UPS RETIREE PLAN RU/RV

Delivering better healthcare over the long haul

Summary Plan Description
UPS Retiree Plan RU/RV

Retiree Plan Benefit Booklet

Benefits Specialists are available
Monday through Friday
800-TEAMCARE (832-6227)
MyTeamCare.org

TeamCare Partners

BlueCross BlueShield
bcbsil.com

Medical Mutual
(OH Zip Codes)
medmutual.com

Teladoc
teladoc.com/TeamCare
800-TELADOC

MinuteClinic
minuteclinic.com
866-389-2727

Caremark
caremark.com
888-483-2650

Lab Benefit
(Quest Lab Card)
labcard.com
800-646-7788

Imaging Benefit
(USIN)
877-674-0674

Humana Dental
humanadentalnetwork.com
800-592-3112

EyeMed Vision Care
eyemed.com
866-723-0514

My Information

TeamCare ID Number ______________________________

MyTeamCare.org Login ______________________________

Notes ______________________________

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My Reminders

- ☑ Register online at **MyTeamCare.org** and go paperless.
- ☑ Make sure that TeamCare always has my current mailing address, email address, and phone number.
- ☑ Notify TeamCare of any life events which may affect my coverage.
- ☑ Carry both my Medical ID Card and TeamCare Benefits ID Card and remind my covered dependents to do the same.
- ☑ Contact TeamCare through the secure Message Center or call **800-TEAMCARE** with any benefit questions.

PREVENT AN OVERPAYMENT

If you or your covered dependent is eligible for Medicare parts A, B, or D*—even if you elect not to take Medicare for any reason—**the Medicare eligible member does not qualify for Retiree Health Plan Benefits.** You must notify TeamCare immediately to prevent an overpayment that you will be responsible to repay to TeamCare.

*Except if Medicare is due to End Stage Renal Disease (ESRD)

Welcome to TeamCare!

Your retiree healthcare benefits are some of the best in the country. Take time to learn more about your benefits.

This booklet describes all of the benefits you are entitled to under your TeamCare Retiree Health Plan. It includes Your Plan Benefit Profile, which is a snapshot of all your benefits.

We take the responsibility of providing your healthcare benefits seriously, and we look forward to providing you with quality benefits and unmatched service.

Note: If you or your covered dependent is eligible for Medicare, the Medicare eligible member does not qualify for Retiree Health Plan Benefits. To prevent an overpayment, it is your responsibility to notify TeamCare when you or a family member is eligible for Medicare.

The information in this booklet reflects your benefits as of March 1, 2020. We encourage you to take the time to register at **MyTeamCare.org** where updated information is available throughout the year.

Sincerely,

Thomas C. Nyhan
Executive Director

Board of Trustees

Employee / Union Trustees	Employer Trustees
Charles A. Whobrey	Gary F. Caldwell
George J. Westley	Christopher J. Langan
Gary Dunham	Robert Whitaker

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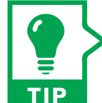
Pay careful attention to the icons used in this booklet.

Healthcare plans can be a bit confusing and so we've taken extra care to keep things simple by sticking with language that's easy to understand.

As you read this booklet, you'll see that we are using icons to alert you to important information and provide tips to help make using your benefits even easier.

*This icon **alerts** you to either plan restrictions or ways to save you from out-of-pocket costs.*



*This icon calls attention to **tips** that will help you get the most out of your benefits.*

We make it easy to confirm your eligibility and benefits—online or by phone.

Get answers to your questions by logging into **MyTeamCare.org** and sending a secure message to our CustomerCare Center or by calling **800-TEAMCARE**.

PLAN BENEFIT PROFILE

UPS RETIREES

Plan RU (Full-Time) and Plan RV (Part-Time) Benefit Profile

Coverage Period: Beginning on or after 01/01/2020

PLAN BENEFIT LIMIT (ANNUAL)	PLAN DEDUCTIBLE (ANNUAL)	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
$250,000 per Individual	$100 per Individual $200 per Family	$1,000 per Individual $2,000 per Family

TEAMCARE PPO OFFICE VISIT	OUT-OF-NETWORK PENALTY
$20 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 allowances.

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 behaviorial health at no cost ($0 copay). Plan Deductible does not apply.
CVS MinuteClinic CVS.com/MinuteClinic 866-389-2727	♦ 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 vaccinations 7 days a week (hours vary) at no cost ($0 copay). Plan Deductible does not apply.
Hospital Expense Benefit	♦ After Plan Deductible, 80% of semi-private room rate with no maximum day limit; then 100% after Medical Out-of-Pocket Expense Limit is met.
Surgical and Obstetrical Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Ambulance Service Benefit	♦ After Plan Deductible, 80% of covered charges subject to medical necessity review; then 100% after Medical Out-of-Pocket Expense Limit is met.
Emergency Room Services	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Lab Benefit For more information call 800-646-7788 or visit **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 Lab Card. If a physician does not submit specimens through Quest Lab Card, simply visit a Quest Diagnostics 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, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met 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 $20 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, 70% of covered charges to a maximum $800 per person per calendar year. The Out-of-Pocket Expense Limit does not apply.
Behavioral Health Benefits – Inpatient	♦ After Plan Deductible, 80% of covered charges to a maximum 21 days per person per calendar year; maximum 42 days per person Lifetime. The Medical Out-of-Pocket Expense Limit does not apply.
Behavioral Health Benefits – Outpatient	♦ After Plan Deductible, 80% of covered charges to a maximum 30 visits per person per calendar year. The Medical Out-of-Pocket Expense Limit does not apply.
Major Medical Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.

CCM RETIREE – 12/19/2019 BASE R4 - SPD RURV

A CENTRAL STATES HEALTH PLAN

UPS RETIREES

Plan RU (Full-Time) and Plan RV (Part-Time) Benefit Profile

Coverage Period: Beginning on or after 01/01/2020

PRESCRIPTION BENEFIT

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

RETAIL PHARMACY STORE:
25% copayment for short-term prescription fills and non-maintenance medications to a maximum copayment of $200 per prescription.

MAINTENANCE CHOICE / MAIL SERVICE PHARMACY:
20% copayment to a maximum copayment of $200 per prescription 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 and the per prescription maximum does not apply. 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*.

The Dental Plan Benefit maximums are per person per calendar year.

Annual Dental Maximum	$1,500*
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)	100%
Orthodontic Maximum (Child/Adult Child)	$1,500 Lifetime Maximum

** Annual Dental Maximum does not apply to children under age 19.*

TeamCare offers a voluntary network through Humana Dental that provides negotiated discounts and protection from balance billing – stretching the Annual Dental Maximum further.

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)

Your Plan does not have Short-Term Disability Benefits.

LIFE INSURANCE BENEFITS

Your Plan does not have Life Insurance Benefits.

FAMILY PROTECTION BENEFIT

Your Plan does not have the TeamCare Family Protection Benefit.

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.

TeamCare PPO (Preferred Provider Organization)

The TeamCare PPO is the same extensive network of the best doctors and hospitals in your area you had as an active participant. The providers in our PPO have agreed to accept negotiated rates for the services they provide to you or your covered family members. This lowers your out-of-pocket costs and also protects you against charges above those considered reasonable and customary.

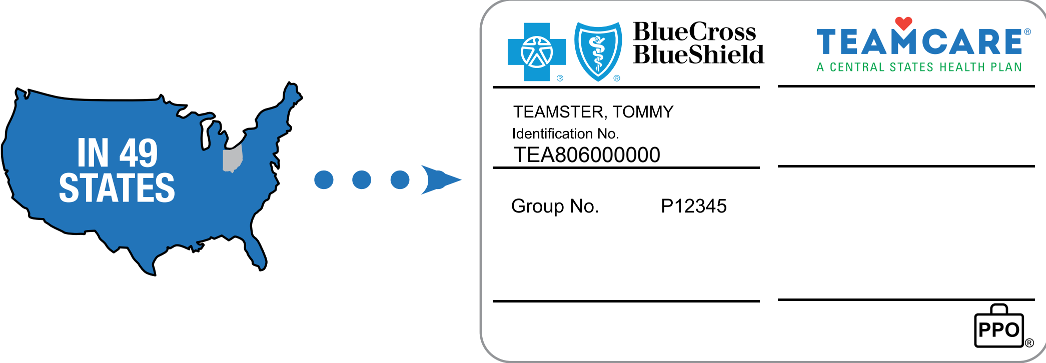
- Under this plan, you and your family can receive care from any physician or hospital that you choose in the extensive TeamCare network.
- When you get care from a network provider, you receive higher in-network benefits that lowers your out-of-pocket costs, plus you are not responsible for filing claims.

If you don't use in-network doctors and hospitals for non-emergency care, it may result in an out-of-network penalty—and additional money coming out of your own pocket.

