UPS Health Program

FOR PART-TIME EMPLOYEES

SUMMARY PLAN DESCRIPTION

Schedule 115
Central Ohio Locals 20, 40, 908, 957
Indiana Locals 89, 135
Kentucky Locals 89 (Center 4210), 957
Metro Detroit Locals 20, 164, 243, 339
Michigan Locals 7, 328, 332, 339, 406, 486, 580
North Ohio Locals 20, 377
South Illinois Locals 215, 236
Since this booklet was last updated, certain changes, required notifications and clarifications have been made to the Plan. You’ll find any notices of these changes, called Summary of Changes, at the end of this booklet. Refer to this information when reviewing your coverage.
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. The UPS Health Program (the Plan) provides health benefits to help pay for the cost of your health care. The Plan also protects you and your family with life insurance, accidental death and dismemberment and short-term disability income coverage. UPS pays the full cost of the benefits described in this booklet.

YOUR PLAN

As an employee of United Parcel Service, you’re eligible for benefits from the Plan once you’ve met the eligibility requirements. There may be a waiting period for certain coverage for you or for your dependents. Please see “When Coverage Begins” in this booklet for eligibility requirements you and/or your dependents must meet before you receive benefits from this Plan.

The UPS Health Program Schedule 115 covers part-time union member employees in the following work groups:

- Central Ohio Locals 20, 40, 908, 957
- Indiana Locals 89, 135
- Kentucky Locals 89 (Center 4210), 957
- Metro Detroit Locals 20, 164, 243, 339
- Michigan Locals 7, 328, 332, 339, 406, 486, 580
- North Ohio Locals 20, 377
- South Illinois Locals 215, 236

Other benefit schedules have been prepared describing this Plan as it applies to employees in other employment groups. Please be certain you have the proper information for your employment group.

Your coverage from the Plan is a result of the Company’s agreement with your collective bargaining unit. You’ll find specific reference to the coverage in your labor agreement.

WHO IS COVERED

As a part-time bargaining unit employee of UPS, you and your qualified dependents are covered once you meet the Plan’s eligibility requirements as described in the “When Coverage Begins” section of this booklet.

An “eligible dependent” is defined as:

- Your legal spouse
- An unmarried child who is:
  - A natural child, an adopted child, a stepchild or a child for whom you are the legal guardian or custodian and who depends on you for financial support and lives with you in a parent-child relationship, and
  - Under age 19, or up to age 25 if a full-time student and still financially dependent on you.

Incapacitated Children

A child who becomes incapacitated before age 19 (or before age 25, if a full-time student) will continue to have medical coverage as long as the incapacitation exists and you remain eligible for the Plan. This continuing coverage is available as long as the child becomes incapacitated while covered by the Plan, is unmarried and primarily dependent on you for support and maintenance. Dependent life insurance continues through the end of the year in which your child turns 19 (or age 25 if a full-time student).
Your child must have a mental or physical incapacity that renders the child unable to care for herself/himself, as determined by the claims administrator. For this purpose, the incapacity must be verified before coverage can be continued. In addition, periodic medical documentation of the continuing incapacity is required.

When Spouses or Children Are UPSers
If you and your spouse both work for UPS and are both covered through a UPS-administered plan, you may not cover your spouse as a dependent in the Health Program. Your dependent children can have health care coverage as one parent’s dependent only.

If you and your dependent child both work for UPS and are both covered through a UPS-administered plan, you cannot cover your child as a dependent in the Health Program.

There is no coordination of benefits available between two UPS-administered plans.

WHEN COVERAGE BEGINS

Eligibility for medical, life and accidental death and dismemberment (AD&D) coverage for you and your dependents begins on the first day of the month following one full month of employment, provided you have attained seniority. If you have not attained seniority at this time, coverage will begin on your seniority attainment date.

Eligibility for vision and dental coverage begins six months from your hire date, provided you have attained seniority.

A definition of seniority can be found in your collective bargaining agreement.

Qualified Medical Child Support Orders (QMCSO)
Medical, dental and vision coverage will comply with the terms of a Qualified Medical Child Support Order. A QMCSO 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 QMCSO must meet certain form and content requirements in order to be valid. When an order is received, each affected participant and each child covered by the order will be notified of the implementation procedure to determine if the order is valid. If you have any questions or would like to receive a copy of the UPS written procedure for determining whether a QMCSO is valid, please contact your Human Resources department.
WHEN COVERAGE ENDS

For You...
- Coverage ends 31 calendar days after you leave UPS
- The end of the second month of a layoff period
- The day you start a personal leave that is not covered by the Family Medical Leave Act

For Your Spouse...
The earliest of:
- The date your coverage ends
- The date you and your spouse are divorced
- The date you and your spouse are legally separated

For Your Dependent Children...
The earliest of:
- The date your coverage ends
- The end of the calendar year in which your dependent turns 19
- The end of the calendar year in which your dependent turns 25, provided he or she is a full-time student
- The date your dependent marries or otherwise fails to meet the requirements of an eligible dependent as described in the “Who is Covered” section

See the “Continuation of Coverage During Disability” section for information on extension of coverage for you and your dependents during a disability period.

There is also important information about the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Family Medical Leave Act (FMLA) and conversion privileges in later sections of this booklet. These provisions may extend the date on which coverage will end.

IMPORTANT INFORMATION ABOUT PLAN EXPENSES

All expenses covered by this Plan must be:
- Medically necessary, as determined by the claims administrator, Aetna
- Neither investigational nor experimental, as determined by the claims administrator
- Within the standards for the reasonable and customary amount, as determined by the claims administrator
- Not excluded by the Plan

Medically Necessary Services and Supplies
Only medically necessary services are covered by the UPS Health Program. A service or supply is medically necessary if the Plan determines that it is required for the diagnosis, care or treatment of a disease, injury or pregnancy in accordance with generally accepted medical practice. This determination is at the sole discretion of the Plan Administrator.

To be medically necessary, the service or supply must be:
- Care or treatment that is as likely to produce as significant a positive outcome (and no more likely to produce a negative outcome) as any alternative service or supply, with respect both to the disease or injury involved and to the person’s overall health condition, or
- A diagnostic procedure, indicated by the health status of the person, that is as likely to result in information that could affect the course of treatment as (and no more likely to produce a negative outcome than) any alternative service or supply, with respect to both the disease or injury involved and the person’s overall health condition, and
As to diagnosis, care and treatment, no more costly (taking into account all health care expenses incurred in connection with the service or supply) than any alternative service or supply that meets the above tests.

**Reasonable and Customary Charges**
A reasonable and customary (R&C) charge is the lower of either the provider’s usual charge or the prevailing fee for a medical service or supply in your geographic area as determined by the claims administrator. If you’re charged more than what is considered reasonable and customary, you’ll be responsible for paying anything over the R&C amount. R&C charges are regularly reviewed to keep Plan benefits up-to-date with current rates.

**BASIC HOSPITAL COVERAGE**

**Room and Board**
You and your eligible dependents receive full coverage for reasonable and customary room and board charges and for other related services and supplies during a medically necessary confinement in a full-service acute care or specialty hospital. If you choose to stay in a private room, you’re responsible for the difference between the actual semi-private room charge and the private room rate.

**Inpatient Hospital Services**
Your Plan pays full reasonable and customary charges for these other inpatient hospital services as long as they are medically necessary to treat the condition requiring hospitalization and are billed by the hospital:

- 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 Hospital Services**
The following outpatient hospital services are also covered in full under the basic portion of your Plan:

- Pre-surgical testing within seven days of a scheduled inpatient admission or a scheduled ambulatory surgery procedure
- Chemotherapy infusion
- Kidney dialysis performed either in the hospital or in your home
- Hospital charges connected with outpatient surgery
- Hospital emergency room treatment of a diagnosed life-threatening sudden and serious illness, if care is given within 72 hours after the injury occurs or after the illness begins
BASIC MEDICAL COVERAGE

Basic Surgical Coverage
Basic surgical coverage pays 100 percent of the reasonable and customary charges of a surgeon and assistant surgeon (when required) including anesthesia for the procedure. You do not need to pay a deductible before the Plan pays benefits.

For benefit purposes, usual, necessary and related pre-operative and post-operative care is considered part of the surgery. Post-operative care must be given during the 14 days after surgery.

