. Specialty drugs are those high-cost medications that:

- May require specialized patient training and coordination of care prior to and during therapy
- May require unique patient compliance and safety monitoring
- Have unique requirements for handling, shipping and storage, and/or
- Have a potential for significant waste

You may qualify for the specialty drug program if your condition (such as rheumatoid arthritis, auto-immune diseases or multiple sclerosis) requires your doctor to prescribe certain drugs (such as IVIG, Procit, Enbrel or Remicade) that meet the above criteria.

Prior to prescribing a specialty drug, your medical provider must contact Accredo Health Group at 1-800-501-7260. Specialty medications not purchased from Accredo Health Group will not be covered under this plan.

What is Covered by Your Prescription Drug Benefits

- Drugs approved by the federal government
- State-restricted drugs
- Insulin—by prescription only
- Insulin needles, syringes and chem strips—by prescription only
- Over-the-counter diabetic supplies
- Compounded medications
- Smoking deterrents (with a lifetime limit of one 90-day supply)
- Oral contraceptives
- Drugs that are determined by Express Scripts to be medically necessary

What is Not Covered by Your Prescription Drug Benefits

- Contraceptive devices
- Drugs not approved by the federal government
- Therapeutic devices or appliances
- Drugs used for cosmetic purposes
- Infertility drugs without prior authorization
- Drugs labeled "Caution: limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable by Workers' Compensation, occupational disease law, any state or government agency, or medication provided by any other drug or medical service for which no charge is made to the participant
- Medication taken by or administered to a person, in whole or in part, while he or she is a patient in a licensed hospital, nursing home or similar institution which has a facility for dispensing pharmaceuticals on its premises
- Any prescription refilled more than the number of times specified by the prescribing physician or any refill dispensed after one year from the physician's original order
- Erectile dysfunction drugs (such as Viagra and Levitra)
- Dietary supplements, including any supplement for newborn infants
- Growth hormones without prior authorization
- Over-the-counter medications (other than diabetic supplies)

Prescription Formulary

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

A formulary is simply a list of commonly-prescribed medications that have been selected because of their combination of effectiveness and cost. The Express Scripts Formulary operates in conjunction with the mail order pharmacy service. Simply provide a formulary list to your doctor the next time you or a covered family member has an appointment.

All participating pharmacies in the Express Scripts network will be aware of drugs currently on the formulary. Your doctor and non-participating pharmacies should call Express Scripts at 1-800-346-1327 to learn which drugs are formulary drugs.

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

How to File a Claim

See the *Filing a Claim* section of this booklet.

About Generic Drugs

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

Behavioral Health Benefits

When you or a covered family member needs help with a mental health or substance abuse problem, you can turn to a special UPS behavioral health program. The program provides confidential behavioral health counseling, treatment and referrals through a network of trained professionals. This coverage is included in your medical benefits and is subject to all medical annual deductibles and out-of-pocket maximums, as well as lifetime maximums.

Your behavioral health coverage is administered by ValueOptions. You don't need a referral from your medical doctor to take advantage of the program's services. Furthermore, the ValueOptions network is nationwide, so you can get the advice and care you need from a network provider, no matter where you live. To view a summary of your behavioral health benefits, see the *Summary of Benefits* section.

The Plan provides benefits for behavioral health treatment that is medically necessary. Medically necessary means care that, as determined by ValueOptions:

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

Member Services

ValueOptions' Member Services is your link to your behavioral health benefits. You can call a Member Services representative to:

- Discuss your situation in complete confidence
- Obtain a referral to a network provider for emergency or non-emergency care
- Verify that a non-network provider meets state licensing requirements
- Ask questions about your behavioral health benefits or a related service

You can contact ValueOptions toll-free 24 hours a day, 365 days a year, at 1-800-336-9117. Their number is also printed on the back of your medical ID card.

Confidentiality

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

Guide to In-Network Benefits

Through your behavioral health benefit, you and your family have access to the nationwide ValueOptions Network of behavioral health treatment professionals, programs and facilities, including the following.

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

The providers in the network must meet strict membership requirements and have up-to-date credentials. They are regularly reviewed by ValueOptions to make sure they continually meet network membership standards.

All professionals in the network must be licensed at the highest level for their discipline in the state in they are practicing and have at least three years of clinical experience in providing direct patient care. There are both male and female therapists, some of whom are multilingual.

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

If You Use Out-of-Network Providers

If you choose to seek outpatient treatment outside the ValueOptions network, the provider must hold the highest level of licensure or certification offered by the state in which they are practicing. Because licensing requirements vary from state to state, it is best to call ValueOptions before you start treatment to verify that you are seeing an appropriate provider.

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

- Possess all valid and applicable state licenses
- Possess the minimum level of professional liability coverage required by law
- Meet acceptable criteria for malpractice claims history for the past five years
- Possess a Drug Enforcement Administration (DEA) certification, if applicable
- Maintain accreditation from one of the following accrediting bodies:
  - National Committee for Quality Assurance (NCQA)
  - The Joint Commission (TJC)
  - The Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Council on Accreditation (COA)
  - American Osteopathic Association (AOA)
  - Healthcare Facilities Accreditation Program (HFAP)
  - Accreditation for Ambulatory Health Care (AAHC)
  - Det Norske Veritas (DNV)
  - Community Health Accreditation Program (CHAP)

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

What is Covered by Your Behavioral Health Benefits

You receive maximum benefits when you call ValueOptions for a referral. If you seek emergency treatment, you must contact ValueOptions within 48 hours.

Covered outpatient treatment includes, but is not limited to:

- Individual, group, or family therapy
- Medication management

All inpatient treatment (including but not limited to partial hospitalization, intensive outpatient treatment and residential treatment) must be preauthorized by ValueOptions. If you fail to preauthorize an inpatient stay, you will pay a $250 penalty and the $250 will not apply to your out-of-pocket maximum.