Locating a PPO Provider is Easy

You can find an up-to-date list of providers in your network by visiting the *Find a Provider* page at **MyTeamCare.org** or by calling the number on the back of your Medical ID card. You are free to choose any provider within the TeamCare network. It's best to make sure all of your treating physicians are in-network.

Your in-network TeamCare doctor may be required to pre-certify an inpatient hospital admission, surgical procedure or other medical procedure/test. This is your doctor's responsibility.



Plan benefit limits, deductibles and office visit copayments are easy to understand and important to know about when you require healthcare.

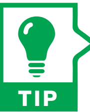
Annual Plan Benefit Limit

All medical benefits paid by the Plan are applied to the annual Plan Benefit Limit. Any medical expenses incurred after the Plan Benefit Limit has been reached will be your responsibility. Please check your **Plan Benefit Profile** to find your specific Plan Benefit Limit.

Annual Plan Deductible

Your plan deductible is the amount of covered medical expenses that you and your covered dependents must pay each calendar year before TeamCare begins paying for certain benefits. Once the deductible limit is reached by either a member or family, TeamCare pays benefits on the remaining covered expenses.

Please refer to your **Plan Benefit Profile** to determine your specific individual and family deductible amounts.



A family deductible means that if two or more covered family members pay that amount in a calendar year, your plan will pay benefits on the remaining covered medical expenses for all covered family members that year.

Plan Out-of-Pocket Expense Limit

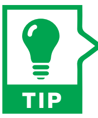
Once your out-of-pocket expenses reach the annual limit under your Plan, all future medical expenses will be paid at 100% up to the annual Plan Benefit Limit.

Please refer to your **Plan Benefit Profile** to find the specific individual and family out-of-pocket expense limit.

TeamCare Office Visit Copayment - Primary Care Physician/Specialist

There are no deductibles you must meet for a TeamCare physician's covered office visit charge. You only need to make an office visit copayment when utilizing a TeamCare physician.

*X-rays and laboratory work performed during an office visit will be subject to your deductible and paid according to your Plan Benefit Profile. For additional information on Lab Card, see the **Lab Benefit** section.*



*You can quickly find and view the status of your annual deductible and out-of-pocket expense limit by visiting our website at **MyTeamCare.org**.*

Please refer to your **Plan Benefit Profile** to determine your office visit copayment.

Wellness Benefit

Preventive Care Is Important To Your Health

Preventive care is routine healthcare that includes screenings, immunizations, services, and counseling to help prevent illness, disease, or other health problems. Getting the right preventive care can help you stay healthy and detect a health issue at an early stage that might be easier to treat.

Don't let disease sneak up on you. Preventive care could save your life. Use your Wellness Benefit and stop health problems before they get serious.

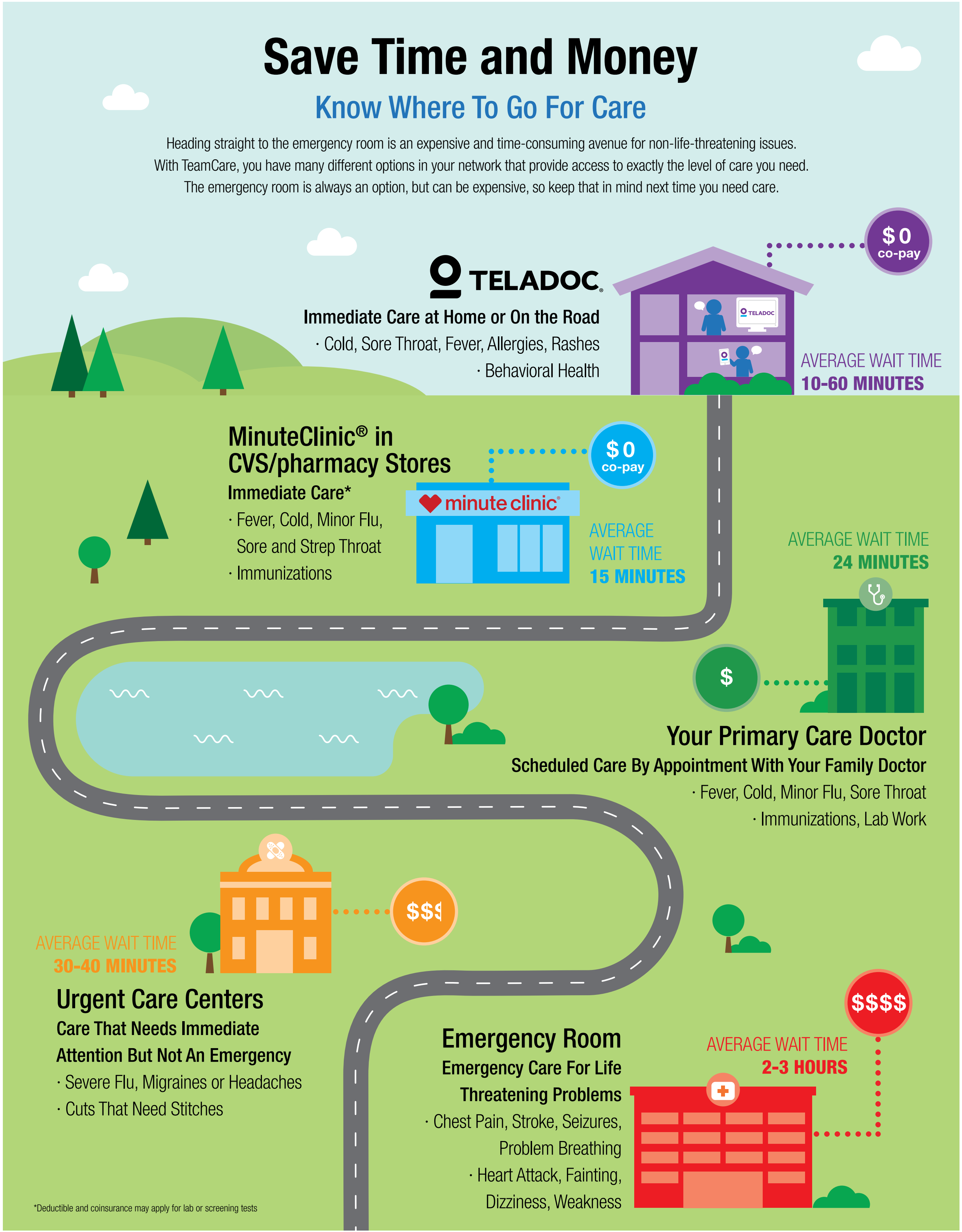
Preventive care is covered at 100% with no out-of-pocket costs **only** when care is provided by an in-network doctor, and services are identified as preventive care under the Affordable Care Act (ACA).

What's Covered?		
	Adult screening tests:	**Other services:**
MEN	• Abdominal aortic aneurysm • Blood pressure • Cholesterol • Colon cancer • Depression • Diabetes • Lung cancer	• Immunizations, including flu shot • Obesity screening and counseling • Quitting tobacco • Sexually transmitted infection (STI) counseling
WOMEN	• Blood pressure • Breast cancer counseling for genetic testing • Cervical cancer screening (Pap test and/ or HPV) • Chlamydia and gonorrhea • Cholesterol • Colon cancer • Depression • Diabetes • Lung cancer • Mammogram (breast cancer) • Osteoporosis	• Contraception • Immunizations, including flu shot • Intimate partner violence • Obesity screening and counseling • Quitting tobacco • Sexually transmitted infection • (STI) counseling
	Pregnancy-related services:	**Pregnancy-related screening tests:**
PREGNANT WOMEN	• Breastfeeding support, supplies and counseling • Folic acid supplementation	• Bacteria in urine • Gestational diabetes • Hepatitis B • Iron deficiency anemia • Postpartum depression
	Routine services and screening tests:	**Other services:**
INFANTS, CHILDREN, & TEENS	• Developmental and behavioral • Fluoride dental varnish and oral health check • Hearing/vision test • Immunizations, including flu shot • Newborn and infant screenings • Well-baby/well-child care	• Depression screening • Lead exposure test • Tobacco and alcohol use counseling • Sexually transmitted infection (STI) screening and counseling • Obesity counseling

The CVS/Caremark Broader Vaccine Network

As part of TeamCare Wellness, routine vaccines are an important part of protecting you and your family against disease. We partner with the CVS/Caremark Broader Vaccination Network to offer immunizations at 100% with no deductible or coinsurance at participating retail pharmacies.

To locate one of the 63,000 CVS/Caremark Broader Vaccination Network pharmacies including CVS, Walgreens, Duane Reade, and many more, please call **888-483-2650** or visit **caremark.com** to look up a location by zip code, distance, or pharmacy name.