Other surgical procedures are covered by the Plan, including functional repair of birth abnormalities or congenital defects; oral surgery, including the removal of impacted and wisdom teeth, and tubal ligations or vasectomies.

Diagnostic Procedures
Outpatient diagnostic X-rays and laboratory procedures are also covered up to the R&C amount, including medically necessary ultrasounds and dental X-rays in connection with an injury. Up to $300 can be paid in benefits for each person each calendar year. The major medical portion of the Plan covers charges above $300.

In addition, radiologists’ and pathologists’ charges for services given while you (or a dependent) are hospitalized are also covered by the basic medical portion of the Plan.

Emergency Care Physician
Emergency care given by a physician is covered in full up to R&C charges. The care may be given in a clinic, doctor’s office or the outpatient department of a hospital.

For benefits to be paid, emergency care must be given within 72 hours of an accidental injury or the onset of a diagnosed sudden and serious illness.

Physician Charges for Hospital Visits
Often when you or your covered dependents are hospitalized, your physician will treat you in the hospital. These charges are covered up to $20 per day.

The total amount payable for all treatments during one period of continuous disability is $7,300 per individual. If you incur charges over the amounts payable under this portion of your coverage, they will qualify for coverage under the major medical portion of the Plan.

See the section “What’s Not Covered by Your Plan” for information on expenses excluded from this coverage.

Mastectomy Coverage
A participant or eligible dependent receiving benefits for a medically necessary mastectomy will also receive coverage for:

- 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 treatment of physical complications of all stages of mastectomy, including lymphedemas.
MAJOR MEDICAL COVERAGE

After you pay a yearly deductible, your major medical coverage pays 80 percent of most medical expenses not covered by the basic portion of the Plan.

Yearly Deductible
You’re responsible for paying a major medical deductible each calendar year. There are individual deductibles and a maximum family deductible.

The individual deductible is the first $50 of covered major medical expenses. The maximum family deductible is $100. This means that if two or more family members have combined covered expenses of $100, no further individual deductibles are required for the balance of that year.

Coinsurance
After the deductible has been met, the Plan pays 80 percent of the reasonable and customary charges for covered major medical expenses. You pay the remaining 20 percent.

Out-of-Pocket Maximum
There is an important provision of your major medical coverage that assures you that your yearly out-of-pocket expenses for covered major medical charges will never be more than a certain dollar amount. This feature can be particularly valuable if you (or a dependent) have a catastrophic illness or injury.

After you meet the out-of-pocket maximum of $1,500 per individual each year, 100 percent of most covered charges are paid for that individual for the rest of the calendar year.

In calculating your out-of-pocket expenses, the dollar amounts included are the deductible and the coinsurance amount. Dollar amounts not included in determining the out-of-pocket maximum are any amounts over reasonable and customary and expenses that are not covered by the Plan.

Lifetime Maximum Benefits
Up to $500,000 in lifetime medical benefits can be paid for each person covered by the Plan. The maximum is a combined amount that is the total benefits paid to you.

Each January 1, up to $1,000 in individual benefits paid during the preceding year or years will automatically be restored. If proof of your (or your dependent’s) good health is approved by Aetna, the $500,000 major medical maximum can be fully restored.

Covered Major Medical Expenses
The following is a general listing of covered expenses under the major medical portion of your Plan:
- Reasonable and customary charges of a physician, including an osteopath, chiropractor or podiatrist for medically necessary treatment
- Second surgical opinions
- Charges of a social worker. In order for expenses to be covered, the social worker must be either a licensed clinical social worker, a diplomat social worker or a member of the Academy of Credited Social Workers and licensed in the state where he or she practices.
- Charges of a registered graduate nurse (RN), licensed vocational nurse (LVN) or licensed practical nurse (LPN)
- Some charges relating to care of mental or nervous disorders, chronic alcoholism or drug addiction (See the “Mental Health Treatment,” and “Substance Abuse” sections.)
• Charges for home health care (See the “Home Health Care” section.)
• Charges for hearing exams and an initial hearing aid. To be covered, the hearing aid must be recommended by an otolaryngologist. Eyeglass-type hearing aids are covered up to the cost of one traditional hearing aid. Replacement or repair of a lost, broken or stolen aid is not covered.
• Outpatient physical therapy and occupational therapy subject to review and approval by the claims administrator
• Charges for speech therapy, depending on the diagnosis and subject to review and approval by the claims administrator (See “Speech Therapy” section.)
• Charges for vision therapy, depending on the diagnosis and subject to review and approval by the claims administrator
• Charges for medically necessary ambulance services to the nearest facility for appropriate treatment of the condition
• Charges for diagnostic X-rays and laboratory exams that are over the $300 paid for by basic medical coverage
• Charges for radioactive therapy
• Charges for outpatient or home chemotherapy
• Charges for the rental (or purchase, if medically necessary) of durable medical or surgical equipment
• Charges for allergy syringes and serums

Maternity
Maternity expenses are covered just like any other condition requiring medical attention.

Your medical coverage for pregnancy and delivery includes full hospital and surgical benefits. Charges for hospital and diagnostic services are covered as described in earlier sections.

Basic surgical coverage pays the cost of Lamaze or other birthing classes. It also pays full surgical benefits for delivery in a licensed birthing center, including anesthesia and pre- and post-operative care. Obstetrical procedures that are fully covered include normal delivery or delivery by cesarean section, services in connection with a miscarriage or abortion, and surgery related to an extrauterine or ectopic pregnancy. The services of a registered midwife are also covered.

The Plan assumes you (or your dependent) will have only one primary obstetrician during a single pregnancy. Typically, an obstetrician establishes a fee for the entire period of care. If you change doctors and the second doctor’s charges are in addition to the first doctor’s fee, only one R&C amount will be covered by the Plan.

The procedure for filing claims is described in the section “Filing a Claim.” As you read that section, keep in mind you may submit your bills for maternity care on an ongoing basis. You do not need to wait until the pregnancy is completed. However, full maternity benefit payment will not be made until completion of the pregnancy.
Newborns’ and Mothers’ Health Protection Act
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).

Mental Health Treatment
Mental health treatment is covered as long as a doctor recommends treatment and the Plan administrator determines it to be medically necessary.

The treatment must be given by a psychiatrist or by a licensed or certified psychologist. Care given by a social worker will be covered as long as he or she meets the criteria listed in the “Covered Major Medical Expenses” section. Major medical benefits for mental health treatment apply toward the $500,000 lifetime benefit maximum.

Inpatient Treatment
Inpatient mental health treatment is covered the same as any other condition requiring hospitalization. The treatment must be recommended by a doctor and be considered medically necessary and appropriate for the condition. Major medical coverage is available for partial confinement in an approved day/night-care facility.

Outpatient Treatment
Outpatient mental health treatment is covered as long as the treatment is recommended by a doctor, is considered medically necessary and appropriate for the condition, and meets the other requirements noted above. Benefits are payable at 80 percent after the yearly deductible is met.

When Benefits Are Not Payable
No benefits are payable for charges of a residential treatment facility or for educational services.

Before you begin treatment that requires any services not specifically identified as covered services for mental or nervous disorders, you should contact the claims administrator to see if benefits are payable.

Substance Abuse
Substance abuse can create difficult problems not only for the person who abuses the substance, but also for all family members. If you would like a referral for yourself or your spouse or a dependent dealing with a substance abuse problem, please see your district Human Resources department, which will refer you to your Employee Assistance Program (EAP) coordinator. Discussions between you and the EAP coordinator will be confidential within the limits of legal and professional constraints.

Major medical benefits for these services apply toward the $500,000 benefit maximum. Psychological counseling by a psychiatrist, licensed or certified psychologist, or a social worker is covered. The social worker must meet the criteria specified in the “Covered Major Medical Expenses” section.
Inpatient Treatment
Inpatient treatment for substance abuse is covered the same as any other condition requiring hospitalization. Major medical coverage is available for partial confinement in an approved day/night-care facility.

Outpatient Treatment
As long as the treatment is recommended by a doctor and meets the other requirements noted above, benefits are payable at 80 percent of covered expenses.

When Benefits Are Not Payable
No benefits are payable for care given in a halfway house or residential treatment facility.

