TEAMCARE®
A CENTRAL STATES HEALTH PLAN

UPS PACKAGE

Plan U1 (Full-Time) and Plan U3 (Part-Time) Benefit Profile

Coverage Period: Beginning on or after 01/01/2021

PLAN BENEFIT LIMIT (ANNUAL)	PLAN DEDUCTIBLE (ANNUAL)	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
None	$100 per Individual $200 per Family	$1,000 per Individual $2,000 per Family

TEAMCARE PPO OFFICE VISIT	OUT-OF-NETWORK PENALTY
$10 copayment for in-network office visit (Plan Deductible does not apply)	For non-emergency medical care, your cost is 10% greater than an in-network provider plus all charges above Reasonable and Customary and the loss of TeamCare Family Protection Benefit.

MEDICAL PLAN BENEFITS	*For further information, including a full Summary Plan Description (SPD), visit our website at MyTeamCare.org.*
TeamCare Wellness A TeamCare Physician must be used.	♦ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.
Teladoc Telemedicine Benefit Teladoc.com/TeamCare 800-TELADOC (835-2362)	♦ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, dermatology and behavioral health at no cost ($0 copay). Plan Deductible does not apply.
CVS MinuteClinic CVS.com/MinuteClinic 866-389-ASAP (2727)	♦ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost ($0 copay). Plan Deductible does not apply.
Hospital Expense Benefit	♦ After Plan Deductible, 100% of covered charges.
Surgical and Maternity Benefit	♦ After Plan Deductible, 100% of covered charges.
Ambulance Service Benefit	♦ After Plan Deductible, 100% of covered charges subject to medical necessity review.
Outpatient Accidental Bodily Injury Benefit	♦ After Plan Deductible, 100% on the first day of treatment for accidental injury; 80% for all other services.
Lab Benefit 800-646-7788 labcard.com	♦ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% (Plan Deductible does not apply) provided the Physician submits the requisition through Quest LabCard. If a Physician does not submit specimens through Quest LabCard, simply visit a Quest LabCard collection site. If you do not use the TeamCare Lab Benefit, after Plan Deductible the outpatient lab benefit is 80%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Imaging Benefit To schedule a service call 877-674-0674	♦ The TeamCare Imaging Benefit is a voluntary program that covers MRI, CT, and PET scans at 100% (Plan Deductible does not apply) provided that the scans are scheduled directly through USIN. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (including x-rays) is paid under Major Medical at 80%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Outpatient Cancer Treatment Benefit	♦ After Plan Deductible, 100% of covered charges for outpatient nuclear therapy, radiation therapy, chemotherapy, x-ray and lab procedures for the treatment of cancer. If treatment is provided in a doctor's office, a $10 TeamCare office visit copayment is due.
Hearing Aid Benefit	♦ After Plan Deductible, 100% of covered charges to a maximum of $1,000 per ear ($2,000 total) every 36 months. The Medical Out-of-Pocket Expense Limit does not apply.
Chiropractic Benefit	♦ After Plan Deductible, 80% of covered charges to a maximum $1,000 per person per calendar year. The Medical Out-of-Pocket Expense Limit does not apply.
Behavioral Health Benefits – Inpatient	♦ Facility: After Plan Deductible, 100% of covered charges. Physician: After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Behavioral Health Benefits – Outpatient	♦ $10 copayment for in-network office visit (Plan Deductible does not apply). Otherwise, after Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Major Medical Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

UPS PACKAGE

Plan U1 (Full-Time) and Plan U3 (Part-Time) Benefit Profile

Coverage Period: Beginning on or after 01/01/2021

PRESCRIPTION BENEFIT

For more information call 888-483-2650 or visit **caremark.com**

RETAIL PHARMACY STORE:
$5 copayment for short-term prescription fills and non-maintenance medications.

MAINTENANCE CHOICE / MAIL SERVICE PHARMACY:
$0 copayment for a 90-day supply of medication. Under Maintenance Choice, Member can receive a 90-day supply of medication at a local CVS pharmacy store.