Save Time and Money
Know Where To Go For Care
Heading straight to the emergency room is an expensive and time-consuming avenue for non-life-threatening issues. With TeamCare, you have many different options in your network that provide access to exactly the level of care you need. The emergency room is always an option, but can be expensive, so keep that in mind next time you need care.
TELADOC.
Immediate Care at Home or On the Road
· Cold, Sore Throat, Fever, Allergies, Rashes
· Behavioral Health
$0 co-pay
AVERAGE WAIT TIME
10-60 MINUTES
MinuteClinic® in CVS/pharmacy Stores
Immediate Care*
· Fever, Cold, Minor Flu, Sore and Strep Throat
· Immunizations
minute clinic
$0 co-pay
AVERAGE WAIT TIME
15 MINUTES
AVERAGE WAIT TIME
24 MINUTES
$
Your Primary Care Doctor
Scheduled Care By Appointment With Your Family Doctor
· Fever, Cold, Minor Flu, Sore Throat
· Immunizations, Lab Work
$$$
AVERAGE WAIT TIME
30-40 MINUTES
Urgent Care Centers
Care That Needs Immediate Attention But Not An Emergency
· Severe Flu, Migraines or Headaches
· Cuts That Need Stitches
$$$$
AVERAGE WAIT TIME
2-3 HOURS
Emergency Room
Emergency Care For Life Threatening Problems
· Chest Pain, Stroke, Seizures, Problem Breathing
· Heart Attack, Fainting, Dizziness, Weakness
*Deductible and coinsurance may apply for lab or screening tests

Know Where To Go For Care

Nobody ever plans to get sick or injured, but that doesn't keep it from happening. When it does happen, it's important to know where to go for care. TeamCare provides you various options to choose from based on the severity of the illness or injury. Whether it's your primary care physician, a CVS MinuteClinic®, an urgent care center, or the emergency room at the hospital—TeamCare has you covered.

Determining which of these options to choose can be a confusing process, and your cost for care varies by the different options. Let's take a look at each one.

There are times when you can't get an appointment to see your primary care physician or you need immediate attention for a minor medical problem. TeamCare has two convenient no-cost options for you and your family. Call Teladoc® from home or on the road or stop by and visit your local MinuteClinic® located inside CVS pharmacy.

- **$0 copay**
- Staffed by U.S. board-certified and state-licensed doctors in all 50 states
- Available 24/7/365
- Visits via phone call or video call
- Visits for general medical (minor illnesses and injuries), behavioral health, and dermatology
- Download the Teladoc app, visit **Teladoc.com/TeamCare**, or call 800-TELADOC

- **$0 copay***
- Staffed by certified family nurse practitioners
- Open 7 days a week
- Treatment for minor illnesses and injuries, skin conditions, and vaccinations
- No appointment necessary
- Visit **minuteclinic.com** to find the nearest location, view current wait times, or secure a place in line

*Lab fees and screenings may be billed separately, and a coinsurance may apply.

Primary Care Physician

There are many advantages to having a Primary Care Physician (PCP).

Finding a PCP you trust is one of the most important decisions you'll make about your health. A doctor that gets to know you and your family is able to track your vital health information and is more likely to identify health issues before they become serious and develop into serious or major illnesses.

TeamCare provides a large network of primary care physicians through our preferred PPO networks. Whether you need a physical, wellness check-up, routine screenings, or care because you're sick or injured—your PCP can help make sure you get the medical care you need.

What's Covered?

- **Wellness**

  Regular visits to your PCP are essential to a lifetime of good health. The TeamCare Wellness Benefit offers you and your family the coverage that gives you peace of mind.

  Wellness visits includes routine exams, preventive screenings, immunizations, well-baby care, and routine women's healthcare from in-network providers. There is no-cost for preventive care and routine physicals when using in-network providers (subject to age and frequency limits). A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

- **Illness or Injury**

  A visit to your in-network PCP's office to treat an illness or injury is covered by making an office visit copayment at the time of service. There is no deductible to meet for an in-network PCP office visit. You only need to make an office visit copayment, as indicated in your **Plan Benefit Profile**, at the time of service for the office visit.

*X-rays and laboratory work performed during an office visit will be subject to your deductible and paid according to your Plan Benefit Profile. For additional information on Lab Card, see the **Lab Benefit** section.*

Urgent Care Center

Urgent care centers provide easy access to quality healthcare for the times when either your PCP's office is closed, or the illness/injury is more severe than those treated at Teladoc or MinuteClinic. Urgent care centers primarily treat non-life-threatening injuries or illnesses requiring immediate care, but not serious enough to require treatment at an emergency room. Urgent care centers are designed to deliver ambulatory care in a dedicated medical facility outside of a traditional emergency department. Most urgent care centers are open late and on weekends and holidays.

To avoid out-of-network penalties and additional cost out of your pocket, it is important to make sure that the urgent care center is in your PPO network.

What's Covered?

- **Services related to an accident or injury**

  Services at an urgent care center related to an accident or injury are covered under the Outpatient Accidental Bodily Injury Benefit. The Outpatient Accidental Bodily Injury Benefit covers the first day of treatment you receive care, provided treatment is performed in a doctor's office, urgent care center or emergency room.

  Please refer to your **Plan Benefit Profile** to determine whether your Plan provides this benefit and, if so, how the benefit will be paid. Charges after the first day of treatment are paid under the appropriate benefit.

  NOTE: If your Plan does not offer the Outpatient Accidental Bodily Injury Benefit, all charges are processed under the Major Medical Benefit.

- **Services related to an illness**

  Services at an urgent care center related to an illness are paid according to the billing received from the urgent care center.

  - Covered services billed by the urgent care center as an office-visit will require you to pay an office visit copayment, the same as you would for visiting your PCP. Lab fees and screenings may be billed separately subject to the Plan Deductible, and a coinsurance may apply.
  - Covered services billed by the urgent care center as a facility charge (similar to a hospital billing), will be subject to the Plan Deductible and paid according to the Plan benefit.

Emergency Room

An emergency is a sudden and unexpected medical problem which if not immediately treated, might result in death or serious bodily harm. Some examples of such emergency illnesses are heart attack, stroke, loss of consciousness and convulsion. Some examples of emergency accidental injuries are severe eye or head injury, animal bite, burn, smoke inhalation, and poison ingestion.

Emergency rooms are intended for true medical emergencies. They can handle trauma, x-rays, surgical procedures, and other life-threatening situations. Most hospitals have an emergency room that's open 24 hours a day, seven days a week.

What's Covered?

- **Services related to an accident or injury**

  Services at an Emergency Room related to an accident or injury are covered under the Outpatient Accidental Bodily Injury Benefit. The Outpatient Accidental Bodily Injury Benefit covers the first day of treatment you receive care, provided treatment is performed in a doctor's office, urgent care center or emergency room.

  Please refer to your **Plan Benefit Profile** to determine whether your Plan provides this benefit and, if so, how the benefit will be paid. Charges after the first day of treatment are paid under the appropriate benefit.

  If you are admitted to the hospital for inpatient treatment, covered services will be paid under the Hospital Benefit.

  NOTE: If your Plan does not offer the Outpatient Accidental Bodily Injury Benefit, all charges are processed under the appropriate benefit or the Major Medical Benefit.

- **Services related to an illness**

  All covered services will be processed under the appropriate benefit or the Major Medical Benefit. If you are admitted to the hospital for inpatient treatment, covered services will be paid under the Hospital Benefit.

"A hospital stay can cost in excess of $100,000, and that's why it's important for you to stay in-network and understand your hospital expense benefit coverage."

Inpatient Hospital Expense Benefit

If you are hospitalized because of an illness, injury or pregnancy, the Inpatient Hospital Benefit (also known as the Hospital Expense Benefit) covers the hospital bill for your room and board and for miscellaneous expenses related to treatment for covered services you receive while you are inpatient in the hospital.

This benefit also covers the charges for miscellaneous expenses related to surgery you have on an outpatient basis.

What's Covered?

- Room and board, if medically required
- Miscellaneous expenses such as medicines, laboratory tests, x-rays, oxygen, anesthesia and other similar services that are provided for you in the hospital

What amount will my plan pay?

Please refer to your **Plan Benefit Profile** to determine how the Inpatient Hospital Expense Benefit will be paid during the duration of the hospital confinement after your plan deductible is met.

Maternity Services

From your prenatal doctor visits and lab/ultrasound screenings, to inpatient hospital services for delivery, to postnatal newborn baby care—TeamCare has you covered.

Plan benefits are payable for charges incurred as a result of pregnancy, childbirth or a related medical condition. Maternity Services, also known as the Surgical and Obstetrical Benefit, covers the doctor's bill for obstetrics performed in a hospital, qualified outpatient facility, or doctor's office. Lab and ultrasound screenings are covered by your Major Medical Benefit or by your Lab Benefit if you use Quest Lab Card.

TeamCare covers a hospital stay for the mother and/or newborn child of at least 48 hours following a normal vaginal delivery, or at least 96 hours following a cesarean section. Federal law generally does not prohibit the mother's or newborn's attending healthcare practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

What's Covered?