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, 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 92-142, 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 preventative treatment. As a result, treatment of these kinds of speech problems is not covered.

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’s Not Covered by Your Medical Benefits” and situations covered by Public Law 94-142, there are other conditions and services not covered by the medical portion of the Plan. These include:

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

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

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.

After the deductible, benefits are paid at 80 percent of reasonable and customary charges.

Covered home health care expenses include:
- 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. Up to 120 home health care visits per Plan year are covered. For the first 40 visits, the patient does not need to have been confined in a hospital in order to be eligible for benefits. For an additional 80 visits, prior hospital confinement is required, and the home health care must begin within seven days following discharge.

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

Outpatient Private Duty Nursing
Benefits may be paid for medically skilled private duty nursing at home if your doctor prescribes it. Benefits cover the home services of registered nurses, licensed practical nurses and licensed vocational nurses up to a maximum of 560 hours per calendar year (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.

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, licensed practical nurse or licensed vocational nurse, and
- Be ordered by the attending physician as necessary treatment

The charges of a private duty nurse 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.

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 will be paid for services given by a nurse who lives with you.

Call the toll-free number on your medical identification card before you make any arrangements for outpatient private duty nursing.

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 six months or less to live.

Charges for room and board made by a hospice facility, hospital, convalescent facility or a 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/or the home and family situation
  — Identification of community resources needed to meet her or his assessed needs
  — Assistance with obtaining the resources needed to meet her or his assessed needs
- Psychological and dietary counseling
- Consultation or case management services by a physician or nurse
- Physical therapy
- Part-time or intermittent home health aid 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 semiprivate 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 caregiver services that are not solely related to care of the person (sitter or companion services for the patient or other members of the family, transportation, housecleaning and maintenance of the house)
  — Respite care
Individual Case Management
While none of us likes to think about a complicated, long-term illness or 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
• Brain injury, including traumatic brain injury
• Newborn respiratory distress, newborn apnea
• Spinal cord injury
• Any complicated, chronic illness

If this type of care is appropriate for your situation, a nurse consultant contacts your doctor or social worker at the hospital to begin case management. You may also call Member Services at the number on your ID card 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.

What’s Not Covered By Your Medical Benefits
The following is a general list of Plan exclusions:
• Charges that exceed the reasonable and customary limit, as determined by the claims administrator
• Services or supplies that are not medically necessary, as determined by the claims administrator, even if prescribed, recommended or approved by the attending physician or dentist
• Care, treatment, services or supplies provided by an individual who usually resides in the same household with you, or who is related by blood, marriage or legal adoption to you or your dependent
• Services or supplies the claims administrator determines to be unnecessary for the diagnosis, care or treatment of the condition involved
• Care, treatment or 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 of 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 by a similar law
• Additional expenses for a private room in a hospital
• 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
• Items listed in other sections as not-covered expenses
• Treatment of a condition incurred while committing an unlawful act of aggression, including a misdemeanor or a felony
• Services or supplies for which benefits are provided by any government law
• Services or supplies that are provided by reason of past or present service in the armed forces of any government
• Services provided before coverage becomes effective or after coverage ends
• Dietary supplements, including any supplement for newborn infants
• Any preventive or routine care
• Services or supplies related to any eye surgery mainly to correct refractive errors
• Services or supplies for or related to sex change surgery or any treatment of gender identity disorders
• Reversal of a sterilization procedure
• Expenses related to the purchase of orthopedic shoes or related corrective devices and appliances
• Personal hygiene or convenience items, such as air conditioners, humidifiers 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
• Weight reduction programs, unless approved by the claims administrator
• Charges for a missed or broken appointment
• Charges for the doctor’s travel
• Claims received more than 24 months from the date of service
• Charges for or related to services, treatment, educational testing or training related to learning disabilities or developmental delays

• Claims that the Plan is not required to pay under the current collective bargaining agreement
• Contraceptive medications and devices, regardless of medical necessity

**PRESCRIPTION DRUG BENEFITS**

Your medical coverage provides prescription drug benefits. The reasonable and customary cost (as determined by the claims administrator) of prescription drugs is covered at 100 percent.

Prescription drug benefits are administered by Aetna. You pay for the full amount of each prescription and submit a completed claim form to be reimbursed. Claim forms may be obtained from your local Human Resources department or by calling the Member Services number on your Aetna ID card.

Prescription drug benefits cover:

- 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

Prescription drug benefits do not cover:

- Contraceptive medications unless medically necessary
- Contraceptive devices
- Drugs not approved by the federal government
- Drugs used for cosmetic purposes
- Viagra
- Therapeutic devices or appliances
• Drugs labeled “Caution—limited by federal law to investigational use,” or experimental drugs, even though a charge is made to the individual
• Medication for which the cost is recoverable by Workers’ Compensation, occupational disease law, any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the participant
• Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order
• Dietary supplements, including any supplement for newborn infants
• Growth hormones without prior authorization
• Over-the-counter medications (other than diabetic supplies)

VISION BENEFITS

You and your eligible dependents are eligible for one complete eye examination and, if your prescription changes, one pair of new single-vision, bifocal or trifocal eyeglasses every 12 months. The eye exam is covered up to reasonable and customary limits, as determined by Aetna, the claims administrator. Eyeglasses, including lenses and frames, are covered according to the following schedule:

<table>
<thead>
<tr>
<th>Lenses (per pair)</th>
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<tbody>
<tr>
<td>Single vision</td>
<td>$30</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$40</td>
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<tr>
<td>Trifocal</td>
<td>$50</td>
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Frames $30

Replacement lenses are covered once every 12 months if required because of a change in prescription. Replacement frames are covered after the first prescription is filled only if the existing frames cannot be used for a new pair of lenses that are prescribed at a later date.

When Benefits Are Not Payable

Beside the general medical exclusions noted earlier in this booklet, your vision benefit does not cover the following:

• Visual analysis that does not include a complete eye refraction
• Frames or lenses costing more than the Plan allows
• Tinted or photochromatic lenses, except for pink tints 1 and 2
• Coated lenses
• Contact lenses (except as described)
• Multifocal plastic lenses
• No-line, blended bifocal lenses
• Orthoptics or vision training
• Subnormal vision aids
• Aniseikonic lenses
• Two pair of glasses instead of bifocals
• Replacement of lost or broken lenses or frames
• 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
• Duplicate or spare glasses
• Eye exams, glasses or contacts provided by any other vision care plan
• Vision care services, materials or procedures covered by other provisions of the UPS Health Program. For example, vision therapy after cataract surgery is covered by your medical benefits.
DENTAL BENEFITS

Services performed by a legally qualified dentist and dental hygienist are covered.

Deductible

Basic and major restorative services are subject to the Plan’s major medical deductible. The deductible does not apply to preventative services or orthodontia. See the section titled “Major Medical” for more information about the deductible.

Reasonable and Customary

All eligible dental expenses 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 the claims administrator. If your dentist charges more than the R&C limit, you’re required to pay any amounts considered above that limit.

Predetermination of Benefits

The Plan has a provision that lets you know, in advance, what benefits will be paid. If you anticipate that charges for a course of dental treatment will be more than $300, you should submit an itemization of the proposed treatment (including recent pre-treatment X-rays) to the claims administrator before work begins. A dental consultant will review the proposed treatment, and the administrator will inform you and your dentist of the amount of covered charges. This way, you’ll understand the benefits that will be paid and have the opportunity to discuss possible treatment options with your dentist before treatment begins. While predetermination is not required, unless it’s an emergency, you may not wish to begin a course of treatment until you know what amount the Plan will pay.