You must also obtain preauthorization from ValueOptions for the following services, or no benefits are payable:

- All substance abuse treatment
- Psychological testing
- Complex medication management
- Electroconvulsive therapy (ECT)
- Biofeedback
- Hypnotherapy
- Aversion therapy

What is Not Covered by Your Behavioral Health Benefits

The following behavioral health services and treatments are not covered by the Plan:

- Court-ordered treatment, unless assessed and certified by ValueOptions to be in keeping with medically necessary standards
- Services and treatment for the purpose of maintaining employment or insurance, unless assessed and certified by ValueOptions to be in keeping with medically necessary standards
- Services and treatments that are:
  - Educational or vocational in nature

  - Required by law to be provided by a school system for a child (such as evaluation for attention deficit disorder)
  - For personal growth and development
  - For adjudication of marital, child support and custody cases
- Services and treatment that are experimental, investigational, mainly for research or not in keeping with national standards of practice as determined by ValueOptions; for example, treatment of sexual addiction, codependency or any other behavior that does not have a psychiatric diagnosis
- Regressive therapy, megavitamin therapy, nutritionally based therapies for chemical dependency treatment, and non-abstinence-based chemical dependency treatment (with the exception of medically necessary methadone maintenance or Suboxone® treatments)
- Custodial care, including, including but not limited to, treatment not expected to reduce the disability to the extent necessary to enable the patient to function outside a protected, monitored or controlled environment
- Service and treatment for:
  - Mental retardation (except initial diagnosis)
  - Autisim spectrum disorders (except 1 hour evaluation and 2 hours testing to confirm initial diagnosis)
  - Pervasive developmental disorders
  - Chronic organic brain syndrome
  - Learning disabilities
- Treatment for:
  - Transexualism
  - Smoking cessation
  - Obesity and/or weight reduction
  - Stammering or stuttering
  - Chronic pain except for psychotherapy, biofeedback or hypnotherapy provided in connection with a psychiatric disorder
- Expenses listed as not covered in this section

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

Maintenance of Benefits and Coordination with Medicare

If you or your covered dependent(s) are also covered under another group health care plan and/or Medicare, there are rules that determine whether the UPS Plan pays benefits first, or whether the other payer is primary. Benefits paid under the UPS Plan, when added to the benefits paid by another group plan and/or Medicare for the same services, will not exceed the amounts that would have been paid under the UPS Plan. See *Maintenance of Benefits* and *Coordination with Medicare* in the *Filing a Claim* section for more information.

ValueOptions requires verification of other coverage once per year prior to paying any claims.

Right of Recovery Provision

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See *Right of Recovery Provision* in the *Filing a Claim* section for details on the Plan's right of recovery provisions.

How to File a Claim

See the *Filing a Claim* section of this booklet.

Dental Benefits

Dental coverage is from the Aetna Dental PPO.

The dental program covers four categories of necessary dental care:

- Preventive services — including check-ups, cleanings and routine X-rays
- Basic services — including fillings, simple extractions, space maintainers and root canal therapy
- Major services — including inlays, onlays, crowns and dentures
- Orthodontia — the straightening of your children's teeth

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

To help you understand the dental coverage, we defined some of the key terms used in this section at the bottom of the next several pages. For a summary of your dental benefits, see the *Summary of Benefits* chart in this SPD or your SPD insert.

Aetna Dental PPO

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

If you live outside the dental network boundaries you can choose to travel to a network provider and receive all the benefits of the network. If you wish to "opt-in" to the dental network, call the UPS Benefits Service Center at 1-800-UPS-1508 for additional information.

Advantages of Using the Dental Network

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

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

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

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

The following information will help you use the dental network:

- **Selecting a network dentist.** A list of local participating dentists is available from a link at *www.aetna.com* or by calling the number on your dental ID card. You may use any dentist in the network to receive the in-network benefit. You may also select a non-participating dentist.
- **Scheduling an appointment.** When you call your participating dentist to make an appointment, make sure to identify yourself as a Plan participant. When you visit the dentist's office, please be sure to show your dental ID card.
- **Specialty treatment.** Although your participating dentist will provide most dental care, occasionally you may require a specialist's services for more complex dental work. The network includes a listing of specialty dentists.

Necessary dental care means preventive dental care and certain other care necessary to diagnose and treat dental disease (as determined by Aetna). The Plan limits benefits to those services and supplies which are customarily used nationwide for treatment and deemed by the profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice. The patient's total current oral condition will be taken into account when determining benefits.

Member Services

Member Services is your link to the dental network. You can call Member Services toll-free at the number on the back of your dental ID card to:

- Ask questions about your benefits
- Obtain information about a network provider or service
- Obtain help in filing claims

Important Dental Coverage Features

Maximum Benefits

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

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

Reasonable and Customary

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

What is Covered by Your Dental Benefits

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

Preventive Services

Covered preventive services are:

- Oral exams (twice a year*)
- Prophylaxis — any type (twice a year*)
- Topical fluoride applications for children, until the end of the year in which the child turns 15 (twice a year)

- X-rays:
  - Full-mouth or panoramic (once every three years)
  - Bitewing (twice a year)
- Sealants for children, until the end of the year in which the child turns 14:
  - One application per tooth per 36-month period
  - Permanent first and second molars only

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

> *Network* means a group of dentists who have contracted with Aetna Dental PPO to provide dental benefits to eligible participants of the Plans.
>
> *Participating dentist* is a network dentist who has agreed with Aetna to provide care at negotiated rates. You may use any participating dentist for yourself and each of your covered dependents each time you seek treatment.