After your plan deductible is met, TeamCare pays the Maternity Benefit as indicated in your **Plan Benefit Profile**. The Maternity Benefit covers your doctor's bill for surgery and obstetrics performed in a hospital, qualified outpatient surgical facility or doctor's office.

Certain prenatal care/maternity related preventive care expenses are payable (as listed on **healthcare.gov**) including but not limited to screening for gestational diabetes, breastfeeding supplies and rental of breastfeeding equipment, and comprehensive lactation support and counseling. These services are covered under the Wellness Benefit at no-cost to you.

If you are breastfeeding, TeamCare covers comprehensive lactation support and counseling by a trained lactation educator during pregnancy and/or in the postpartum period. TeamCare also provides coverage for a standard manual or standard electric breast pump, plus necessary breast pump supplies. Rental versus purchase is at the option of the Plan. Repair is payable when medically necessary. Please send receipts to the address on the back of your TeamCare Medical ID Card or through the secure Message Center at **MyTeamCare.org**.

Surgical Services (Inpatient and Outpatient)

Surgery is a medical specialty that focuses on the use of operative techniques to investigate and resolve certain medical conditions caused by disease or injury. Surgery can have many possible purposes, such as to improve bodily function, enhance physical appearance, or repair damaged or ruptured areas.

The Surgery Benefit, also known as the Surgical and Obstetrics Benefit, covers your inpatient or outpatient surgery performed in a hospital, qualified outpatient surgical facility, or doctor's office.

Certain medical services require precertification to ensure that the healthcare services meet or exceed accepted standards of medical care.

- If you are using an **in-network PPO provider**, that provider will perform the precertification duties for you.
- If you are using an out-of-network medical plan provider, you will be responsible for obtaining the precertification before the services are provided. You also will be responsible for any out-of-network penalty and all charges above the negotiated in-network costs.

In addition, all bariatric procedures (including but not limited to gastric bypass, gastric stapling, and intestinal bypass) must have prior approval from TeamCare and be performed at a TeamCare approved facility.

After your plan deductible is met, TeamCare pays the Surgical and Obstetrical Benefit as indicated in your Plan Benefit Profile.

The fact that a physician recommends or provides treatment doesn't mean that the recommended services or supplies will be an eligible expense or considered medically necessary under your TeamCare plan. Any covered service must be considered standard medical care or treatment.

Outpatient Cancer Treatment Benefit

The Outpatient Cancer Treatment Benefit covers charges for outpatient nuclear therapy, radiation therapy, chemotherapy, x-ray and laboratory procedures, and related doctor visits for the treatment of cancer. These outpatient treatments can be given at a doctor's office or a hospital.

Please refer to your **Plan Benefit Profile** to determine how the Outpatient Cancer Treatment Benefit will be paid. If your plan does not offer the Outpatient Cancer Treatment Benefit, all charges related to outpatient cancer will be covered under the appropriate benefit.

Ambulance Service Benefit

The Ambulance Service Benefit covers transportation charges for a professional, licensed ambulance service that are incurred for medical treatment **required** during transport. This includes charges for licensed air ambulance service, but only when air transportation is required to receive urgently needed medical attention and only to the nearest facility where the required medical treatment can be administered.

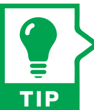
After your plan deductible is met, TeamCare pays for professional, licensed ambulance service as indicated in your **Plan Benefit Profile**.

Many ambulance services are out-of-network providers. Although TeamCare covers these services without an out-of-network penalty, TeamCare will only pay these charges up to the reasonable and customary amount. You may be responsible for charges above the reasonable and customary amount.

We back up your coverage with a Major Medical Benefit.

The Major Medical Benefit covers certain medical expenses for illness, injury or pregnancy that are not covered by benefits previously described.

After your plan deductible is met, the Major Medical Benefit pays all covered medical expenses as indicated in your **Plan Benefit Profile**.



Once you reach the out-of-pocket limit, your plan pays 100% of all future covered Major Medical expenses, up to your annual plan maximum.

What's Covered?

The following items and services performed or prescribed by your doctor if medically necessary are covered under the Major Medical Benefit:

- Rental of braces, crutches, wheelchairs and hospital-type beds necessary for the temporary treatment of an illness or injury; however, purchase will be allowed only if deemed more economical than rental
- Prosthetic devices
- Assistant surgeon's fees
- Outpatient diagnostic x-rays and laboratory services (see **Lab Benefit** section)
- Services of physiotherapists, registered nurses and other licensed health professionals, provided such services are not provided by a member of your family
- Professional services, including charges for office visits if the doctor is not an in-network TeamCare provider (an out-of-network penalty will also apply)
- Prescription drugs and medicines when not covered by the Hospital, Surgical Expense Benefit, or Prescription Drug Benefit
- Charges for outpatient cardiac rehabilitation programs that began less than six months after onset of heart attack or other invasive cardiac procedure, which are performed at a hospital, and do not exceed three months in duration
- Contact lenses and/or glasses prescribed to treat glaucoma, keratoconus or resulting from cataract surgery, once per lifetime
- Repair of natural teeth when the damage is the result of an accident

Your Major Medical benefit is a very important part of TeamCare because it covers expenses that could bankrupt the average person without proper coverage.

Prescription Benefit

TeamCare has joined with CVS Caremark to manage your pharmacy benefit program. CVS Caremark operates both a **Retail Pharmacy Service** and a **Mail Service Pharmacy.**

What's Covered?

Your Prescription Drug Benefit covers charges for eligible drugs prescribed by a physician, dispensed by a pharmacist and available with a prescription.

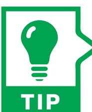
- The Retail Pharmacy Service is most convenient when filling your short-term prescription needs.
  - For example, if you need an antibiotic to treat an infection, you can receive up to a 30-day supply at any one of the 63,000 pharmacies that participate in the network. The Retail Pharmacy Service includes most national pharmacy chains like CVS, Walgreens, Ralph's, Kroger, Albertson's, and many more.

  - *Walmart and Sam's Club are not participating pharmacies, and you will be responsible for the full cost of any prescription that is filled there.*

- The Maintenance Choice Program, or the CVS Caremark Mail Service Pharmacy, provides service for your long-term prescription needs (prescriptions taken for more than 60 days). You can receive up to a 90-day supply of covered medication.

After the second fill of the same medication, long-term maintenance medication must be filled through the Maintenance Choice program or be subject to a 50% copayment if filled through the retail pharmacy.

The maximum cost per prescription does ***NOT*** apply when a brand-name drug is selected and the generic equivalent is available. If you use a brand-name drug when a generic equivalent is available, there is no limit on the amount that you may be required to pay.



Generic-equivalent drugs have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety, and strength as the original brand name drug. The big difference is they save you money.

Prescription drugs can cost a lot of money and that's why it's important to understand how these Rx benefits can help keep your out-of-pocket expenses to a minimum.

How Do I Fill My Prescriptions?

Filling your short-term prescription or getting refills is easy. Simply show your TeamCare Benefits ID Card at any participating pharmacy, pay your share of the cost, and pick up your prescription.

	Short-Term Prescriptions: 30-Day Supply	Long-Term Prescriptions: Up To A 90-Day Supply	
	For prescriptions that will be taken temporarily, such as antibiotics	For prescriptions that will be taken on a long-term basis, such as blood pressure medication	
	Network Retail Pharmacy/ CVS Pharmacy	**Mail Service**	**CVS Pharmacy**
For A Covered Prescription	Please refer to your **Plan Benefit Profile** to determine how the Prescription Benefit will be paid.		

Ordering your prescription through the CVS Caremark Mail Service Pharmacy can be done by mail, fax, online at **caremark.com**, or by telephone at **888-483-2650**.

Your medication will be delivered to you within 7 to 10 days after your order has been received and there is no charge for standard delivery.

Is there a mandatory formulary?

A prescription drug formulary is simply a list of commonly prescribed medications that have been selected by Caremark because of their combination of effectiveness and cost. All participating retail pharmacies, along with the Caremark mail-order program, will be aware of drugs currently on the formulary.

Your doctor should call Caremark or visit **caremark.com** to learn which drugs are covered under your Prescription Benefit. Encourage your physician to prescribe preferred medications whenever possible, because drugs not on the formulary will not be covered and will cost you more money.

Is there an out-of-pocket maximum on injectable medications?

Yes, there is a separate annual out-of-pocket maximum that applies only to injectable medications. Once your out-of-pocket for prescription medications costs reach the annual limit of $1,000, all future injectable medication costs will be paid at 100%.

Please refer to your **Plan Benefit Profile** to determine the specific information for how your injectable medication coverage will be paid.

Organ Transplant Benefit

The Organ Transplant Benefit is limited to the following aggregate amounts and applies to all medical expenses relating to the transplant of the following organs:

- Heart - $350,000
- Lung - $300,000
- Liver - $275,000
- Pancreas - $175,000
- Kidney - $125,000
- Bone Marrow
    - Autologous - $200,000
    - Allogeneic Related - $300,000
    - Allogeneic Unrelated - $400,000

What's Covered?