Preventative Services

These services are covered in full:

- Oral exams (once every six months)
- Prophylaxis (once every six months)
- Topical fluoride applications for children until the end of the year in which the child turns 15 (once every six months)
- X-rays
  —Full-mouth or panoramic (once every 36 months)
  —Bitewing (once every six months)
- Sealants for children until the end of the year in which the child turns 14
  —One application per tooth per 36-month period
  —Permanent first and second molars only
Basic Services
These services are covered at 80 percent after the Plan deductible has been met:

- Visits and exams
  - Professional visit after hours
  - Consultation by a specialist
  - Emergency palliative treatment

- X-ray and pathology
  - Single films (up to 13)
  - Intra-oral, occlusal view, maxillary or mandibular
  - Upper or lower jaw, extra-oral
  - Biopsy and examination of oral tissue
  - Study models
  - Microscopic examination

- Oral surgery, including local anesthetics and routine postoperative care
  - Extractions
    - Uncomplicated
    - Surgical removal of erupted tooth
    - Postoperative visit (sutures and complications) after multiple extractions and impaction
  - Impacted teeth
    - Removal of tooth
  - Alveolar or gingival reconstructions
    - Alveolectomy (edentulous) per quadrant
    - Alveolectomy (in addition to removal of teeth) per quadrant
    - Alveoplasty with ridge extension, per arch
  - Removal of exostosis
  - Excision of hyperplastic tissue, per arch
  - Excision of pericoronar gingiva
  - Odontogenic cysts and neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor

- Other surgical procedures
  - Sialolithotomy—removal of salivary calculus
  - Closure of salivary fistula
  - Dilation of salivary 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
  - Radial resection of mandible with bone graft
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Suture of soft tissue injury
  - Injection of sclerosing agent into temporomandibular joint
  - Treatment of trigeminal neuralgia by injection into second and third divisions

- General anesthetics—when provided in conjunction with an eligible surgical procedure

- Periodontics
  - Emergency treatment (periodontal abscess, acute periodontitis, etc.)
  - Subgingival curettage or root planing and scaling, per quadrant (not prophylaxis), limited to four quadrants per year
  - Correction of occlusion related to periodontal surgery, per quadrant
  - Gingivectomy (including postsurgical 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.

• 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 restorations excluding inlays, crowns (other than stainless steel) and bridges. Multiple restorations in one surface are considered as a single restoration.
  —Restorations (involving one, two or three or more surfaces)
    • Amalgam filling
    • Silicate cement filling
    • Plastic filling
    • Composite filling—the alternate benefit of an amalgam filling will be given when placed on posterior teeth
  —Pins
    • Pin (retention) when part of the restoration used instead of gold or crown restoration
  —Crowns
    • Stainless steel (when tooth cannot be restored with a filling material)
    • Crown build-up—will be reviewed by a dental consultant for necessity

—Full and partial denture repairs
  • Broken dentures, no teeth involved
  • Partial denture repairs (metal)
  • Replacing missing or broken teeth except congenitally missing teeth
—Adding teeth to partial denture to replace extracted natural teeth
  • Teeth and clasps
—Recementation
  • Inlay
  • Crown
  • Bridge
—Repairs—crowns and bridges

• Space maintainers including all adjustments within six months after installation
  —Fixed space maintainer (band type)
  —Removable acrylic with round wire rest only
  —Removable inhibiting appliance to correct thumb sucking
  —Fixed or cemented inhibiting appliance to correct thumb sucking

**Major Services**
These services are covered at 80 percent after the Plan deductible has been met:

• Major restorative—gold restorations, inlays, onlays and crowns are covered only for treatment of decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge or partial denture. Only restorations needed for severe attrition, abrasion or erosion are covered.
  —Inlays and onlays
    • One or more surfaces
—Crowns
  ▪ Acrylic
  ▪ Acrylic with gold
  ▪ Acrylic with non-precious metal
  ▪ Porcelain
  ▪ Porcelain with gold
  ▪ Porcelain with non-precious metal
  ▪ Non-precious metal (full cast)
  ▪ Gold (full cast)
  ▪ Gold (3/4 cast)
  ▪ Gold dowel pin

• Prosthodontics
  —Bridge abutments
    (see inlays and crowns)
  —Pontics
    ▪ Cast gold (sanitary)
    ▪ Cast non-precious metal
    ▪ Slotted facing
    ▪ Slotted pontic
    ▪ Porcelain fused to gold
    ▪ Porcelain fused to non-precious metal
  —Removable bridge (unilateral)
    ▪ One piece casting, chrome cobalt alloy clasp attachment (all types), including pontics
  —Dentures and partials (fees for dentures, partial dentures and relining include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
    ▪ Complete upper denture
    ▪ Complete lower denture
    ▪ Partial acrylic upper or lower with chrome cobalt alloy clasps, base, all teeth and two clasps
    ▪ Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two clasps
  ▪ Additional clasps
  ▪ Stress breakers
  ▪ Stayplate, base-additional clasps
  ▪ Office reline, cold cure, acrylic
  ▪ Laboratory reline
  ▪ Special tissue conditioning, per denture
  ▪ Denture duplication (jump case), per denture
  ▪ Adjustment to denture more than six months after installation

• Other services
  —Precision attachments (eligible with dentures if they are functionally necessary)
  —Implants (if specifically approved in advance and the teeth are extracted or missing while covered by the Plan)

Alternate Benefit Provision
In some circumstances, an alternate service or supply may be suitable to treat or restore a dental condition, other than the service or supply recommended by your dentist. In this case, the Plan will pay only for the alternate service or supply. If you choose the recommended course of treatment, you’ll 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 must pay the difference between the composite and the amalgam filling. While predetermination is not required, you may wish to submit your course of treatment in advance so you know what amount the Plan will pay (see “Predetermination of Benefits”).
Orthodontia
The Plan allows benefits for orthodontics 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 the treatment began before the child’s 19th birthday. The Plan pays 50 percent of the R&C charges for orthodontia, up to a $1,500 lifetime maximum for each child. This maximum includes treatment for TMJ syndrome (described below) for children under age 19.

Orthodontia benefits are not subject to the annual deductible. Orthodontic payments are made on a monthly basis. The first payment is equal to 50 percent of the down payment plus 50 percent of the fee for the diagnostic records. However, quarterly certification is required to verify that treatment is continuing. Payments begin when an active appliance is installed in your child’s mouth.

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

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

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

What’s Not Covered By Your Dental Benefits
In addition to services not specifically listed in the “Covered Expenses” section, the following expenses are not covered by the dental portion of the Plan:

- Services not required for the treatment of a specific condition or to maintain good dental hygiene, as determined by the claims administrator
- Services not reasonably necessary or customarily performed, as determined by the claims administrator
- 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 Plan’s medical options
- Treatment of a work-related injury
- Services furnished by or for the United States government or for any other government, including a service that may be covered by a government plan
- Charges for a missed or broken appointment
- Charges for the dentist’s travel
- Occlusal adjustment (unless following periodontal surgery) or retainers if charged separately from orthodontic treatment
- Claims received more than 24 months past the date of service
• Intravenous sedation, except in certain circumstances. Call Member Services to determine if covered.

• Appliances, restoration or procedures needed to alter vertical dimensions or restore occlusion or for the purpose of splinting or correcting non-severe attrition or abrasion

• Dentures and bridgework when they are for the replacement of teeth that were extracted before the patient was covered by the Plan

• Orthodontic treatment begun before covered by the Plan

• Root canal therapy if the pulp chamber was opened before the patient was covered by the 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 Program 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)

• Education programs, such as plaque control or oral hygiene instruction

• 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 replacement or modification of an inlay, onlay, crown or cast processed restoration, within five years after installation

• Actisite

• Local anesthesia or nitrous oxide as a separate charge

• Any prescription drug

• Full mouth debridement

• Guided tissue regeneration

• Desensitization treatment

• Precision attachments except as noted under “Major Services”

• Infection control

• Behavior management

• Canal preparation, if submitted as a separate charge

• Rubber dam
Life Insurance and Accidental Death and Dismemberment (AD&D) Coverage

Employee Life Insurance
If you were hired after July 2, 1982, UPS provides you with life insurance coverage of $20,000.

If you were hired on or prior to July 2, 1982, UPS provides you with life insurance coverage of $40,000.

Spouse Life Insurance
Your spouse’s life insurance coverage is $5,000.

Dependent Child Life Insurance
Your dependents’ life insurance coverage is $2,000.

Employee Accidental Death and Dismemberment
If you were hired after July 2, 1982, UPS provides you with AD&D coverage of $20,000.

If you were hired on or prior to July 2, 1982, UPS provides you with AD&D coverage of $40,000.

Accidental death and dismemberment insurance pays a benefit if you die or have certain injuries resulting from an accident. If your death is caused by an accident, your beneficiary receives the full amount. If you’re injured as a result of an accident, you receive all or a portion of the benefit, depending on the nature of the injury. Benefits are not paid unless your death or injury occurs within 90 days of the accident.