After the second fill of the same prescription, long-term maintenance medications must be filled through Maintenance Choice or CVS/Caremark Mail Service Pharmacy or be subject to a 50% co-payment if filled through the Retail Pharmacy Program. On both Retail and Mail Order, if a generic equivalent is available, the Member must take the generic or be responsible for the cost difference plus any copayment. Plan Deductible does not apply. The Medical Out-of-Pocket Expense Limit does not apply.

TeamCare does not cover drugs or medicines on a formulary exclusion list compiled by CVS/Caremark. The formulary exclusion list is available at MyTeamCare.org or by contacting CVS/Caremark.

DENTAL BENEFITS

You may use any dental provider for services without an out-of-network penalty. However, TeamCare does offer a voluntary dental network through TeamCare*Dental*.

Annual Dental Maximum	None
Annual Dental Deductible	None
Preventive Services	100%
Diagnostic and Restorative	100%
Crown and Bridge Work	80%
Dentures (Full and Partial)	100%
Orthodontic (Child/Adult Child)	50%
Orthodontic Maximum (Child/Adult Child)	No Lifetime Maximum

TeamCare offers a voluntary network through Humana Dental that provides negotiated discounts and protection from balance billing.

To find a provider, call 800-592-3112 or visit: **humanadentalnetwork.com**.

VISION BENEFITS

You can use any vision provider for services. However, TeamCare does offer a voluntary vision network through the TeamCare*Vision* program.

Vision Plan Benefits do not have an out-of-network penalty but there is a maximum reimbursement per service as indicated.

The Vision Plan Benefits are payable once every 12 months.

TeamCare*Vision* is a voluntary vision network offered through EyeMed Vision Care:

Routine Eye Exam	$10 copayment
Frames	$0 copayment up to $150 allowance
Lenses (per pair)	$0 copayment
Contacts (in lieu of glasses)	$0 copayment up to $120 allowance

For a directory of EyeMed providers in the **Select** network, call 866-723-0514 or visit **eyemed.com**.

For non-EyeMed providers, the maximum reimbursement for Vision Plan Benefits is:

Routine Eye Exam	$50.00 *
Frames	$75.00
Lenses (per pair)	$50.00
Bi-Focal Lenses (per pair)	$50.00
Tri-Focal Lenses (per pair)	$50.00
Lenticular Lenses (per pair)	$60.00
Contacts (in lieu of glasses)	$80.00

Plan Deductible does not apply.

* *Routine Eye Exam charges from non-EyeMed providers for Covered Dependents under age 19 will be subject to Reasonable and Customary allowances and paid at 80%.*

SHORT-TERM DISABILITY BENEFITS
(Member Only)

Benefit provides 60% of average weekly base pay up to $500 per week for a maximum of 26 weeks; and includes continued coverage while on Short-Term Disability.

LIFE INSURANCE BENEFITS

Member Death	Full-Time Plan U1:	2080 hours x hourly wage to maximum of $100,000 (min of $40,000)
	Part-Time Plan U3:	1040 hours x hourly wage to maximum of $100,000 (min of $40,000)
Accidental Death	Full-Time Plan U1:	2080 hours x hourly wage to maximum of $100,000 (min of $40,000)
	Part-Time Plan U3:	1040 hours x hourly wage to maximum of $100,000 (min of $40,000)

Spouse Death *	$5,000
Child/Adult Child Death *	$2,500
Total Permanent Disability (Waiver of Premium)	$16,000

* *Dependent Life Insurance Benefits are only payable on Covered Dependents.*

FAMILY PROTECTION BENEFIT

In the event of a Member's death, the TeamCare Family Protection Benefit provides a maximum of five years of free TeamCare PPO coverage for the Covered Spouse and Dependents provided that during the two-year period prior to death, TeamCare providers were used exclusively for all non-emergency care. Please refer to the TeamCare Summary Plan Description for further information.

MyTeamCare.org or 800-TEAMCARE

For further benefit information, visit our website at **MyTeamCare.org** or call CustomerCare at 800-TEAMCARE (832-6227).

If there is a discrepancy between the Plan Benefit Profile and Plan Document, the Plan Document will be the controlling document in determining the benefit.

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act, or PPACA). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Research and Correspondence Department, TeamCare – A Central States Health Plan, PO Box 5126, Rosemont IL 60017-5126 or call 800-TEAMCARE. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.