Basic Services

- Visits and exams
  - Professional visit after hours
  - Emergency palliative treatment
  - Routine postoperative care
- X-ray and pathology
  - Single films (up to 13)
  - Intra-oral, occlusal view, maxillary or mandibular
  - Upper or lower jaw, extra-oral
- Extractions
  - Uncomplicated
  - Postoperative visit (sutures and complications) after multiple extractions and impaction
- Emergency treatment
- Periodontics
  - Root planing and scaling, per quadrant (not prophylaxis), limited to four quadrants per year
  - Correction of occlusion related to periodontal surgery, per quadrant
- Endodontics
  - Pulp capping
  - Therapeutic pulpotomy (in addition to restoration)
  - Vital pulpotomy
  - Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only
  - Root canals (devitalized teeth only), including necessary X-rays and cultures but excluding final restoration
    - Canal therapy (traditional or Sargenti method)
    - Single rooted
    - Bi-rooted
    - Tri-rooted
    - Apicoectomy (separate procedure)
- Basic restorative — excludes inlays, crowns and bridges; multiple restorations in one surface will be considered as a single restoration
  - Pins
    - Pin (retention) when part of the restoration used instead of gold or crown restoration
  - Repairs — crowns and bridges

  - Special tissue conditioning, per denture
  - Recementation
    - Inlay
    - Crown
    - Bridge
  - Restorations (involving one, two or three or more surfaces)
    - Amalgam filling
    - Silicate cement filling
    - Plastic filling
    - Composite filling — the alternate benefit of an amalgam filling will be given when placed on posterior teeth

Major Services

- Oral surgery — includes local anesthetics
  - Extractions
    - Surgical removal of erupted tooth
  - Impacted teeth
    - Removal of tooth
  - Alveolar or gingival reconstructions
    - Alveolectomy (edentulous) per quadrant
    - Alveolectomy (in addition to removal of teeth) per quadrant
    - Alveoplasty with ridge extension, per arch
    - Removal of exostosis
    - Excision of hyperplastic tissue, per arch
    - Excision of pericoronal gingiva
  - Odontogenic cysts and neoplasms
    - Incision and drainage of abscess
    - Removal of odontogenic cyst or tumor
  - Other surgical procedures
    - Sialolithotomy — removal of salivary calculus
    - Closure of salivary fistula
    - Transplantation of tooth or tooth bud
    - Removal of foreign body from bone (independent procedure)
    - Maxillary sinusotomy for removal of tooth fragment or foreign body
    - Closure of oral fistula of maxillary sinus
    - Sequestrectomy for osteomyelitis or bone abscess, superficial
    - Condylectomy of temporomandibular joint
    - Meniscectomy of temporomandibular joint
    - Radical resection of mandible with bone graft
    - Crown exposure to aid eruption
    - Removal of foreign body from soft tissue
    - Frenectomy
    - Suture of soft tissue injury
    - Treatment of trigeminal neuralgia by injection into second and third divisions
- Anesthetics
  - General, only when provided in conjunction with an eligible surgical procedure
- Periodontics
  - Subgingival curettage
  - Gingivectomy (including post-surgical visits) per quadrant
  - Gingivectomy, treatment per tooth (fewer than five teeth)
  - Osseous or muco-gingival surgery (including post-surgical visits)
  - Crown lengthening — reviewed on a per claim basis. Predeterminations are suggested.

- Major restorative — gold restorations, inlays, onlays and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge or partial denture. Only restorations needed for severe attrition, abrasion or erosion are covered.
  - Inlays and onlays
    - One or more surfaces
  - Crowns
    - Stainless steel (when tooth cannot be restored with a filling material)
    - Crown build-up — will be reviewed by a dental consultant for necessity
    - Acrylic
    - Acrylic with gold
    - Acrylic with non-precious metal
    - Porcelain
    - Porcelain with gold
    - Porcelain with non-precious metal
    - Non-precious metal (full cast)
    - Gold (full cast)
    - Gold (3/4 cast)
    - Gold dowel pin
- Prosthondontics
  - Bridge abutments (see inlays and crowns)
  - Pontics
    - Cast gold (sanitary)
    - Cast non-precious metal
    - Slotted facing
    - Slotted pontic
    - Porcelain fused to gold
    - Porcelain fused to non-precious metal
    - Plastic processed to gold
    - Plastic processed to non-precious metal
  - Removable bridge (unilateral)
    - One piece casting, chrome cobalt alloy clasp attachment (all types), including pontics
  - Dentures and partials (Fees for dentures, partial dentures and relining include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
    - Complete upper denture
    - Complete lower denture
    - Partial acrylic upper or lower with chrome cobalt alloy clasps, base, all teeth and two clasps
    - Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two clasps
    - Additional clasps
    - Office reline, cold cure, acrylic
    - Laboratory reline
    - Adjustment to denture more than six months after installation
  - Full and partial denture repairs
    - Broken dentures, no teeth involved
    - Partial denture repairs (metal)
    - Replacing missing or broken teeth except congenitally missing teeth
  - Adding teeth to partial denture to replace extracted natural teeth
    - Teeth and clasps
- Space maintainers — includes all adjustments within six months after installation
  - Fixed space maintainer (band type)
  - Removable acrylic with round wire rest only

- Other services
  - Implants (if specifically approved in advance and the teeth are extracted or become missing while covered under the Plan)

> *Coinsurance* means the percentage of covered expenses that you pay after the dental option has paid its share and the deductible (if there is one) is met.

Orthodontia

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

Covered orthodontic services are:

- Initial consultation
- Moldings and impressions
- Installation of braces
- Regular visits
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking

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

If your child is involved in a course of orthodontic treatment when your coverage becomes effective, the dental Plan will not pay benefits toward that treatment.

Accidents

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

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

Temporomandibular Joint (TMJ) Therapy

The Plan covers temporomandibular joint dysfunction for adults and dependent children. This coverage is for TMJ appliance therapy (bite splints) and adjustments only. Diagnostic materials, including impressions, are not covered.

The Plan covers 50 percent of the reasonable and customary cost of TMJ therapy up to a $1,500 lifetime maximum. The $1,500 lifetime maximum limit for children's TMJ benefits is combined with the orthodontia maximum.