Exclusions and Limitations
AD&D benefits are not payable for death and dismemberment caused by:
- Bodily or mental infirmity
- Disease, ptomaines or bacterial infections
- Medical or surgical treatment (except if the loss is caused by an infection which results directly from the injury or surgery needed because of the accidental injury)
- Suicide or intentionally self-inflicted injury
- War or any act of war (declared or undeclared)
- An injury incurred while committing an unlawful act of aggression, including a misdemeanor or felony
- Use of alcohol, intoxicants or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of the motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred is deemed to be caused by the use of alcohol.
- Inhalation of poisonous gases
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release

Life insurance and AD&D benefits are provided through an insurance contract with Aetna Life Insurance Company. If there is any conflict between the contract and this description, the contract provisions apply.

Your Beneficiary
You may name anyone you choose as beneficiary for your life insurance and AD&D benefits. AD&D benefits payable for a reason other than for death are payable directly to you. To name a beneficiary or change your current beneficiary at any time, call 1-800-353-9877 to request a form.
Your beneficiary change is not effective until the UPS Benefits Service Center receives your completed beneficiary designation form.

**Conversion of Life Insurance**
If you terminate your employment or retire from UPS, you are eligible to convert your life insurance coverage and your dependent life insurance coverage to individual policies. Your AD&D policy is not eligible for conversion. If you lose coverage due to any other reason, you are not eligible for conversion until either termination or retirement occurs. If you are totally disabled and receive a waiver of premium, you will not be eligible for conversion.

If you choose to convert your life insurance to a self-paid individual policy offered by Prudential, you must apply for conversion within 31 days of your last day of coverage. When you apply for conversion coverage, Prudential will explain the individual policies that are available to you. To request a Conversion Kit or to make inquiries regarding conversion, please contact Prudential Group Conversion office toll free at (877) 889-2070.

**Waiver of Premium**
You may be eligible for a waiver of premium if you're permanently and totally disabled and under age 60. This means your life insurance benefit will continue at no cost to you even though you’re no longer able to work. Total disability for this purpose means a disability resulting from illness or injury that completely prevents you from performing any work or engaging in any occupation for wage or profit.

Prudential Insurance Company of America determines eligibility for premium waiver and will notify you in writing of the status of your application. Please note that premium waiver does not continue your spouse’s or dependents’ life insurance coverage. Premium waiver claims must be received within three months of your date of disability.

**SHORT-TERM DISABILITY INCOME**
Short-term disability (STD) protects your wages if you have an absence caused by a non-occupational illness or accidental injury. An absence for maternity is treated like an absence for illness.

**Short-term Disability Benefits**
Once you qualify for benefits, you will receive the following disability income:

*If you were hired after July 2, 1982*

$125 per week for up to 26 weeks.

*If you were hired on or prior to July 2, 1982*

$300 per week for the first 10 weeks of disability and $350 per week for the next 16 weeks of disability up to 26 weeks.

**Who Qualifies for STD Benefits?**
For STD purposes, you are considered disabled if the claims administrator, Kemper National Services, determines that you are unable to perform the material and substantial duties of your regular occupation because of an illness or injury.
Qualification for STD benefits is subject to Kemper obtaining information supporting your disability. You may also need medical approval prior to returning to work.

When Do You Start to Receive STD Benefits?
If you were hired after July 2, 1982
- If you are injured
  — STD benefits are payable from your disability date (as determined by a physician) if you have received medical treatment within one day before or three days after the disability date indicated by the doctor. Otherwise, the first date of medical treatment after that date is used to start your STD benefits.
- If you are ill or pregnant
  — STD benefits are payable from the eighth day after your disability date (as determined by a physician) if you have received medical treatment within one day before or three days after the date indicated by the doctor. Otherwise, STD benefits begin eight days after you receive medical attention.

If you were hired on or prior to July 2, 1982
Benefits begin on the first day of an absence due to an accidental injury and on the fourth day of an illness or pregnancy.

If You Have More Than One STD Absence
If you are absent and receiving STD benefits, return to work for at least one day and are later absent for an entirely different cause, you're eligible for a new period of STD benefits (after the applicable waiting period).

If your second absence is due to the same cause, you must have returned to work for 30 consecutive calendar days before a new disability period begins. Otherwise, your second absence is considered a continuation of the first disability period. Both periods of absence count toward the maximum coverage.

Disability Benefit Offsets
Your STD benefit is reduced by the full amount of other earnings, disability income or retirement income you may receive, or be eligible to receive, including:
- Any amount received from a retirement plan or pension plan that UPS contributes to or sponsors
- Any amount you receive from another group insurance plan (personal insurance plans are not offset)
- Any disability benefits received from the Veterans Administration
- Any work-loss provision of a no-fault or third-party benefit or settlement
- Any primary benefit received under the U.S. Social Security Act

The Plan requires that you apply for Workers’ Compensation if your disability is work-related. If you are receiving or have received payment from a Workers’ Compensation claim, you cannot collect STD benefits for the same disability.

Exclusions and Limitations
No STD benefits are payable from this Plan for any disability that results from:
- Any injury or illness sustained in the course of any employment for compensation or gain
- Intentionally self-inflicted injuries
- Participation in a felony
- War, or act of war (whether declared or not), insurrection, rebellion or participation in a riot or civil commotion
EXTENSION OF MEDICAL COVERAGE DURING DISABILITY

If you become unable to work due to an illness or injury that leaves you totally disabled, basic and major medical coverage for you and your eligible dependents may be extended.

If You Lose Coverage Due to a Non-occupational Illness or Injury
UPS provides coverage for you and your covered dependents for the first six months of disability. You then pay to continue coverage for you and your dependents during months seven through 12. If you remain disabled, UPS will again pick up the premium for your and your dependents’ coverage for months 13 through 18. All dependent coverage ends after 18 months.

If your disability continues beyond 18 months, UPS will continue to provide coverage for you (the employee) only for an additional 12 months. The first three months of this extension period will include basic and major medical coverage; the last nine months will include major medical coverage only. All services previously covered by the basic portion of the Plan will be paid by the major medical portion, subject to the deductible and co-insurance amounts.

If You Lose Coverage Due to an Occupational Illness or Injury
UPS provides coverage for you and your dependents during the first 12 months following the date your disability began. All dependent coverage ends after the first 12 months. (Dependents may continue coverage for an additional six months by self-paying for the balance of their COBRA period. See “Continuation of Coverage under COBRA” section later in this booklet.)
If you continue to be disabled beyond 12 months, UPS will continue to provide coverage for you (the employee) only for an additional 12 months. The first three months of this extension period will include basic and major medical coverage; the last nine months will include major medical coverage only. All services previously covered by the basic portion of the Plan will be paid by the major medical portion, subject to the deductible and co-insurance amounts.

This extended medical coverage is coordinated with COBRA continuation coverage. This means your extended Company-provided basic and major medical coverage is credited toward your or your eligible dependents’ COBRA coverage period. If you become disabled, you’ll receive information concerning how and when you can elect COBRA for the portion of your COBRA coverage period that remains after your extended Company-provided basic and major medical coverage ends.

The above rules regarding the extension of Company-provided coverage and the duration of the COBRA continuation period may be modified to reflect your rights, if applicable, under the Family and Medical Leave Act. If required by FMLA, your COBRA continuation period would not begin until you terminate employment or otherwise fail to return from your FMLA leave. However, if Company-provided coverage extends beyond the FMLA leave, it will be credited toward your COBRA continuation period.

**HOW TO FILE A CLAIM**

**Medical, Vision and Dental Claims**
Benefit claim forms are available by calling Aetna Member Services at 1-800-237-0575 for medical, vision and prescription claims and at 1-877-263-0659 for dental claims.

Please remember to attach to your claim forms all invoices for which you’re claiming benefits. A different claim form should be filled out for each dependent. Be sure each form includes:

- The patient’s full name and date of birth
- Your member number from your medical ID card
- Dates of service
- Diagnosis
- Charge for each service
- The provider’s full name, address and taxpayer identification number
- Whether you want payment made to you or the provider

If your claim is approved, you’ll receive payment of benefits, unless you’ve assigned payment to a doctor, hospital or other service provider. If you assign benefits, you’ll receive a copy of the payment statement so you’ll know what portion of the bill you must pay yourself, if any.