After your plan deductible is met, the organ transplant surgery and related hospital charges are payable to the above limits under your Surgical and Obstetrical Benefit and the Hospital Benefit as indicated in your **Plan Benefit Profile**. The Organ Transplant limits do not apply to the annual Plan Benefit Limit indicated in your **Plan Benefit Profile**.

*A Predetermination of Benefits, along with medical documentation, **must** be submitted through your PPO network for review and approval. All organ transplant procedures must have prior approval from TeamCare.*

The Organ Transplant Benefit includes hospital and related facility charges, physician's fees, ancillary charges, and all related expenses associated with the surgical transplant procedure. Organ procurement expenses are also covered and are considered part of the transplant procedure.

Organ Donor Benefit

What's Covered?

This benefit covers charges for medical treatment the donor receives for the donation of an organ. It covers these charges only when the donor does not have a group or individual health insurance policy that covers these charges.

The donor's medical treatment will be covered under the applicable benefit. Expenses are payable while the donor is in the hospital for the surgery and will continue for 90 days after the donor is released from the hospital.

Please refer to your **Plan Benefit Profile** to determine how the Organ Transplant Benefit and Organ Donor Benefit will be paid.

An organ transplant is a very serious undertaking and it's important to understand your TeamCare Benefits when you or someone in your family needs this procedure.

Lab Benefit

Lab Card®

When you want to save money on quality outpatient lab testing, you can take advantage of the Lab Benefit through the Quest Lab Card program. Quest Lab Card is completely voluntary. This is a patient driven benefit that allows you to obtain outpatient laboratory testing services at **no cost to you**. You pay no deductible, no copayment, and no coinsurance.

Using Your Lab Card Is As Easy As 1-2-3

1. At your physician's office or a Lab Card collection site, show your TeamCare Benefits ID Card and request to use the Lab Card Program.
2. If your physician collects Lab Card specimens in their office, they can continue to do so. After the collection is complete, your physician must send directly to Quest or you will not be eligible for the 100% benefit.
3. If your physician does not collect specimens in their office, you may find an approved Lab Card collection site at **LabCard.com** or by calling **800-646-7788**.

What's Covered?

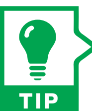
If you use this voluntary program for covered lab work, you pay nothing toward lab work performed through Quest Lab Card. You receive a 100% lab testing benefit. If you choose not to participate in the program, your covered lab work will be paid as indicated in your **Plan Benefit Profile**.

The Quest Lab Card program applies to diagnostic **outpatient** laboratory testing, which includes blood testing, urine testing, cytology and pathology, and cultures. If you should have any questions concerning this program, please call Quest Lab Card Client Services at **800-646-7788**.

Here's What's Not Covered:

- Lab work ordered during inpatient hospitalization
- Lab work needed on an emergency basis
- Time-sensitive, specialized out-patient laboratory testing such as fertility testing, bone marrow studies, and spinal fluid tests
- Non-laboratory work such as mammography, x-ray imaging, and dental work
- Lab work performed by another lab
- Testing that is not covered by your plan provisions

Remember: *Your physician must mark the lab requisition submitted with the specimen as Quest Lab Card or you will not be eligible for the 100% lab testing benefit.*



If your physician does not take specimens, simply visit a Quest Diagnostics collection site to have your specimen taken. Be sure to show your TeamCare Benefits ID Card which lists your Quest Lab Card information.

Imaging Benefit (MRI, CT, and PET Scans)

When you want to save money on advanced imaging services, you can access USIN facilities that perform these important procedures. USIN is able to obtain appointments for you at a high-quality, credentialed in-network facility of your choice. MRI, CT, and PET scans are covered at 100% only when scheduled through USIN.

What's Covered?

USIN is a voluntary program provided by TeamCare for advanced radiology procedures, including MRI, CT and PET scans. When you schedule your procedure through USIN, your MRI, CT, and PET scans are covered at 100%.

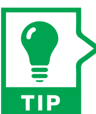
You pay no deductible or coinsurance for your advanced radiology benefit.

*If you choose not to participate in the program, your covered advanced radiology procedures will be paid according to your **Plan Benefit Profile**.*

How to Use This Benefit:

The USIN program is a premier network with over 2,200 radiology facilities serving many areas across the country. All facilities are credentialed to ensure that USIN facilities meet the highest quality standards in the industry.

- When your doctor prescribes an MRI, CT or PET scan, you or your doctor must call USIN at **877-674-0674** to schedule an appointment.



If the nearest USIN facility is more than 40 miles from your home, TeamCare will make a network exception and your outpatient advanced imaging test will be covered at 100%. To utilize this network exception you must contact TeamCare prior to getting your test conducted at an in-network PPO facility.

If you do not call USIN to schedule your advanced imaging test or you do not have a network exception, your claim will be paid as indicated in your **Plan Benefit Profile**.

You or your doctor must call USIN to schedule your MRI, CT or PET scans or you will not be eligible for the 100% advanced radiology benefit.

What's not covered?

- Advanced radiology ordered during inpatient hospitalization
- X-rays, mammograms, sonograms, ultrasounds, bone scans, or testing that is not covered by your plan provisions

Teladoc also offers outpatient behavioral health visits at no cost to you! Please visit ***Teladoc.com/TeamCare*** *for more information.*

Behavioral Health Benefit

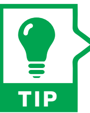
Inpatient Treatment

If you are being treated inpatient in an approved psychiatric, alcoholism or drug abuse treatment facility or a qualified hospital—your TeamCare plan will pay as indicated in your **Plan Benefit Profile**. Precertification is required by the PPO network for all inpatient, partial hospitalization (PHP), intensive outpatient (IOP), and ABA therapy to qualify under the Behavioral Health Benefit.

Outpatient Treatment

If you are being treated outpatient in an approved psychiatric, alcoholism or drug abuse treatment facility, and your treatment program is prescribed and performed by a psychiatrist, physician, psychologist, or a state-licensed/registered social worker or counselor:

- If covered services are provided in an outpatient hospital setting or during a physician office visit, after your plan deductible, your plan pays as indicated in your **Plan Benefit Profile**.
- The out-of-pocket limit does no apply to Behavioral Health Benefits.



Be sure to stay in-network for behavioral health benefits and avoid high out-of-pocket expenses for treatment centers and any other programs that are not covered under your plan.

Chiropractic Benefit

The Chiropractic Benefit covers charges for all services provided, directed, or supervised by a chiropractor, subject to the exclusions and limitations summarized in the **Non-Covered Medical Services** section. This includes x-rays, laboratory charges, therapy, hospitalization, office visits and all other covered services.

Please refer to your **Plan Benefit Profile** to determine how the Chiropractic Benefit will be paid. The out-of-pocket limit does not apply to the Chiropractic Benefit.

Hearing Aid Benefit

The Hearing Aid Benefit covers charges for hearing devices (hearing aids), fittings, and the first set of batteries. All services must be provided by an audiologist or certified hearing aid specialist and recommended or prescribed by a doctor.

Please refer to your **Plan Benefit Profile** to determine how the Hearing Aid Benefit will be paid. The out-of-pocket limit does not apply to the Hearing Aid Benefit.

Non-Covered Medical Services

General Non-Covered Medical Services

- Any test, examination, procedure, service or product which is not uniformly and professionally endorsed by the general medical community as Standard Medical Care, Treatment, Services or Supplies;
- Any charges over the Reasonable and Customary allowance established by TeamCare;
- Charges covered by any other group plan or individual health insurance policy;
- Any costs for transportation or lodging;
- Charges for educational programs or materials, unless covered under the Wellness Benefit;
- Specialized furniture or equipment unless approved by the Plan;
- Cosmetic care or treatment (except to the extent it is required due to an accidental bodily injury);
- Personal comfort items, state taxes or surcharges;
- Routine dental x-rays and laboratory work (see Dental and Orthodontic Benefit);
- Eye examinations for the correction of vision and fitting of glasses or contact lenses, except contact lenses or glasses for treatment of glaucoma, keratoconus or resulting from cataract surgery (see Vision Benefit);
- Injury or illness that is work-related or covered by Workers' Compensation or an Occupational Disease Law;
- Hospital confinements that are longer than accepted standards of medical practice;
- Maintenance Care;
- Treatment or services that are covered or provided by the Social Security Act;
- Treatment or services for complications of medical, dental or vision procedures not covered by TeamCare;
- Treatment or services (unless five years have passed since the original occurrence of the illness or injury) for illness or injury or for complications of illness or injury that:
    - Is work-related or covered by a Workers' Compensation Act or similar law (see "Workers' Compensation");
    - Is received while in the armed services;
    - Arises out of declared or undeclared war or any act of war or civil disturbance;
    - Is sustained while participating in an illegal act that is in violation of a local, state or federal statute;
- Treatment outside the United States shall be limited to treatment, services or supplies that are uniformly and professionally endorsed by the general medical community in the United States. Benefits will be paid in U.S. dollar amounts under Plan limitations not to exceed maximum amounts allowed for similar treatment, care or services in the United States;
- Services and supplies for which the covered individual would not legally be required to pay; and
- Any charges that exceed the Annual Plan Maximum.