What is Not Covered by Your Dental Benefits

In addition to services not specifically listed in the *What is Covered by Your Dental Benefits* section, the following expenses are not covered by your dental benefits:

- Services not required for the treatment of a specific condition or to maintain good dental hygiene
- Services not reasonably necessary or customarily performed, as determined by Aetna
- Charges for services not furnished by a licensed dentist, except services provided by a licensed hygienist under the direction of a dentist or X-rays ordered by a dentist
- Services for which you would not be required to pay in the absence of dental coverage
- Charges covered by the medical options
- Treatment of a work-related injury
- Services furnished by or for the United States government, including a service that may be covered under a government plan
- Charges for your missed or broken appointment
- Charges for the dentist's travel
- Occlusal adjustment (unless following periodontal surgery) or retainers if charged separately from orthodontic treatment
- IV sedation, except in certain circumstances. Call Aetna at 1-800-435-7324
- Appliances, restorations or procedures needed to alter vertical dimensions or restore occlusion or for the purpose of splinting or correcting non-severe attrition or abrasion
- Dentures and bridgework when they are for the replacement of teeth that were extracted before the patient was covered by a UPS dental option
- Orthodontic treatment begun before covered by a UPS dental option
- Root canal therapy, if the pulp chamber was opened before the patient was covered by a UPS dental plan
- Relines and adjustments of dentures and partial dentures within six months after installation
- Cosmetic dental services and supplies, including personalization or characterization of dentures
- Prosthetic devices and appliances, including bridges and crowns, and expenses for fitting or modifying them, if the patient is not covered by the UPS Health and Welfare Package for Retired Employees – IBT when they are ordered, when an impression was made or when a tooth was prepared. The above are also not covered if installed or delivered more than 30 days after the patient's coverage ends
- Replacement of lost, stolen or broken appliances
- Replacement of congenitally missing teeth
- Dental implants (unless specifically approved in advance)
- Educational programs, such as plaque control or oral hygiene instruction
- A charge for a replacement or modification of a partial or fully removable denture, a removable bridge or fixed bridgework, or for adding teeth to any of these, or for a replacement or modification of an inlay, onlay, crown or cast processed restoration, within five years after installation. This includes temporary appliances placed for 12 or more months as they will be considered as permanent and subject to the five year frequency.
- Actisite
- Local anesthesia or nitrous oxide, as a separate charge
- Any prescription drug
- Full mouth debridement
- Guided tissue regeneration
- Desensitization treatment
- Precision attachments except as noted under *Major Services* in this section
- Infection control
- Behavior management
- Canal preparation, if submitted as a separate charge

- Rubber dam
- Claims received more than 12 months past the date of service

Alternate Treatment

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

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

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

Coordinating with Medical Coverage

If you are enrolled in a network-based medical option and need dental surgery that requires hospitalization, your medical claims administrator must be notified in advance of the hospitalization in order for you to receive in-network benefits. If you're enrolled in the Traditional Out-of-Area Program, you should follow the required steps to precertify your hospital admission. (See the *Precertification* section in this booklet for additional information.) In all cases, if you're hospitalized for dental care, the dentist's charges are covered by dental benefits. Other eligible charges are covered by your medical benefits.

Predetermination of Benefits

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

Preauthorization of Benefits

You will not need to seek preauthorization from Aetna for covered services, except in the case of dental implants, which must be preauthorized in advance by Aetna. Your dentist will be required to provide all necessary or requested documentation for review.

> Dental implants must be preauthorized in advance by Aetna, or no expenses or related expenses will be paid.

Right of Recovery Provision

In some situations, you or your covered dependents may be entitled to certain payments from another source following an injury or illness, or you may receive Plan payments in error. See *Right of Recovery Provision* in the *Filing a Claim* section for details on the Plan's right of recovery provisions.

How to File a Claim

See the *Filing a Claim* section of this booklet.

Vision

All participants in the Plan receive coverage for an annual eye exam and vision materials, such as frames and lenses or contact lenses, to help you cover expenses for vision care.

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

For routine vision care, you have the choice of using a Vision Service Plan (VSP) network provider or any provider you choose. However, the Plan pays a higher benefit level when you use a VSP provider. For a summary of your vision benefits, see the *Summary of Benefits* chart in this SPD.

If You Don't Use a VSP Provider

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

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

How Your Vision Benefits Work

VSP has more than 22,000 member doctor locations that provide professional eye care, including eye examinations and the necessary corrective lenses. In order to access vision care benefits, simply contact your VSP participating doctor to make an appointment. If you need help locating a VSP participating doctor, contact VSP's Member Services at 1-800-877-7195 or online at *www.vsp.com*.

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

Special Benefit If You Use a VSP Provider

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

What is Covered by Your Vision Benefits

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

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

The R&C cost of contact lenses required after cataract surgery or for special medical conditions is provided whether through VSP or any provider.

Vision Benefit Limitations

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

Available at an Additional Cost

Vision benefits are designed to cover your corrective visual needs and not cosmetic materials. If you select any of the following items, you will be responsible for additional charges (at reduced prices if you use a VSP provider):

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

You are also eligible for the following discounts from your VSP provider, if purchased within 12 months of your examination:

- 20 percent discount on additional pairs of glasses
- 15 percent discount on contact lens professional services (fitting, evaluation and follow-up)

Discounts on Laser Vision Correction Surgery

As a VSP member, laser vision correction surgery is available at discounted prices through VSP's Laser VisionCare℠ network of doctors.

Visit *www.vsp.com* to learn more about laser vision correction and participating doctors. Or, call VSP at 1-800-877-7195 for more information.

What is Not Covered by Your Vision Benefits

The vision plan will not pay benefits for professional services or materials connected with:

- Visual analysis that does not include a complete eye refraction
- Orthoptics or vision training
- Subnormal vision aids
- Aniseikonic lenses
- Two pairs of glasses instead of bifocals
- Replacement of lost or broken lenses or frames (unless you have not already received a pair of lenses or frames that year)
- Medical or surgical treatment of eyes
- Services or materials provided as a result of Workers' Compensation or similar legislation or provided through a government agency or program
- Eye exams, glasses or contacts provided by any other vision care plan

- Duplicate or spare glasses
- Vision care services, materials or procedures covered by other provisions of the Plan. For example, vision therapy after cataract surgery is covered by the medical benefits.

How to File a Claim

See the *Filing a Claim* section of this booklet.

Quit For Life Tobacco Cessation Program

The Plan offers a tobacco cessation program to help participants quit tobacco use. This benefit is provided to you and your eligible dependents at no additional cost. All tobacco types are included (cigarettes, cigars, and smokeless tobacco).