**Important:** Claims must be received within 24 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 are void.
Life Insurance, AD&D and Premium Waiver Claims
Contact the UPS Benefits Service Center at 1-800-353-9877 for information on filing Life, AD&D and premium waiver claims. If you have a question on a claim already filed, contact Prudential Insurance Company of America at 1-877-877-2955 for more information.

**Important:** Life Insurance and AD&D claims must be received within 12 months of the date of the death or accident, or no benefits will be paid. Premium waiver claims must be received within three months of your date of total disability. Reimbursement checks that are not cashed within 12 months of the date the checks are issued are void.

Short-term Disability Income Claims
If you become unable to work because of an injury, illness or pregnancy, call the claims administrator, Kemper National Services, at 1-866-825-0186 at the end of your applicable waiting period so Kemper can begin processing your claim.

**Important:** If you do not call to file a claim within 90 days of the initial date of disability, you will not be eligible for benefits.

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**IF YOUR CLAIM IS DENIED**

If your claim is denied, in whole or in part, you usually will receive a written notification of the denial within 90 days (45 days for disability claims) of submitting the claim. If you don’t receive a response within this time period, you should consider your claim denied. The denial notice will explain:

- The reasons for the denial
- The Plan provisions on which it is based
- Any additional material or information needed to make the claim acceptable and the reason it is necessary, and
- The procedure for requesting a review

If special circumstances require more time for processing the claim, you’ll be notified of that fact, in writing, within the 45- or 90-day time period. The notice you receive will explain what special circumstances make an extension necessary and indicate the date a final decision is expected to be made. The extension may be for up to another 90 days (or two 30-day periods, for disability claims).

**Appealing Your Denial**

You or your beneficiary are entitled to a review of a denied claim. The situation should first be appealed to the highest available level with the claims administrator.

If you then believe further review is needed, you may (within 60 days of the administrator’s final appeal denial) submit a written request for an appeal with the UPS Claims Review Committee. All appeals to this committee must be submitted through your region Human Resources department.

The Claims Review Committee will normally make a decision on the denial within 60 days after your request for review is received. You’ll receive notice of the decision in writing, including the specific reasons for it and references to the Plan provisions on which it’s based.

If special circumstances require a review period of longer than 60 days, the time for making a decision may be extended, and you’ll be notified of the extension within 60 days after your requested review. However, the total review period will not be longer than 120 days.
Appeal Procedures for Short-term Disability

All of the claims procedure information described above applies to disability claims filed under Short-term Disability Income except as follows.

The amount of time the Plan has to respond to your claim is reduced from 90 days to 45 days and the extension period changes from one 90-day period to two 30-day periods. If an extension is needed because of incomplete information, you will have 45 days in which to respond (during which the time period for making a determination does not run).

If your claim is denied, you must file an appeal within 180 days (instead of 60 days). You will be notified of the decision within 45 days, with one 45-day extension period permitted for reasons beyond the Plan’s control.

Limitation on Legal Action

Any legal action to recover Plan benefits must be filed within 180 days of the Plan’s decision on appeal. Your failure to appeal within 180 days results in the loss/waiver of your right to appeal and file suit.

RIGHT OF RECOVERY/SUBROGATION

This section describes the Plan’s right to seek reimbursement of expenses that were 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 any insurance proceeds, settlement amounts or amount recovered in a lawsuit.

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:

- Execute an agreement provided by the claims administrator acknowledging the Plan’s right to recovery, agreeing to repay any claims paid by the Plan, pledging amounts recovered by the Covered Individual from the third party as security for repayment of any claims paid by the Plan, and to the extent provided below, assigning the Covered Individual’s cause of action or other right of recovery to the Plan. If the Covered Individual fails to execute such an agreement, by filing claims (assigning benefits or having claims filed on your behalf) related to such act of a third party, the Covered Individual shall be deemed to agree to the terms of this reimbursement provision.
- Provide such information as UPS or the claims administrator may request.
- Notify UPS and/or the claims administrator in writing by copy of the complaint or other pleading of the commencement of any action by the Covered Individual to recover damages from a third party.
- Agree to notify UPS and/or the claims administrator of any recovery.
The Plan’s right to recover the benefits it has paid is not subject to reduction for attorney’s fees or other expenses of recovery, and 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 (that is, 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 from the Plan in the amount of any claims paid. 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 by 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 by 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.

**COORDINATION OF BENEFITS**

If you or one of your dependents are 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 coordination of benefits provision is always the primary plan. If all plans have this provision, the primary plan is determined in this order:

- The plan covering the person as an employee is primary
- If a child is covered by both parents’ plans, the plan of the parent whose birthday falls first in the calendar year is considered the primary plan
When the UPS Health Program is the secondary plan, it has no obligation to pay benefits until benefits from the primary plan are exhausted. The amount of benefits paid is determined by the terms of the Plan (including applicable deductibles and co-payments), reduced by the amount payable by the primary plan. The combined payment from both plans will equal no more that 100 percent of the allowable expenses.

Coordinating With Medicare
Medicare benefits will be primary to the extent permitted under applicable law. Covered individuals who are covered under the Health Program based on criteria other than current employment status — e.g., COBRA continuers, certain disabled employees — will have Medicare as their primary coverage. Individuals with End Stage Renal Disease (ESRD) may be subject to a coordination period, after which Medicare will become primary.

As a general rule, if you or your covered dependent becomes eligible for Medicare benefits, there are rules that determine whether the Health Program pays benefits first, or whether Medicare is primary.

- If you are an active employee covered by the Health Program, the Plan would be primary for you and your covered dependent who is eligible for Medicare (for example, due to a disability or being age 65 or older)
- If you are disabled and not actively working, the Plan would be primary for you and any covered dependents who may be eligible for Medicare for the first six calendar months of your disability period. After the six-month period, if you are not actively working at UPS, Medicare pays benefits first for you and any covered dependents (if they are also eligible for Medicare).

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

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

During the time the Health Program 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.

**LIFE EVENTS**

The UPS Benefits Service Center maintains all of your and your dependents’ benefits eligibility information. If you experience any of the following life events, it’s important to contact the Service Center at 1-800-353-9877 to update your information:

- Marriage
- Divorce or legal separation
- Birth or adoption
- Dependent gains or loses eligibility
- Death of a dependent

You’ll need to have your Personal Identification Number (PIN) handy to make these changes. Your PIN is provided to you when your coverage begins.
What If...
If your employment status with UPS changes, it may affect Plan coverage for you and your eligible dependents. The following is a list of events and their impact on your eligibility for coverage.

...You Leave UPS?
If you leave UPS, health care and life insurance coverage for you and your dependents ends 31 days after your last day at work. Accidental death and dismemberment and short-term disability income benefits end on the day you leave.

You can continue your health care coverage under COBRA. Also, you may convert your, your spouse’s and your children’s life insurance to individual policies. You cannot convert AD&D coverage to an individual policy.

...You Get Divorced or Legally Separated
Coverage for your spouse will end the day you get divorced or legally separated. While an ex-spouse is no longer eligible for Plan benefits, he or she is eligible for COBRA coverage. You’re required to notify the Plan within 60 days of a divorce or legal separation in order for your spouse to be eligible for COBRA. See the “Continuation of coverage under COBRA” section for more information.

...You Die?
If you die while you’re covered by the UPS Health Program as an active employee, UPS will continue your eligible dependents’ health care and life insurance coverage at no cost to your dependents for 31 days from your date of death.

When this UPS-paid coverage ends, your dependents may extend health care coverage in accordance with COBRA provisions.

...You’re Laid Off?
If you’re laid off, your UPS Plan coverage will continue until the last day of the month following the month in which your layoff begins.

...You Take an Approved Leave of Absence?
- FMLA Leave
  — If you’re on an approved leave of absence as provided by the Family and Medical Leave Act or UPS policy, full Plan coverage for you and your dependents will continue for up to six weeks if you have three or more years of service. If you have less than three years of service, coverage is extended through the end of the day your leave begins.
  — If your leave is approved for an extension beyond six weeks or if you’re not eligible for FMLA, coverage from the Plan will continue provided you pay the full cost. You’ll need to notify UPS in writing that you want to extend your leave.

