

## Deductibles/Out-of-Pocket Costs

	UPS Plan		Teamcare (New Members)		Teamcare (Existing)	
	In-Network	Out-of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Annual Deductible	None	* \$250 per person * \$500 per family	\$0 for 2014-17; 100 for individuals, 200 for family in 2018	10% penalty for out-of-network	\$100 for individuals, \$200 for family for every year of the contract	10% penalty for out-of-network
Annual out-of-pocket maximum	\$1000 per person	\$3000 per person	\$1000 per person \$2000 per family	\$2000 per family	\$1000 per person \$2000 per family	\$2000 per family
Life-time Max (will be "none" under Affordable Care Act in 2014)	\$1,000,000 per person		No Cap Under ACA		No Cap Under ACA	

\* For most out-of-network expenses under Teamcare, the member is charged a 10% penalty plus the difference in what the plan pays and what the doctor charges.

## Medical Benefits

Physician Costs	UPS Plan		Teamcare (New Members)		Teamcare (Existing Members)	
	In-Network	Out-of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Office Visit	Paid at 100% after \$10 co-pay	Paid at 80%	\$10 co-pay	\$20 co-pay plus 10% penalty plus	\$20 co-pay	\$20 co-pay plus 10% penalty plus
Inpatient Surgery	Paid at 100%	80%	100%	100% of "reasonable and customary" cost less %10 plus difference in bill.	100%	100% of "reasonable and customary" cost less 10% plus difference in bill.
Outpatient Surgery	Paid at 100%	80%	100% after plan deductible		100% after plan deductible	
Allergy testing and treatment services	Paid at 90%	80%	80%	80% plus 10% and difference in bill.	80%	80% plus 10% and difference in bill.

### Hospital Costs

Hospital Admission Fee	None	\$250 with pre-certification	None		None	
Inpatient Service	100% Paid after \$10 co-pay	80%	100%	70% plus difference in bill	100% of semi-private room after deductible met. No maximum daily limit.	70% plus difference in bill
Outpatient Service	Paid at 100%	80%	100%	80% plus 10% and difference in bill. 100% after deductible for outpatient cancer.	80%	80% plus 10% and difference in bill. 100% after deductible for outpatient cancer.
Emergency Room Care	Paid at 100% within 72 hours of incident; \$25 co-pay after 72 hours	Paid at 100% within 72 hours of incident; \$25 co-pay after 72 hours	100% on first day of accident; after first day, 80% after out-of-pocket met.	100% less 10% plus difference in bill on first day. After first day, 80% plus 10% and difference in bill.	100% on first day of accident; after first day, 80% after deductible met.	100% less 10% plus difference in bill on first day. After first day, 80% plus 10% and difference in bill.
Ambulance due to emergency	100%	100%	100% after plan deductible (subject to review)		100% after plan deductible (subject to review)	
Ambulance (non-emergency)	100%	80%				

	UPS Plan	Teamcare (New Members)	Teamcare (Existing Members)
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### Maternity

Physician Charges	100% after \$10 co-pay (first visit)	80%	100% after plan deductible	90% plus difference in bill	100% after plan deductible	90% plus difference in bill
Facility Charges	Paid at 100% (No Admission Fee)	Paid at 80% after \$250 admission fee	None after deductible met	90% After Deductible Met	None after deductible met	90% After Deductible Met

### Preventative Care

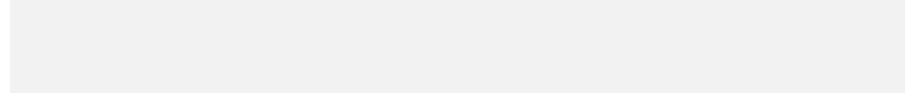
Routine Physicals	100% after \$10 co-pay	Not covered	\$10 co-pay	Network must be used	\$20 co-pay	Network must be used
OB-GYN Exams	100% after \$10 co-pay	Not covered	\$10 co-pay	Network must be used	100% after plan deductible	Network must be used
Well-Child Care	100% after \$10 co-pay	Not covered	\$10 co-pay	Network must be used	\$20 co-pay	Network must be used
Routine Mammograms	100% after \$10 co-pay	Not covered	100% after plan deductible	Network must be used	100% after plan deductible	Network must be used

### Other Medical

Chiropractic (up to \$40 per visit with a maximum of \$1000 per year)	90%	80%	80% after deductible met; \$1000 per person per year. Out-of-pocket limit does not apply.		80% after deductible met; \$1000 per person per year. Out-of-pocket limit does not apply.	
Diagnostic x-ray and labs	90%	80%	100% if TeamCare Imaging Benefit or TeamCare Lab Benefit is used, otherwise 80% after deductible.		100% if TeamCare Imaging Benefit or TeamCare Lab Benefit is used, otherwise 80% after deductible.	
Hospice Care-Inpatient	100%	80%	80% after deductible; 0% after out-of-pocket is met	70% after deductible	80% after deductible; 0% after out-of-pocket is met	70% after deductible
Hospice Care-Outpatient (8 hours per day)	100%	80%				
Skilled Nursing Facility	100%	80%; limited to 60 days per year				
Outpatient Private Duty Nursing (560 hours per year limit)	100%	80%	Not Covered		Not Covered	
Home Health Care	100%	80%; limited to 120 four hour visits per year	80% after deductible; 0% after out-of-pocket is met	70% after deductible	80% after deductible; 0% after out-of-pocket is met	70% after deductible
Rehabilitation and Speech Therapy (Combined Inpatient and Outpatient)	90%	80%; limited to 60 days per year				
Medical Equipment	90%	80%	80% after deductible	70% after deductible plus difference in bill.	80% after deductible	70% after deductible plus difference in bill.