Eligibility

Quit For Life® is available to all retired employees under age 65 and their adult dependents aged 18 and older who are covered under the medical plan of the UPS Health and Welfare Package for Retired Employees – IBT. Benefits for this program begin when coverage under the Medical Plan begins, or the date you enroll in Quit For Life (if later). Please refer to the *Eligibility* section of this SPD for details regarding eligible dependents and when coverage begins. Details on enrolling in this program are provided at *www.quitnow.net/ups*.

Two Lifetime Quit Cycles

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

Contact a quit coach at 1-866-QUIT-4-LIFE (1-866-784-8454) or online at *www.quitnow.net/ups*. TTY is available at 1-877-777-6534. Quit coaches are available 24/7 Monday through Sunday. Voicemail is also available and all messages are returned within 24 hours.

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

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

What the Program Includes

- Up to five outbound counseling and intervention calls to you.
- In-depth assessment to evaluate readiness to quit tobacco use.
- Assistance and support with over-the-counter Nicotine Replacement Therapy (NRT) in the form of patch or gum only. If you decide that NRT is right for you, this program provides direct mail order of NRT. There is no cost to the participant for the NRT. This program provides assistance and support with NRT throughout the program cycle.
- Your own packet of printed materials, including a Quit Guide sent to your home following program registration.

- Assistance and support regarding prescription medications such as bupropion and Chantix*
- Unlimited and easy access to Quit Coaches through a toll- free number for twelve months from the time of enrollment.
- Access to Web Coach®, an interactive website that helps you stay on track between calls.

** Prescription medication is not covered under this program. If you are a participant in the Medical Plan, you should check your Medical Plan's Summary Plan Description (SPD) for prescription drug coverage information. Assistance and support provided by Alere™ Wellbeing, the program's administrator, should not be a substitute for your doctor's advice.*

Filing a Claim

This section reviews what you need to do to file claims in the UPS Health and Welfare Package for Retired Employees – IBT. If you have any questions about filing claims, please call the appropriate carrier.

Medical

When to File a Claim

If you participate in the PPO option and receive care through network providers, you won't have to worry about filing medical claims. On your first visit to your network provider, you'll sign a form to assign benefits. For subsequent visits, your in-network provider will take care of claims for you.

If the provider doesn't do it for you, you will be responsible for filing your own claims if:

- You participate in the PPO option and receive care from an out-of-network provider
- You participate in the Traditional Out-of-Area Program (even if you see a network provider)

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

Completing a Medical Claim Form

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

- Provide all the information requested
- Use a separate form for each family member
- Indicate whether you want payment to be made to you or assigned to your health care provider

You can either attach itemized bills or have your doctor complete the physician's section of the form. Either way, the following information must be provided:

- Patient's full name, date of birth and relationship to you
- Your Social Security number
- Doctor's full name, address and tax identification number
- Diagnosis
- Date and charge for each service

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

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

Behavioral Health

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

ValueOptions
PO Box 1347
Latham, NY 12110-8847

If you have a question about a claim, you may call 1-800-336-9117.

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

Prescription Drugs

The procedure for filing prescription drug claims depends on whether you fill your prescription at a participating pharmacy, a non-participating pharmacy or through the mail order pharmacy service.

At a Participating Pharmacy

If you fill your prescription at a participating pharmacy, you do not have to file a claim form. You simply present your prescription ID card and pay any deductible and/or coinsurance at the pharmacy.

At a Non-Participating Pharmacy

If you fill your prescription at a non-participating pharmacy, you have to pay the full amount for each prescription and file a claim form to be reimbursed. Your cost will equal the difference between the full retail price and the discounted amount (as if you had used a participating pharmacy), plus your deductible and/or coinsurance. Call 1-800-UPS-1508 to obtain claim forms. Mail your completed and signed claim form with the necessary documentation to:

Express Scripts
P. O. Box 650322
Dallas TX 75265-0322

Mail Order Pharmacy Service

You don't file claim forms if you fill your maintenance drug prescriptions through the mail order pharmacy service. To order drugs through the program, send your prescription with your payment (if payment is necessary) and an Express Scripts order form to the address listed on the order form.

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

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

Dental

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

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

Vision

If you use a VSP provider, your provider will file all necessary claim forms.

If you use a non-VSP provider, you must pay the full amount of the charges and then submit a completed claim form for reimbursement. Claim forms are available at *www.vsp.com* or by calling VSP at 1-800-877-7195. Mail the completed form to:

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

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

Maintenance of Benefits

This provision does not apply to prescription drug benefits.

This Plan has a maintenance of benefits provision. That means that benefits from the option you select, when added to the benefits paid by another group plan for the same services, will not exceed the amounts that would have been paid by the UPS option you select.

If a person is covered by two plans, one of the plans is considered primary and the other is considered secondary. When a claim is made, the primary plan pays benefits first.

A plan without a maintenance of benefits provision is always the primary plan. If all plans have this provision, the primary plan will be determined in this order:

1. The plan covering the person as an employee or retiree rather than the plan covering the person as a dependent (or a qualified beneficiary under COBRA) is primary
2. If a person is covered as an employee or retiree by two plans, the plan covering the person the longest is the primary plan
3. If a child is covered by both parents' plans, the plan of the parent whose birthday falls first in the calendar year is considered the primary plan
4. In the case of divorce or separation:
   - First, the plan covering the child as a dependent of the parent legally declared financially responsible by court decree is primary
   - Second, the plan covering the parent who has custody of the child (if there is no court decree) is primary
   - Third, in the event there is no court decree and the parent who has custody has remarried, the order of priority is:
     - The plan covering the parent who has custody is primary
     - The plan covering the spouse of the parent who has custody is primary
     - The plan covering the parent without custody is primary

If the Plan is secondary in accordance with these provisions, but the primary plan attempts to reduce its responsibility under the primary plan solely because you or your family is covered under another plan, the Plan will only pay benefits under this Plan in accordance with the maintenance provisions of this Plan as though the primary plan paid benefits without regard to other coverage you may have.

The Plan Administrator has sole discretion to determine the amount that the primary plan would have paid, taking into account the other plan's governing documents.

When a determination cannot be made, the plan covering the eligible dependent longer is considered primary.