- Military Leave
  — Except for military leaves of less than 31 days (or as otherwise required by federal law), benefits cease. Refer to the COBRA section for information on continuing your coverage.

- Personal Leave
  — You’re responsible for the full cost of coverage during a personal leave and will be billed if your leave extends beyond 20 days. If you fail to make timely payment of this bill, your coverage will be terminated.
**CONTINUATION OF COVERAGE UNDER COBRA**

In certain circumstances, health care coverage for you and your dependents 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).

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.

If you decide to continue coverage, you must pay the full cost of that coverage, plus a two percent administrative cost. The monthly premium amount will be provided to you at the time a qualifying event occurs.

Continued coverage will be available for either an 18- or 36-month period, as noted in the following table. However, this continued coverage period will end sooner for an individual if, after a COBRA election:

- The premium for continued coverage is not paid when it’s due
- That person becomes covered by another health care plan (except a plan that excludes a preexisting condition for which that person needs treatment)
- That person becomes eligible for Medicare, or
- The UPS Health Program terminates for all employees

If you (or your dependent) are disabled at the time (or within 60 days from the time) you terminate employment or have a reduction in hours, you may extend COBRA coverage for an additional 11 months. This coverage is available at 150 percent of the applicable premium. To be eligible for this extension, you (or your dependent) must:

- Receive a determination of disability from the Social Security Administration, and
- Notify the UPS Benefits Service Center within 60 days of receiving the disability determination and before the original 18-month period ends

If during the 11-month extension you’re no longer considered disabled based on the Social Security Act, you must notify the Benefits Service Center at 1-800-353-9877 within 30 days of this determination. COBRA coverage may then continue until the end of the first month that starts more than 30 days after Social Security’s decision.

---

**Continuation of Coverage under COBRA**

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Continuation of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You terminate UPS employment before retiring</td>
<td>You: 18 months, Your dependent spouse: 18 months, Your dependent child: 18 months</td>
</tr>
<tr>
<td>Your work hours are reduced*</td>
<td>You: 18 months, Your dependent spouse: 18 months, Your dependent child: 18 months</td>
</tr>
<tr>
<td>You retire</td>
<td>You: 18 months, Your dependent spouse: 18 months, Your dependent child: 18 months</td>
</tr>
<tr>
<td>You become divorced or legally separated</td>
<td>NA: 36 months, Your dependent spouse: 36 months, Your dependent child: 36 months</td>
</tr>
<tr>
<td>Your child ceases to be a qualified dependent</td>
<td>NA: 36 months, Your dependent spouse: NA, Your dependent child: 36 months</td>
</tr>
<tr>
<td>You die</td>
<td>NA: 36 months, Your dependent spouse: NA, Your dependent child: 36 months</td>
</tr>
</tbody>
</table>

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

Note: Company-provided extension periods during disability and FMLA leave are included as part of the maximum coverage period under COBRA.
**Life Events Requiring Notification**

<table>
<thead>
<tr>
<th>Event</th>
<th>Responsible for Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination</td>
<td>UPS Benefits Service Center will automatically send COBRA enrollment materials to employee’s address on file</td>
</tr>
<tr>
<td>Retirement</td>
<td></td>
</tr>
<tr>
<td>Layoff</td>
<td></td>
</tr>
<tr>
<td>Death of employee</td>
<td>You, your spouse or your child must call the UPS Benefits Service Center at 1-800-353-9877 immediately. If you do not notify the Service Center within 60 days, you forfeit any right to COBRA coverage.</td>
</tr>
<tr>
<td>Transfer to ineligible position</td>
<td></td>
</tr>
<tr>
<td>Leave of absence</td>
<td></td>
</tr>
<tr>
<td>Loss of dependent status due to age</td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td></td>
</tr>
<tr>
<td>Legal separation</td>
<td></td>
</tr>
<tr>
<td>Loss of dependent status not due to age</td>
<td></td>
</tr>
</tbody>
</table>

**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 UPS Benefits Service Center immediately. You must notify the Service Center within 60 days of the qualifying event or continued coverage will not be available. The chart above shows when UPS will automatically send COBRA enrollment materials and when you or your dependent must notify the Service Center.

**The COBRA Administrator**
The UPS Benefits Service Center is the COBRA administrator and handles all COBRA enrollment and billing. The Service Center can be reached at 1-800-353-9877.

**YOUR RIGHT TO OBTAIN INDIVIDUAL COVERAGE**
A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires all health insurance carriers offering coverage in the individual market to accept any eligible individuals who apply for coverage, without imposing a preexisting condition exclusion. To take advantage of this HIPAA right, you must complete your 18-, 29- or 36-month COBRA coverage period under the UPS Plan 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 of insurance or see an independent insurance agent.
ERISA INFORMATION

The information contained in this booklet is a summary of the applicable administrative and legal documents relating to the UPS Health Program. For insured benefits, in the event there is any difference between this booklet and the applicable contracts or certificates, the insurance documents will govern.

UPS 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 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.

Plan Amendment or Termination

UPS has established the 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 this Plan applies to all coverage hereunder.

Your participation in the UPS Health Program does not guarantee your continued employment with the Company. If you quit, are discharged or laid off, the Plan does not give you a right to any benefit or interest in the Plan except as specifically provided in the Plan document.

All benefits described in this booklet—both for you and your family—are paid for by United Parcel Service and are made available to you as part of the compensation you receive for your work with the Company.

Your ERISA Rights

The Health Program is an employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA). As a participant in the Plan, you have certain rights and protection based on ERISA.

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

…receive information about your Plan and benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations such as work-sites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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.

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.

…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 (pension, 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 reviewed 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 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
  Pension and Welfare Benefits Administration
  U.S. Department of Labor
  200 Constitution Ave., N.W.
  Washington, DC 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 ADMINISTRATION

The Plan Administrator 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 service providers. Presently, certain administrative services with regard to the processing of claims and payment of benefits are provided under contract as follows:

Medical, Dental, Vision and Prescription coverage is administered by:
Aetna
151 Farmington Avenue
Hartford, CT 06156

Life Insurance and AD&D coverage is administered by:
Prudential Insurance Company of America
751 Broad Street
Newark, NJ 07102

Short-term disability is administered by:
Kemper National Services
1601 SW 80th Terrace
Plantation, FL 33324

GENERAL INFORMATION

Name of Plan
The UPS Health Program

Plan Number
503

Plan Year
January 1 through December 31

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

Employer Identification Number (EIN)
95-1732075

Plan Administrator
UPS Health Program
United Parcel Service of America, Inc.
55 Glenlake Parkway, NE
Atlanta, GA 30328

Plan Trustee
Boston Safe Deposit and Trust Company
135 Santilli Highway
Everett, MA 02149

Information booklets describing the Plan have been prepared for different groups of employees. Benefit schedules may vary by local union, work group or hire date to reflect the negotiated benefits as stated in your local collective bargaining agreement.
Each year we announce any material changes to the UPS Health Program. This notice details Plan changes and clarifications to your Plan. Please review this information carefully, and keep this document with your Summary Plan Description booklet for future reference. The information included in this notice should be considered an addition to the language already in your SPD; however, if any provision in this notice is inconsistent with the language in the SPD, you should consider the language in this notice the prevailing language. This notice is intended to fulfill UPS’s legal obligation to notify employees of significant changes to the UPS Health Program and formally amends the coverage available under the UPS Health Program.

**WHEN CHILDREN ARE UPSERS**
If you and your dependent child both work for UPS and are both covered through a UPS-administered plan, you cannot cover your child as a dependent in the Health Program. There is no dual coverage available between two UPS-administered plans.

**MEDICAL**
**Medically Necessary Services and Supplies**
Only medically necessary services are covered by the UPS Health Program. A service or supply is medically necessary if the claims manager determines that it is required for the diagnosis, care or treatment of a disease, injury or pregnancy in accordance with generally accepted medical practice.

**Investigational or Experimental Treatment**
Investigational or experimental services and supplies continue to be excluded. Investigational and experimental 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.

