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)	
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.	

Prescription Benefits (New and Existing TeamCare Members)

Retail Prescription	$5 co-payment for generic or brand-name (if you generic exists) using any pharmacy in CVS Caremark Network.
Mail Order/Maintenance	$0 co-payment for generic or brand name.
Maintenance Medication	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%
Maximum "out-of-pocket" for injectable	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

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

Life Insurance and Supplemental Benefits

	UPS Plan	Teamcare (New Members)	Teamcare (Existing Members)
Life Insurance			
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
Employee Supplemental Life Insurance	Up to a $1million max in $1000 increments	None Offered	None Offered
Supplemental AD&D Insurance	Up to a $1million max in $1000 increments	None Offered	None Offered
Children's Supplemental Life Insurance	I $2500-7500 additional coverage if elected	$2000 Basic Life	$2000 Basic Life
Spousal Supplemental Life Insurance	$5000, $20,000 and $45,000 additional coverage available	$4000 Basic Life	$4000 Basic Life
Other Sup. Benefits			
Pre-tax Flexible Spending Accounts	Spending account for use in health care and child/elder care expenses	None Offered	None Offered
Legal Insurance	Optional insurance to assist in legal services	None Offered	None Offered
Personal Insurance for auto, home, etc.	Discounts and low group rates for members	None Offered	None Offered