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

An Example

To show how maintenance of benefits works, let's assume your spouse is covered by another plan that is primary and also covered by the UPS option you select. Let's also assume your spouse has covered expenses of $100, the other plan would pay benefits of $75 and the UPS option would pay benefits of $80. Since the other plan is primary, your spouse will receive $75 from the other plan first. The UPS Plan will pay an additional $5 to make the total reimbursement $80, or the amount that would have been paid by the UPS option if there were no other coverage. However, if the other plan had paid $95 and the UPS option would pay $80, the UPS option would not pay any additional amount because the benefit paid by the other plan exceeds the UPS benefit amount.

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

Maintenance of benefits also applies to dental and vision coverage.

Coordination With Medicare

Medicare benefits will be primary to the extent permitted under applicable law. As a general rule, if you or your covered dependent becomes eligible for Medicare benefits, there are rules that determine whether the UPS Plan pay benefits first, or whether Medicare is primary. If you fail to enroll in Medicare, these rules will be applied as though you were enrolled in Medicare.

UPS Health and Welfare Package for Retired Employees – IBT

If you are covered by the UPS Health and Welfare Package for Retired Employees – IBT and become disabled prior to becoming eligible for Medicare due to age, Medicare would be primary for you from the date of your disability (except ESRD; see below). Coverage in the UPS Health and Welfare Package for Retired Employees – IBT ends at age 65.

End Stage Renal Disease (ESRD)

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

During the time the Plan pays benefits first, you should submit a claim for any remaining expenses not covered by the Plan to Medicare. Incidentally, you should apply for Social Security disability income benefits during the fifth month of disability to make sure you have no gaps in income protection. During the time Medicare pays benefits first, you should first submit claims to Medicare for payment. Apart from the above, the Plan will coordinate with Medicare to the extent permitted under applicable law.

Right of Recovery Provision

This section describes the Plan's right to seek reimbursement of expenses that are paid by the Plan on behalf of you or your covered dependents (referred to in this section as a "covered individual") if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident). The Plan may seek reimbursement of these expenses from any recovery you may receive from

the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. The terms of the Plan's reimbursement rights are described below:

If a covered individual incurs expenses covered by the Plan as a result of the act of a third party (person or entity) you may receive benefits pursuant to the terms of the Plan. However, the covered individual shall be required to refund to the Plan all benefits paid if the covered individual recovers from any other party (such as proceeds from a settlement, judgment, lawsuit or otherwise as a result of the act). The covered individual may be required to:

a. Execute an agreement provided by 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;
b. Provide such information as UPS, or the claims administrator may request;
c. 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;
d. 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 or other expenses of recovery. The reduction is limited to the lesser of the actual attorney fees and other expenses or one-third of the Plan's lien. The Plan's right of recovery shall apply to the entire proceeds of any recovery by the covered individual. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Plan's right to recover shall not be limited by application of any statutory or common law "make whole" doctrine (in other words, the Plan has a right of first reimbursement out of any recovery, even if the covered individual is not fully compensated) or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained.

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

If the covered individual fails to take action against a responsible third party to recover damages within one year or within 30 days after the Plan requests, the Plan shall be deemed to have acquired, by assignment or subrogation, a portion of the covered individual's claim equal to the amounts the Plan has paid on the covered individual's behalf. The Plan may thereafter commence proceedings directly against any responsible third party. The Plan shall not be deemed to waive its rights to commence action against a third party if it fails to act after the expiration of one year nor shall the Plan's failure to act be deemed a waiver or discharge of the lien described above.

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

In addition, the Plan has a right to recover benefits that were paid in error (for example, benefits paid to an ineligible person) or benefits that were obtained in a fraudulent manner, as determined by the Plan Administrator. Benefits may be recovered by either direct payment to the Plan by you or a beneficiary

(through voluntary payments or legal action) or by an offset of future benefits equal to the amount of the overpayment.

If a Claim Is Denied

If your claim for benefits under the Plan is denied, you may have it reviewed in accordance with the following claims review procedures. The procedures will vary depending on the type of benefit claim it is.

Denial of Insured Claims

Certain benefits offered under the Plan are provided through an insurance contract issued to UPS by an insurance carrier. In this case, the insurance carrier is the applicable claims fiduciary with respect to claims for benefits provided under the insurance contract. This means that UPS has no discretionary authority with respect to benefit claims that are insured by an insurance carrier. If your claim for an insured benefit is denied under the Plan, you should refer to the applicable policy or Certificate of Coverage provided by the carrier, or contact the insurance carrier for more information on the applicable claims procedures. The Fiduciary Chart below identifies which claims should be submitted to the insurance carrier.

Denial of Claims

If the denied claim is one for which the UPS Claims Review Committee (the Committee) makes the final decision (see chart below), the following claims review procedures apply.

Types of Claims

There are three types of claims: Pre-Service, Concurrent Care, and Post Service Claims. Also, certain Pre-Service or Concurrent Care Claims may involve "urgent care."

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 and any claim for which the Plan does not require preauthorization.

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).

Fiduciary Chart

If you are covered by	*Appeal 2nd level to UPS*
Aetna	X
ValueOptions	X
Express Scripts	X
Vision Service Plan	X

Appeals Procedures

Generally, the following steps describe your appeal procedures (regardless of the type of claim — pre-service, concurrent care, etc.). A claim is not deemed "filed" for purposes of these claims review procedures until it is filed in accordance with the *Filing a Claim* section of this SPD and it is received by the claims administrator, or where applicable, the UPS Claims Review Committee.

The following provides other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (in other words, the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have the right to request documents or other records relevant (as defined by ERISA) to your claim.
- If a claim involves medical judgment, then the claims administrator and the Claims Review Committee will consult with an independent health care professional during the first and second level appeal who has expertise in the specific area involving medical judgment.
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Step 1: Notice is received from claims administrator. If your claim is denied, you will receive written notice from the claims administrator that your claim is denied (in the case of urgent claims, notice may be oral). The time frame in which you will receive this notice is described in the *Claims and Appeals Procedures Chart* and will vary depending on the type of claim. In addition, the claims administrator may take an extension of time in which to review your claim if necessary for reasons beyond the claims administrator's control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The time period during which the claims administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

Step 2: Review your notice carefully. Once you have received your notice from the claims administrator, review it carefully. The notice will contain:

a. The reason(s) for the denial and the Plan provisions on which the denial is based;
b. A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your appeal;
d. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request;
e. If the denial is based on a medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
f. If the claim was an Urgent Care Claim, a description of the expedited appeal process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you not later than three days after the oral notification.