Medical claims must be filed within one year of your date of service because claims filed more than one year from that date will be denied.

Non-Covered Wellness Benefit Services

- Examinations, procedures or tests performed by an out-of-network provider;
- Body scanning procedures;
- Department of Transportation (DOT) physicals; and
- Executive exams including Mayo Clinic.

Non-Covered Prescription Benefit Services

- Therapeutic devices or appliances (hypodermic needles, support garments and other non-medicinal items);
- Drugs or medications dispensed directly by a physician or dentist;
- Cosmetic or beauty aids;
- Immunizing agents, blood or blood plasma, or medication prescribed for parenteral administration, except insulin;
- Medications for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or federal governmental agency;
- Any medication furnished by any other drug or medical service for which no charge is made to the covered individual;
- Any drug labeled, "Caution – Limited by Federal Law to Investigational Use" or any experimental drug;
- Any drug, dietary supplements or vitamins available over-the-counter – unless required under the Affordable Care Act;
- Any drug used for enhancing sexual function; or medication primarily intended for cosmetic or lifestyle enhancement;
- Any drug or medication ordered from outside the United States;
- Drugs or supplies on a formulary exclusion list compiled by the Plan's pharmacy benefits manager available by contacting CVS Caremark at **caremark.com**;
- Food and/or specialized nutritional products unless approved by the Plan; and
- Drugs or medications filled at Walmart or Sam's Club.

Non-Covered Surgical and Obstetrical Benefit Services

- Reversal of sterilization procedures;
- Services related to artificial insemination and/or in-vitro fertilization;
- Charges for stand-by surgeons; and
- Surgical procedures that are considered cosmetic unless they are a result of an accidental injury. Examples of cosmetic surgery include but are not limited to:
    - Augmentation mammoplasty (breast enlargement surgery), unless it is part of reconstruction following breast surgery due to cancer;
    - Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction;

- Otoplasty (plastic surgery on ears), sometimes referred to as "lop ears" or "cauliflower ears;"
- Blepharoplasty (repair of drooping eyelids), unless the droop restricts the field of vision as verified by an ophthalmologist;
- Keratectomy or keratotomy–for diagnosis of myopia (nearsightedness) when the myopia is correctable by lenses; and
- Rhytidectomy (face lift);
- Dyschromia (tattoo removal); and
- Genioplasty (chin augmentation).

Non-Covered Organ Transplant Services

- Charges for a transplant that was not pre-certified through the TeamCare network;
- Expenses for any transplants other than those specified; and
- Expenses related to a transplant of an animal organ or a mechanical device to replace a human organ.

Non-Covered Ambulance Services

- Transportation in any privately-owned vehicle;
- Services and supplies for which the covered individual is not legally required to pay;
- Transportation for reasons other than receiving needed medical treatment; and
- Transportation to any location when the required medical treatment is available at the present location.

Non-Covered Chiropractic Services

- Any treatment that is not required due to an illness or injury;
- Any treatment for children under the age of 12; and
- Maintenance Care.

Non-Covered Hearing Aid Services

- Replacement of lost, missing or stolen appliances;
- Repair or replacement of broken appliances;
- Replacement batteries; and
- Hearing aids purchased without a prescription or recommendation from a physician or without a waiver approved by the Food and Drug Administration.

Non-Covered Behavioral Health Services

- Treatment in a half-way house or similar facility;
- Inpatient, partial hospitalization (PHP), intensive outpatient (IOP) treatment, and ABA therapy not pre-certified by the appropriate TeamCare network;
- Legal services and recreational, vocational, financial or educational counseling, except as part of a chemical dependency treatment program;

- Detoxification or drug withdrawal programs not rendered by an approved hospital or as part of an approved program;
- Personal comfort items;
- Marriage or family counseling, except as part of a psychiatric treatment program;
- Services rendered by a social worker or counselor who is not licensed or registered in the state in which services are performed;
- Court-ordered treatment, unless assessed and certified to be in accordance with medically necessary standards;
- Services and treatment for the purpose of maintaining employment or insurance, unless assessed and certified to be in accordance with medically necessary standards services and treatments that are:
    - Educational or vocational in nature,
    - Required by law to be provided by a school system for a child (such as evaluation for attention deficit disorder),
    - For personal growth and development,
    - For adjudication of marital, child support and custody cases;
- Services and treatment that are experimental, investigational, and/or unproven mainly for research or not in keeping with national standards of practice as determined in accordance with guidelines adopted by the Plan;
- Regressive therapy, megavitamin therapy, nutritionally based-therapies for chemical dependency treatment, and non-abstinence based chemical dependency treatment;
- Custodial care, including, but not limited to, treatment not expected to reduce the disability to the extent necessary to enable the patient to function outside a protected, monitored or controlled environment;
- Services and treatment for intellectual disabilities, autism spectrum disorders (ASD) and/or developmental delays except for initial diagnosis. Applied Behavioral Analysis (ABA) may be covered for ASD;
- Treatment for stammering or stuttering; and
- Treatment for chronic pain except for except for psychotherapy, biofeedback or hypnotherapy provided in connection with a psychiatric disorder.

At Mayo Clinic, over 3,300 physicians, scientists and researchers are ready to share their expertise to empower you.

Mayo Clinic

Under TeamCare, you have complete and direct access to Mayo Clinic for any medical care. Whether it's for a second opinion or the actual treatment—the Mayo Clinic stands ready to provide you the best care.

- For most illnesses and injuries, treatment with your local doctor or hospital is appropriate; however, for more highly specialized cases, access to the Mayo Clinic can be crucial.
- Whether confirming the original diagnosis and treatment or providing treatment, Mayo Clinic has experience in dealing with all types of cases, making the best care available to you and your family.

With locations in Rochester, MN, Jacksonville, FL, and Scottsdale, AZ, arranging for services at the Mayo Clinic is easy. Visit **mayoclinic.com** for more information.

At Mayo Clinic, you are still responsible for your plan deductible, the office visit copayment and any coinsurance. Services that are not medically necessary, not covered by your plan, and travel and lodging expenses are your responsibility.

Health Management Program

TeamCare has partnered with Conifer Health Solutions to identify and help members who are chronically ill, suffering from a complex medical condition, or experiencing an acute illness. Through an in-depth detailed medical management review, Conifer identifies potential TeamCare members for the program and contacts these members by phone and mail. If you are a candidate for personal health management services, a nurse will call to discuss your personal health needs and share program information.

If you're contacted and choose to enroll in the program, there is no cost. A Conifer nurse will discuss your healthcare needs and give you some key information on the program. The Conifer nurse becomes your personal health nurse and serves as your healthcare advocate—helping you live a healthier life through personalized and convenient support.

Remember, the program is free. If identified and contacted by Conifer, TeamCare encourages you to participate in this valuable option.

All your medical information is confidential and will not be shared with any party not associated with your healthcare plan in accordance with the HIPAA Privacy Rules and the Health Funds Privacy Policy (available at **MyTeamCare.org**).

Tooth decay is one of the most common chronic conditions in the United States. Untreated tooth decay can cause pain and infections that may lead to problems with eating, speaking, and other medical conditions.

Humana

TeamCare has joined with Humana, one of the nation's largest dental preferred provider networks to offer TeamCare Dental. TeamCare Dental allows you and your family members to maximize your dental benefits through negotiated discounted fees with in-network dental providers.

TeamCare Dental is a voluntary program. You may choose dental care with a non-participating dentist and your benefits will be paid at the reasonable and customary fee levels in your area. You will be responsible for any charges above the reasonable and customary fee level. If you choose to use one of the 175,000 dental providers in the Humana network, you'll enjoy the following additional benefits:

- An in-network dentist allows you to receive your dental care **at a lower cost**.
- An in-network dentist protects you from any charges above the negotiated fee.
- An in-network dentist will file all claims directly with TeamCare.

To find a participating dentist in your area or for further information, please access the Humana website at **humanadentalnetwork.com**, or call **800-592-3112** to speak with a Humana representative.

Dental Benefits

The Dental Benefit covers treatment usually provided by dentists (including specialists) to prevent or correct dental problems.

What's Covered?