**FILING CLAIMS:**
Medical claims should be sent to: Aetna, P.O. Box 14079, Lexington, KY 40512-4079

Dental claims should be sent to: Aetna, P.O. Box 14066, Lexington, KY 40512-4066

**DEPENDENT CHILD LIFE INSURANCE**
Stillborn births are not covered.

**LIFE INSURANCE**
To request a Conversion Kit or to make inquires regarding conversion, please contact the Prudential Group Conversion office at (877) 889-2070.

**SHORT-TERM DISABILITY**
Kemper National Services will determine whether your disability began as the result of an illness or injury. Qualification for STD benefits is subject to Kemper obtaining medical information from you (or your physician at your request) supporting your disability.

No STD benefits are payable for an injury or illness sustained when you are not currently employed by the company, on strike or layoff status or on Workers’ Compensation leave, STD leave or any other leave of absence other than an approved vacation, holiday or day off.

**BENEFITS AFTER MEDICARE ELIGIBILITY**
Medicare benefits will be primary to the extent permitted under applicable law, e.g. with respect to the covered individual who receives Plan coverage other than by virtue of current employment status (COBRA continuees, certain disabled individuals, and individuals with end stage renal disease) after any mandatory Medicare secondary period. The UPS Plan will coordinate with Medicare to the extent permitted under applicable law.

**RIGHT OF RECOVERY/SUBROGATION**
The Plan’s right to recover benefits it has paid is subject to a reduction for attorney’s fees or other expenses of recovery. The reduction is limited to the lesser of actual attorney fees and other expenses or one-third of the Plan’s lien.

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

In addition, the Plan has a right to recover benefits that were paid in error (e.g., benefits paid to an ineligible person) or benefits that were obtained in a fraudulent manner, as determined by the Plan Administrator. Benefits may be recovered by either direct payment to the Plan by you or a beneficiary (through voluntary payments or legal action) or by an offset of future benefits equal to the amount of the overpayment.
Reinstatement of Lifetime Maximum Following Subrogation
In the event the Plan recovers in accordance with the Plan’s Right of Recovery Provisions, the Plan will reinstate your lifetime maximum under the Plan equal to the amount recovered reduced by the Plan’s costs incurred to obtain the recovery.

COBRA
The initial premium must be paid within 45 days of your enrollment date. Subsequent premiums are due on the first of each month. Failure to make premium payments within 30 days of the due date will cause your coverage to terminate retroactive to the end of the last month in which payment was received.

If, during your 11-month COBRA extension (due to a Social Security approved disability), you or another qualified beneficiary are determined to no longer be disabled by the Social Security Administration, your COBRA coverage may continue up to the first day of the month that is more than 30 days after Social Security’s decision or when your coverage would otherwise end, if earlier.

LIFE EVENTS
Add the following language under the section “...You take an approved leave of absence.” If you are eligible for protection under the Family and Medical Leave Act of 1993 (FMLA), full coverage for you and your eligible dependents will continue for 12 weeks. Contact your local Human Resources department for information as to whether you are eligible for FMLA leave.

PLAN ADMINISTRATION
All benefits described in this booklet are paid for by UPS. UPS has established a special trust, called a voluntary employee beneficiary association trust, to serve as the funding vehicle. All contributions to the trust are made from the general assets of UPS.

The Plan Administrator may delegate certain discretionary authority to one or more committees.

Short-term disability is administered by: Kemper National Services, 1601 SW 80th Terrace, Plantation, FL 33324.

ERISA RIGHTS
Please add the following language to Your ERISA Rights, under the heading:

ERISA provides that, as a Plan participant, you are entitled to: ...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 preexisting condition under your group health plan, if you move to another plan and you have creditable coverage from this Plan. The Health Program does not contain any exclusionary periods of coverage for preexisting conditions. You will be provided a certificate of creditable coverage, free of charge, from the Health Program 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage in another plan.

IF YOUR CLAIM IS DENIED
Certain claims and appeals procedures have changed as a result of new regulations and are effective January 1, 2002 for Short-Term Disability claims and January 1, 2003 for all group health claims.

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
UPS-provided basic life and AD&D coverage is provided through an insurance contract issued to UPS by Prudential. This means Prudential is the applicable claims fiduciary with respect to life and AD&D claims for benefits and UPS has no discretionary authority with respect to these claims. Contact Prudential for information about the applicable claims and appeals procedures.

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

Group Health Claims
There are three types of group health claims: Pre-Service, Concurrent Care, and Post-Service Claims. Also, certain pre-service or concurrent care claims may involve “urgent care.” See below for a detailed description of the types of claims.

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

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

**Step 2:** Review your notice carefully. Once you have received your notice from the claims administrator, review it carefully. The notice will contain:
- 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 final 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 1st Level Appeal with the claims administrator. If you do not agree with the decision of the claims administrator, you may file a written appeal with the claims administrator within 180 days of receipt of the claims administrator’s letter (or oral notice if an urgent care claim) referenced in Step 1. If the claim involves urgent care, your appeal may be made orally. In addition, you should submit all information referenced in Step 2 above. The notice will contain the same type of information that was identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

**Step 4:** 1st Level Appeal notice is received from claims administrator. If the claim is again denied, you will be notified by the claims administrator within the time period described in the Claims and Appeal Procedures Chart, depending on the type of claim.

**Step 5:** Review your notice carefully. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the claims administrator.

**Step 6:** If you still disagree with the claims administrator’s decision, file a 2nd Level Appeal with the Committee. If you still do not agree with the claims administrator’s decision, you may file a written appeal to the Committee within 60 days after receiving the first level denial notice from the claims administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim. The appeal should be sent to: UPS Claims Review Committee, 55 Glenlake Parkway NE, Atlanta, GA 30328.

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

**Important Information**
Other important information regarding your appeals:
- Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- If a claim involves medical judgment, then the claims administrator and the Claims Review Committee will consult with an independent health care professional during the 1st and 2nd level appeal who has expertise in the specific area involving medical judgment.
- You cannot file suit in federal court until you have exhausted these appeals procedures.

**Short-Term Disability**
The same steps described above for group health claims apply to short-term disability claims; however, the time periods for making a decision for disability claims are different. See the Claims and Appeals Procedures chart below for more information.

<table>
<thead>
<tr>
<th>Pre-Service Claim—a claim for health care where prior approval for any part of the care is a condition to receiving the care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Post-Service Claim—a claim for care that has already been received, any claim for which the Plan does not require pre-authorization.</td>
</tr>
<tr>
<td>Urgent Care Claim—a Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:</td>
</tr>
<tr>
<td>– 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</td>
</tr>
<tr>
<td>– 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).</td>
</tr>
</tbody>
</table>
Claims and Appeals Procedures Chart

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

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Initial Claims</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Health Claims</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Service</td>
<td>15 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
<tr>
<td>Pre-Service involving Urgent Care</td>
<td>72 hours (24 hours if additional information is needed from you)</td>
<td>None</td>
<td>48 hours (claims administrator must notify you of determination within 48 hours of receipt of your information)</td>
</tr>
<tr>
<td>Concurrent: To end or reduce treatment prematurely</td>
<td>Notification to end or reduce will allow time to finalize appeal before end of treatment</td>
<td>N/A</td>
<td>Denial letter will specify filing limit</td>
</tr>
<tr>
<td>Concurrent: To deny your request to extend treatment</td>
<td>15 days from receipt of the claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
<tr>
<td>Concurrent involving Urgent Care</td>
<td>24 hours, if your claim is submitted at least 24 hours before the scheduled end of treatment. Otherwise, treated as Pre-Service Urgent Care</td>
<td>None</td>
<td>N/A</td>
</tr>
<tr>
<td>Post-Service</td>
<td>30 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term Disability</td>
<td>45 days from receipt of claim</td>
<td>Two extensions of 30 days each</td>
<td>45 days of date of extension notice</td>
</tr>
</tbody>
</table>

*The extension period is measured from the end of the original determination due date.

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UPS Health Program

Schedule 115

Member Services Directory

Benefits Service Center
- Verify employee and dependent eligibility
- Add or remove dependents
- Request benefits material
- COBRA administration

Aetna Medical
- Medical, vision and prescription drug coverage

Aetna Dental
- Dental coverage

Kemper National Services
- Short-term disability claims

Prudential Insurance Company of America
- Inquiry on life insurance and AD&D claims
  (Benefits Service Center provides claim forms)

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