Step 3: If you disagree with the decision, file a first level appeal with the claims administrator. If you do not agree with the decision of the claims administrator and wish to appeal, you must file a written appeal with the claims administrator within 180 days of receipt of the claims administrator's letter (or oral notice if an urgent care claim) referenced in Step 1. If the claim involves urgent care, your appeal may be made orally. In addition, you should submit all information referenced in Step 2 with your appeal. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

Step 4: You receive a notice of the first level appeal from the 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 first level appeal notice carefully. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the claims administrator.

Step 6: If you still disagree with the claims administrator's decision, file a second level appeal with the Committee. If you still do not agree with the claims administrator's decision and wish to appeal, you must file a written second (and final) level appeal to the Committee within 60 days after receiving the first level appeal denial notice from the claims administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim. The appeal should be sent to:

UPS Claims Review Committee
55 Glenlake Parkway, N.E.
Atlanta, GA 30328

Step 7: Review your second level appeal notice carefully. If the Committee denies your second level appeal, you will receive notice within the time period described in the C*laims and Appeals Procedures Chart*, depending on the type of claim. The notice will contain the same type of information that was referenced in Step 2 above.

Claims and Appeals Procedures Chart

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

Claims and Appeals Procedures							
	Initial Claims			***1st Level Appeal***		***2nd Level Appeal***	
Type of Claim	You'll be notified of determina-tion as soon as possible but no later than…	Extension period allowed for circumstances beyond claims administrator's control…	If additional information is needed, you must provide within…	You must file your appeal within…	You'll be notified of determination as soon as possible but no later than...	You must file your appeal within…	You'll be notified of determina-tion as soon as possible but no later than…
Group Health Benefit Plans							
Pre-Service	15 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	15 days from receipt of appeal	60 days of 1st level appeal denial	15 days from receipt of appeal
Pre-Service involving Urgent Care	72 hours (24 hours if additional information is needed from you)	None	48 hours (claims administrator must notify you of determina-tion within 48 hours of receipt of your information)	180 days of claim denial	72 hours from receipt of appeal	N/A	N/A
Concurrent: To end or reduce treatment prematurely	Notification to end or reduce will allow time to finalize appeal before end of treatment	N/A	N/A	(Denial letter will specify filing limit)	15 days from receipt of appeal	(Denial letter will specify filing limit)	15 days from receipt of appeal
Concurrent: To deny your request to extend treatment	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim
Concurrent: Involving Urgent Care	24 hours, if claim submitted at least 24 hours before the scheduled end date of treatment. Otherwise, treated as Pre-Service Urgent Care	None	N/A	180 days of claim denial	72 hours from receipt of appeal	N/A	N/A
Post-Service	30 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	30 days from receipt of appeal	60 days of 1st level appeal denial	30 days from receipt of appeal

Continuation of Coverage under COBRA

In certain circumstances, health care coverage for you and your dependents (if qualified beneficiaries) can continue beyond the date it would otherwise end. This continuation of coverage is required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

As the retired employee, you are offered COBRA continuation in the UPS health plan that covered you at the time of your retirement, and are therefore not eligible for further COBRA continuation coverage under this Plan – even if you lose coverage. There are special rules that apply if the employer files for bankruptcy.

A "qualified beneficiary" is a spouse and/or dependent child who loses coverage under this Plan as a result of a qualifying event. Qualified beneficiaries have independent COBRA election rights and can elect to continue group health plan coverage for themselves.

The information included here is a general overview of COBRA provisions. If you become eligible for continued coverage (that is, if you have a qualifying event), you'll be given more information that reflects your situation at the time.

How COBRA Works

Eligibility for COBRA is triggered by a "qualifying event." The 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 booklet.

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 once a qualifying event occurs.

The initial premium must be paid within 45 days of your enrollment date (there is no grace period). Subsequent premiums are due on the first of each month. Failure to make subsequent payments within 30 days of the due date will cause your coverage to terminate retroactive to the end of the last month for which full payment was received.

Qualifying Events	***Continuation of Coverage***		
	You	***Your dependent spouse***	***Your dependent child***
You become divorced or legally separated	N/A	36 months	N/A
Your child ceases to be a qualified dependent	N/A	N/A	36 months

Continued coverage will usually be available for 36 months. You or the qualified beneficiary should call the Benefits Service Center immediately. If you do not notify the Benefits Service Center within 60 days, you (or the qualified beneficiary) forfeit any right to gain COBRA coverage.

COBRA Notification Deadline

In most cases, you'll be notified when you become entitled to continue health care coverage. However, for other events, you or your dependent should notify the Benefits Service Center immediately. You must notify the Benefits Service Center within 60 days of the qualifying event (or the date you would otherwise lose coverage as a result of the qualifying event), or continued coverage will not be available.

The chart below shows when UPS will automatically send COBRA enrollment materials and when you or your dependent must notify the Benefits Service Center.

Event	***Responsible for Notification***
Loss of dependent status due to age	Benefits Service Center will automatically send your COBRA enrollment materials to the retiree's address on file.
• Divorce • Legal separation • Loss of dependent status not due to age	You or the qualified beneficiary should call the Benefits Service Center immediately. If you do not notify the Benefits Service Center within the 60 days, you (or the qualified beneficiary) forfeit any right to COBRA coverage.

The 60-Day Notice

If you do not notify the Benefits Service Center within 60 days of a divorce, legal separation or loss of dependent status (not due to age), you (or the qualified beneficiary) forfeits your right to COBRA coverage.

Enrollment in COBRA

There are two type of enrollment: initial enrollment when you first become eligible and annual enrollment.