- **Diagnostic and Preventive Dental Care**
  - Oral exams once every six months*
  - Full-mouth or panorex x-rays every two years*
  - Bite-wing x-rays every six months*
  - Prophylaxis (cleaning) once every six months*
  - Fluoride treatments for covered children once every six months*
  - Sealants for covered children through age 13 every 18 months*

- **Restorative Dental Treatments and Extractions**
  - Fillings and routine extractions
  - Root canal treatments and similar services

- **Oral Surgery and Anesthesia**
  - Removal of impacted teeth
  - Alveoplasties
  - General anesthesia when used in conjunction with oral surgical procedures

- **Periodontal Surgery**
  - Full mouth debridement, periodontal scaling, and/or root planing
  - Gingivectomies or gingivoplasty
  - Mucogingival surgery
  - Osseous surgery
  - Osseous graft
  - Gingival curettage
  - Periodontal prophylaxis once every six months*
  - General anesthesia when used in conjunction with periodontal procedures

- **Fixed and Removable Prosthetic Devices and Related Services**
  - Full or partial dentures (including overdentures) once every three years*
  - Fixed bridgework, crowns, inlays, and onlays once every three years*
  - Implants
  - Repair of dentures, partials, bridges, and crowns

*The frequency may vary by plan. Refer to your Dashboard at **MyTeamCare.org** or your **Plan Document**.

For covered dental treatments, by dental providers not in the Humana network, TeamCare pays a percentage of the covered charge, subject to reasonable and customary fees in that area. The percentage payable depends on the type of dental treatment or service you receive as indicated in your **Plan Benefit Profile**. Benefits will be paid to the annual maximum as indicated in your **Plan Benefit Profile**.

Continued Dental Care

Certain dental treatments that typically require a longer time to complete will be payable after your plan coverage ends if they are started while you or your dependents are covered.

The following procedures are covered based on the date that work was begun:

- The completion of dentures (full or partial) is payable if you or your dependents were covered on the date the impression was made.
- The completion of fixed bridgework, gold restorations, and crowns is payable if you or your dependents were covered on the date any affected teeth were prepared.
- The completion of root canal therapy (endodontics) is payable if you or your dependents were covered on the date the affected teeth were opened for treatment.

*All procedures are subject to the limitations listed in your **Plan Document**.*
All time limitations are determined by the last date of service of each applicable treatment.

Orthodontic Benefit

For covered children, your plan provides part of the cost of straightening teeth (braces, including interceptive or retention orthodontic appliances). To be covered under the Orthodontic Benefit, charges must be incurred while your child is covered under your plan.

*The dental exclusions and limitations listed in your **Plan Benefit Profile** also apply to orthodontic treatment. Orthodontic Benefits are only payable for covered children.*

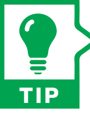
- For covered orthodontic benefits, your plan pays a percentage of the charge, subject to reasonable and customary limitations. The percentage payable is indicated in your **Plan Benefit Profile**.
- Your plan will pay a maximum Orthodontic Benefit (if applicable) for each covered child as indicated in your **Plan Benefit Profile**.

Avoid Surprises—Use Predetermination for Dental and Orthodontic Benefits

TeamCare offers you or your dentist a Predetermination of Benefits. After the dental examination, your dentist may recommend dental treatment:

- A Predetermination of Benefits lets you and your dentist know what amount will be payable for the proposed treatment.
- Both you and your dentist will receive a statement from TeamCare with the amounts TeamCare will pay for services.

This Predetermination of Benefits is not a guarantee of payment. The projected benefits will be paid only if you, or your dependent, are still covered at the time of treatment.



Follow these steps to have the proposed dental treatment reviewed in advance:

1. *Ask your dentist to complete a Predetermination of Benefits request showing the proposed treatment and charges.*
2. *Your dentist should submit your request electronically, through **MyTeamCare.org**, or to the address on the back of your TeamCare Benefits ID Card.*

Both you and your dentist will receive a statement of the amount your plan will pay for the proposed services.

Filing a Dental or Orthodontic Claim

If you use a Humana dental provider, no claim forms will be required. In most cases, claim forms are not required since dentists send their itemized statement for services directly to TeamCare.

If you do need to file a claim, send the itemized statement from the dental provider directly through **MyTeamCare.org** or to the address indicated on the back of your TeamCare Benefits ID Card.

Coordination of Benefits

If you or your dependents are covered by another group plan that provides dental benefits, we will coordinate with your other plan. TeamCare pays a percentage of the dentist's charges subject to the limitations noted in this section. In no case will the total combined payment from TeamCare and any other insurance exceed the dentist's charges. It is important to notify TeamCare if you have other group healthcare coverage.

Dental and orthodontic claims must be filed within one year of date of service. Claims filed more than one year from date of service will be denied.

Vision Benefits

The Vision Benefit covers charges for routine eye examinations, lenses, frames, and contact lenses for you and your covered dependents as follows:

- Eye examination
- Pair of eyeglasses (lenses and frames)
- Pair of contact lenses, instead of glasses

The vision services must be performed by an optician, optometrist or ophthalmologist.

In-Network Vision Benefits

Enjoy easy in-network access to eye exams and prescription eyewear by using EyeMed's Select Plan Network.

TeamCare has developed a partnership with EyeMed Vision Care using their Select Network. EyeMed has more than 24,000 network providers. The network includes LensCrafters, Pearle Vision Centers, America's Best, For Eyes, and Target, along with numerous independent practices.

For a copayment, you and your covered dependents can receive an eye examination and glasses or contact lenses as indicated in your **Plan Benefit Profile.**

Your copayment allows you the following:

- Routine eye exam and prescription for eyeglass lenses or contact lenses are covered. You are responsible for paying any additional fee associated with the contact lenses exam, fitting, and follow-up.
- Standard eyeglass lenses, including progressive lenses, with uncoated plastic lenses, regardless of size or power, are covered.
- Lens options such as polycarbonate, ultraviolet coating, scratch resistant coating, tints, etc. are available at reduced costs through your EyeMed Vision provider.
- Frames are covered up to the allowance specified in your **Plan Benefit Profile**. If you choose frames costing more than the covered allowance, you will be responsible to pay the difference in price, at a reduced cost.
- In lieu of glasses (lenses and frames), contact lenses are covered up to the allowance specified in your **Plan Benefit Profile**. If you choose contact lenses costing more than the covered allowance, you will be responsible to pay the difference in price.

It's easy to receive in-network care.

Contact lenses can be obtained from an in-network EyeMed Vision provider or through the mail using Contacts Direct, which offers an economical alternative for purchasing contact lenses. For pricing or ordering information, please visit **contactsdirect.com** or call **800-987-5367**.

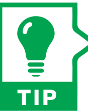
To use your Vision Benefit, simply call for an appointment or visit any one of the many vision providers and show your TeamCare Benefits ID Card that has your EyeMed Vision information. The EyeMed Vision provider will verify your eligibility, benefits and copayment.

For the location nearest you or if you have questions concerning participating provider locations, contact EyeMed at **866-723-0514**, or visit **eyemed.com**.

Out-of-Network Vision Benefits

If you choose to go to a vision provider who is not in-network, TeamCare will reimburse you to the limits specified in your **Plan Benefit Profile**. Claim forms are not required. You can send a copy of your itemized receipt directly to TeamCare as indicated on the back of your TeamCare Medical ID Card. When submitting the receipt, be sure to indicate your name along with your identification number that appears on your TeamCare Medical ID Card.

Out-of-network vision receipts must be filed within one year of the date of service. Receipts filed more than one year from the date of service will be denied.



In compliance with the Affordable Care Act, the eye exam benefit for glasses for covered children under the age of 19 from out-of-network providers will be subject to reasonable and customary limitations or subject to your plan's PPO office visit copayment.

*It is important to refer to your **Plan Benefit Profile** for your specific Vision Benefits.*

An eye exam can detect eye health problems like glaucoma or cataracts, but it can also help identify early signs of diseases that impact your whole body—high blood pressure, diabetes, and high cholesterol—just to name a few.

Eligibility for UPS Retirees

Coverage for the TeamCare Retiree Health Plan begins on the later of either your retirement date or the date your active plan coverage ends (if you are still covered by your active plan when you retire). Coverage for your Spouse and dependents begins when your coverage begins, provided they are still eligible under the Plan.

If eligible:

Full-time UPS retirees are covered by **TeamCare Retiree Health Plan RU**, and

Part-time UPS retirees are covered by **TeamCare Retiree Health Plan RV**.

To qualify for the TeamCare Retiree Health Plan, you must meet four requirements:

1. Minimum Service Requirement

- **UPS Freight Employees** - The Minimum Service Requirement to qualify for the Retiree Plan is at least 10 years of credited service with a UPS pension plan or at least 20 years under a recognized Teamster collective bargaining agreement. The credited service requirement will be determined by the UPS pension plan based on your UPS employment, including UPS employment prior to the time contributions were required to TeamCare.

- **UPS Package Employees** - The Minimum Service Requirement to qualify for the Retiree Plan is to receive a pension (from a pension plan contributed to by UPS) based on at least 20 years of bargaining unit employment with UPS or have at least 20 years under a recognized Teamster collective bargaining agreement. Employment with UPS includes employment prior to the time contributions were required to TeamCare.