## Behavioral Health

	UPS Plan		Teamcare (New Members)		Teamcare (Existing Members)	
	In-Network	Out-of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Substance Abuse	100%	None	80% after deductible met; must be a Plan approved provider. 21 days per person, per calendar year. Maximum 42 days lifetime.		80% after deductible met; must be a Plan approved provider. 21 days per person, per calendar year. Maximum 42 days lifetime.	
Mental Health-Inpatient	100%	None				
Mental Health-Outpatient	100% after co-pay	80%; 40 visits per year	80% after deductible met; must be a Plan approved provider. 30 visits per person, per year.		80% after deductible met; must be a Plan approved provider. 30 visits per person, per year.	



## Dental

	UPS Plan		Teamcare (New Members)		Teamcare (Existing Members)	
	In-Network	Out-of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Deductible	None	None	None	None	None	None
Annual Max Per Person	None	\$2,500	None		\$1500 (does not apply for children under 19)	
Lifetime Max for orthodontia and TMJ (Each Dependent Under 19)	\$1500 Combined In-Network and out-of-Network		\$1500 lifetime max		\$1500 lifetime max	
Preventative Dental Care	100%	80%	100%	100%	100%	100%
Basic	100%	80%	100%	100%	100%	100%
Major	80%	50%	80%	80% (includes crowns and bridgework). 100% coverage for dentures.	80%	80% (includes crowns and bridgework). 100% coverage for dentures.
Orthodontia	50%	50%	50%; no lifetime max (Children)		\$1500 lifetime max (Children)	

## Vision

	UPS Plan		Teamcare (New Members)		Teamcare (Existing Members)	
	In-Network	Out-of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Eye Exams	100%	\$40 max	\$10 co-pay In-Network	\$25 Reimbursement	\$10 co-pay In-Network	\$25 Reimbursement
Single-vision lenses	100%	\$30 max	100%	\$30 Reimbursed	\$80 max	\$30 Reimbursed
Bifocals	100%	\$40 max	\$80 max	\$40 Reimbursed	\$80 max	\$40 Reimbursed
Trifocals	100%	\$50 max	\$80 max	\$50 Reimbursed	\$80 max	\$50 Reimbursed
Frames	100%	\$30 max	\$100 max	\$30 Reimbursed	\$100 max	\$30 Reimbursed
Contact Lenses Instead of Glasses (standard daily wear)	100%	\$60 max	\$80	\$60 Reimbursed	\$80	\$60 Reimbursed

## Prescription Benefits (New and Existing TeamCare Members)

<b>Retail Prescription</b>	\$5 co-payment for generic or brand-name (if you generic exists) using any pharmacy in CVS Caremark Network.
<b>Mail Order/Maintenance</b>	\$0 co-payment for generic or brand name.
<b>Maintenance Medication</b>	For maintenance medication you must use either a CVS Pharmacy or CVS Caremark Mail Service. After your second fill of medication at another retail pharmacy, the co-pay will increase to 50%
<b>Maximum "out-of-pocket" for injectable</b>	There is no copay after member meets \$1000 maximum out-of-pocket expense

## Short-Term Disability Benefits

UPS Plan	Teamcare (New Members)	Teamcare (Existing Members)
60% of average weekly base pay up to \$500 per week. 26 weeks total.	60% of average weekly base pay up to \$500 per week. 26 weeks total.	\$300 per week for the first 10 weeks. \$350 per week for the next 16 weeks. 26 weeks total.

## Additional Basic Benefits

	UPS Plan	Teamcare
Tobacco Cessation	Assistance in quitting tobacco	None
Preventative Wellness Programs	Offered through UPS Healthy Connections-Informed Choices. Provides resources to help improve health.	Includes "Ask Mayo" program to give health advice.
Adoption Assistance	\$3500-5000 for adoption related expenses	None
Employee Assistance Program	Provides support for "work-life" issues	None



## Life Insurance and Supplemental Benefits

	UPS Plan	Teamcare (New Members)	Teamcare (Existing Members)
<b>Life Insurance</b>			
Employee Life Insurance	\$20,000 3hr; \$30,000 6hr	2080 times the hourly rate for "off the street" full-time; 1040 times the hourly rate for part-time. Maximum of \$100,000	\$40,000
AD&D	\$20,000 3hr; \$30,000 6hr	2080 times the hourly rate for "off the street" full-time; 1040 times the hourly rate for part-time. Maximum of \$100,000	\$40,000
Children's Life Insurance	\$2,500	\$2,000	\$2,000
Spousal Life Insurance	\$5,000	\$4,000	\$4,000