Initial Enrollment

Qualified beneficiaries may each elect to continue any of the medical benefits that they had immediately preceding the qualifying event. Qualified beneficiaries cannot make any changes to the coverage that they had immediately preceding the qualifying event. The qualified beneficiary should call the Benefits Service Center immediately. If you do not notify the Benefits Service Center within the 60 days, you (or the qualified beneficiary) forfeit any right to COBRA coverage.

Annual Enrollment

At each enrollment, you can make new choices that are offered to similarly situated retirees who are not receiving COBRA continuation coverage by calling the Benefits Service Center.

Life Events

During a COBRA continuation period, coverage may be modified based on Plan rules if you experience a change in status. See the *Life Events* section for details on allowable changes in status.

If a spouse is dropped from coverage during annual enrollment and later becomes divorced or legally separated from the covered retiree, the spouse may be entitled to COBRA continuation coverage if the termination of coverage is deemed by the Plan Administrator to be "in anticipation of" the divorce or legal separation and the former spouse notifies the COBRA Administrator within 60 days of the divorce or legal separation.

The COBRA Administrator

The Benefits Service Center is the COBRA administrator and will handle all COBRA enrollment and billing.

Your Right to Obtain Individual Coverage

A federal law, Health Insurance Portability and Accountability Act (HIPAA), requires all health insurance carriers offering coverage in the individual market to accept any eligible individuals who apply for coverage, without imposing pre-existing condition exclusion. To take advantage of this HIPAA right you must complete your 36-month COBRA coverage period under the UPS Health and Welfare Package for Retired Employees – IBT and apply for coverage with an individual carrier before you have a 63-day lapse in coverage.

Since this coverage is not sponsored by UPS, you should contact your state's department or commission of insurance or see your independent insurance specialist to secure coverage.

Notifying the COBRA Administrator

If you are required to notify the COBRA administrator, as indicated within this section and elsewhere in the SPD, you must call the Benefits Service Center at 1-800-UPS-1508.

ERISA and Other Important Information

Plan Administration

The information contained in this booklet, including the schedule of benefits, is a summary of the applicable administrative and legal documents relating to the UPS Health and Welfare Package for Retired Employees – IBT.

United Parcel Service, as Plan Administrator, shall have the exclusive right and discretion to interpret the terms and conditions of the Plan, and to decide all matters arising in its administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the Plan. Any such interpretation or decision shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plan's terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents. The Plan Administrator may delegate certain discretionary authority to one or more committees.

All benefits described in this booklet — both for you and your family — are paid for by you and UPS, and are made available to you as part of the compensation you receive or received for your work with the company. UPS has established a special trust, called a voluntary employee beneficiary association trust, to serve as the funding vehicle. All contributions to this trust are made from the general assets of UPS. Depending on the coverage you select, you may be required to pay a portion of the cost of providing those benefits.

The Plan Administrator for the Plan is United Parcel Service, which is authorized to delegate its administrative duties to one or more individuals or committees within UPS, or to one or more outside administrative services providers. Presently, certain administrative services with regard to the processing of claims and the payment of benefits are provided under contract as follows.

Administrative Services Provided

Type of Coverage	Claims Administrator
Medical and dental	Aetna 151 Farmington Avenue Hartford, CT 06156
Prescription drugs	Express Scripts 100 Parsons Pond Drive Fair Lawn, NJ 07410
Behavioral health	ValueOptions 3110 Fairview Park Drive Falls Church, VA 22042
Vision	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670
Quit For Life tobacco cessation program	Alere Wellbeing 999 Third Avenue, Suite 2100 Seattle, WA 98104

General Information

Name of Plan	The UPS Health and Welfare Package for Retired Employees – IBT
Plan Number	525
Plan Year	January 1 through December 31
Employer and Plan Sponsor	United Parcel Service of America, Inc. 55 Glenlake Parkway, N.E. Atlanta, GA 30328 (404) 828-6044
Employer Identification Number (EIN)	95-1732075
Plan Administrator	UPS Health and Welfare Package for Retired Employees – IBT United Parcel Service of America, Inc. 55 Glenlake Parkway, N.E. Atlanta, GA 30328

Your ERISA Rights

The UPS Health and Welfare Package for Retired Employees – IBT is a welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA). As a participant in the Plan, you are entitled to certain rights and protection based on ERISA.

ERISA provides that, as a Plan participant, you are entitled to:

- **Receive information about your Plan and benefits.** You may examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

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

  You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you move to another plan and you have creditable coverage from this Plan. The UPS Health and Welfare Package for Retired Employees – IBT does not contain any exclusionary periods of coverage for pre-existing conditions. You will be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

- **Prudent actions by Plan fiduciaries.** In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

- **Enforce your rights.** If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with your questions.** If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in

your telephone directory, or

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

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

Plan Amendment or Termination

UPS has established this Plan with the expectation that it will be continued indefinitely. Nevertheless, UPS reserves the right to amend or terminate the Plan at any time. The right to amend or terminate the Plan applies to all coverage hereunder. No amendment or termination of the Plan will reduce or eliminate benefits for claims incurred prior to the effective date of the amendment or termination.

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

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Member Services Directory

UPS Benefits Service Center	1-800-UPS-1508
• Verify eligibility	
• Change address	
• Add or remove dependents	
• Report Medicare eligibility	
• Report divorce	
• Request benefits plan materials	
• Inquire about COBRA	
• Inquire about retiree contributions	
• Request HIPAA notice	
• Request creditable coverage notice	
Aetna	www.aetna.com
• Inquire about medical claims	1-800-435-7324
• Inquire about dental claims	1-800-435-7324
• Request medical ID cards	1-800-435-7324
• Inquire about coordination of benefits	1-800-435-7324
Express Scripts	www.express-scripts.com
• Inquire about prescription drug benefits	1-800-346-1327
• Request prescription ID cards	
ValueOptions	www.achievesolutions.net/ups
• Behavioral health	1-800-336-9117
Vision Service Plan (VSP)	www.vsp.com
• Vision	1-800-877-7195
Quit for Life	1-866-QUIT-4-LIFE
• Tobacco cessation program	

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