  Employment in job positions that are covered by a collective bargaining agreement can be counted towards meeting the 20 year Minimum Service Requirement.

PREVENT AN OVERPAYMENT

If you or your covered dependent is eligible for Medicare parts A, B, or D*—even if you elect not to take Medicare for any reason—**the Medicare eligible member does not qualify for Retiree Health Plan Benefits.** You must notify TeamCare immediately to prevent an overpayment that you will be responsible to repay to TeamCare.

*Except if Medicare is due to End Stage Renal Disease (ESRD)

2. Retiree Health Plan Age Requirement

- **UPS Freight Employees** - The minimum retirement age for the Retiree Health Plan is age 55 for both full-time and part-time UPS Freight Employees.
- **UPS Package Employees** - The minimum age for the Retiree Health Plan is either age 52 or 55:
  - Age 52:
    - Full-time prior to August 1, 2013; and
    - Not with a Teamster Local Union in the Central Region that has an age 55 requirement.
  - Age 55:
    - In a bargaining unit that participated in TeamCare prior to August 1, 2013; or in the Central Region with a Teamster Local Union that had the age 55 requirement as of January 1, 2014. Those Local Unions are 7, 20, 40, 89, 90, 215, 236, 243, 328, 332, 339, 377, 406, 455, 554, 688, 908, 957; or
    - Full-time on or after August 1, 2013; or
    - Part-time UPS Package Employee.

3. Contribution Requirement

On your eligibility date or retirement date, you must have:

- At least 40 weeks of active health contributions in each of the five 52-week periods immediately preceding the eligibility date (5 out of 5 rule); or
- At least 40 weeks of active health contributions in at least seven out of the ten 52-week periods immediately preceding the eligibility date (7 out of 10 rule).

NOTE: Contributions submitted to the UPS Health Plan prior to participation in TeamCare will be applied to meet this requirement.

4. Monthly Premium Requirement

If you qualify for coverage under the Retiree Health Plan, you must pay the required monthly premium amount which is determined by the Board of Trustees and negotiated in the National Master UPS Agreement. The premium will remain at the current rate of $200 for one person or $400 per family until such time as the Board of Trustees deems an adjustment is appropriate. Should an adjustment be required, you will be notified in advance by TeamCare.

End of Participant Coverage

Your coverage under the Retiree Health Plan ends on the earliest of the following:

- The date you turn age 65;
- The date you first become eligible for Medicare—even if you elect not to take Medicare Part B;
- The date you become covered by another benefit plan of TeamCare by returning to work (you may reinstate or reestablish your eligibility for the Retiree Health Plan when you stop working again);
- The first of the month during which you cease to pay the monthly premium; or
- The date that you lose Retiree Health Plan eligibility as a result of a voluntary withdrawal by your employer from TeamCare.

PREVENT AN OVERPAYMENT

If you or your covered dependent is eligible for Medicare parts A, B, or D*—even if you elect not to take Medicare for any reason—**the Medicare eligible member does not qualify for Retiree Health Plan Benefits.** You must notify TeamCare immediately to prevent an overpayment that you will be responsible to repay to TeamCare.

*Except if Medicare is due to End Stage Renal Disease (ESRD)

Eligibility for Dependents

What is the Definition of Spouse?

Spouse is defined as an individual who is married to a Participant in a legally recognized civil or religious ceremony. A Participant's common-law Spouse will be considered a Spouse for purposes of the Plan, if:

- The Participant's state of domicile recognizes common-law marriage; and
- The Participant furnishes TeamCare with appropriate documentation that the couple has fulfilled all conditions which his state of domicile requires for such a marriage.

What is the Definition of Child?

A Child is defined as a:

- Participant's natural child, adopted child, step-child under age 19 (or under age 25 if a Qualified Student); or
- A child placed with a Participant for adoption; or
- A child for whom the Participant is obligated to provide support pursuant to a Qualified Medical Child Support Order. A child whose legal guardian or custodian is a Participant shall only be considered a "Child" under this definition if the Participant establishes that the guardianship or custodianship is permanent and established pursuant to court order and the Participant (or the Participant and spouse) is the sole support of the child unless that child is a beneficiary under a Qualified Medical Child Support Order under federal law.

It is important to note that temporary designation of guardianship entered into primarily for the purpose of obtaining coverage for a person under this Plan will not qualify as a "Child" eligible for coverage.

What About a Qualified Medical Child Support Order (QMCSO)?

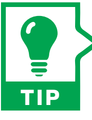
Medical, dental and vision coverage will comply with the terms of a Qualified Medical Child Support Order (QMCSO) to the extent that a QMCSO does not require the Plan to provide coverage it does not otherwise provide. A medical child support order is a judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction or an administrative process established under state law that 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 care plans. Federal law requires that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child covered by the order will be notified of the implementation procedure to determine whether the order is valid.

Start of Dependent Coverage

Generally, your family becomes covered by the Retiree Health Plan when your coverage starts – if you elect to take family coverage.

If you have a Life Event such as you get married or remarried, or have children after your coverage starts, your Dependent's coverage will begin on the date of the Life Event, **provided you notify TeamCare within 60 days of the event.** If you do not notify TeamCare within this 60 day period, your Dependent will **never** be eligible for coverage under the UPS Retiree Health Plan.

Provided that either the Participant or Spouse is eligible for the Retiree Health Plan, a Child will be covered to age 19, or to age 25 if a Qualified Student.



A Qualified Student is any full-time student in an accredited high school, trade school, vocational school, junior college or university.

End of Dependent Coverage

Your dependent's coverage under the UPS Retiree Health Plan will end on the earliest of the following:

- The date of your Spouse's 65th birthday;
- The date your Spouse or Child becomes eligible for Medicare, even if they elect not to take Medicare Part B;
- The date on which your Spouse is no longer married to you, you get divorced, or you have a legally recognized termination of the relationship;
- For a Child, the date neither you or your Spouse is covered under the Plan;
- The first of the month during which you or your Spouse cease to pay the monthly premium for coverage;
- The date that you lose Retiree Health Plan eligibility as a result of a voluntary withdrawal from TeamCare by your employer, either before or after your retirement (see the section entitled "Loss of Retiree Coverage Eligibility");
- The date your Child turns age 19, unless they meet the requirement of a Qualified Student; or
- The date your Child turns age 25 or earlier if they are no longer a Qualified Student.

Who do I notify if I get divorced or legally separated?

It is extremely important that you inform TeamCare immediately should you get divorced. Please contact the CustomerCare Center at **800-TEAMCARE** as failure to do so could result in claims being paid incorrectly.

You will be responsible for reimbursing TeamCare for any claims paid when a former spouse is no longer eligible.

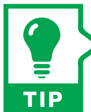
Postponement of Retiree Health Plan Coverage

Retirees and their spouses may each elect, on a one-time basis to voluntarily suspend and postpone their Retiree Health Plan coverage to a later date provided you or your spouse has other insurance coverage in effect.

If you or your spouse are currently eligible to receive or are receiving Retiree Health Plan benefits from TeamCare and wish to voluntarily suspend your coverage and postpone it to a later date, you must complete a **Retiree Health Plan Coverage Voluntary Suspension Form** and include proof of other insurance. This form is available at **MyTeamCare.org**.

Upon approval, TeamCare will suspend the retiree's and/or spouse's coverage and monthly premium payment as appropriate. The coverage and monthly premium payment will remain suspended until the retiree requests reactivation.

At the time of reactivation, continual proof of insurance coverage along with a termination letter must be supplied. TeamCare will accept either a letter or a HIPAA Certification of Continuous Coverage from the other insurance company as proof of termination. Upon reactivation, the retiree and/or spouse will be required to pay the prevailing contribution rate based upon the retiree's original retirement date.



Postponement of Retiree Coverage Example

Joe retires at age 57. Because his wife Jane has other coverage that provides insurance for Joe, Joe and Jane voluntarily postpone coverage until a later date. When Joe submits proof that his wife's insurance no longer covers him, Joe and Jane will return to the TeamCare Retiree Health Plan and pay the required monthly premium.

Scan this QR Code or visit MyTeamCare.org/forms-and-documents for the Retiree Health Plan Coverage Voluntary Suspension Form.

Forced or Involuntary Transfers

If you fail to meet the eligibility requirements for the Retiree Health Plan only because your employment was transferred into or out of TeamCare's geographical area, or there was a change in or dispute over your union's jurisdiction, or a similar situation beyond your control, TeamCare may be able to waive the requirements for you. If you think one of these situations applies to you, you should contact your Union and write a detailed description to:

TeamCare, A Central States Health Plan
P.O. Box 5126
Des Plaines, IL 60017-5126

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).

Generally, you or your qualified dependents are eligible to make self-payments for periods in which a qualified event causes a loss of coverage, subject to certain requirements and limitations. Self-payments must be continuous from the qualified event date. A Self-Payment is a contribution that you or your qualified dependent can submit to TeamCare in order to continue coverage.

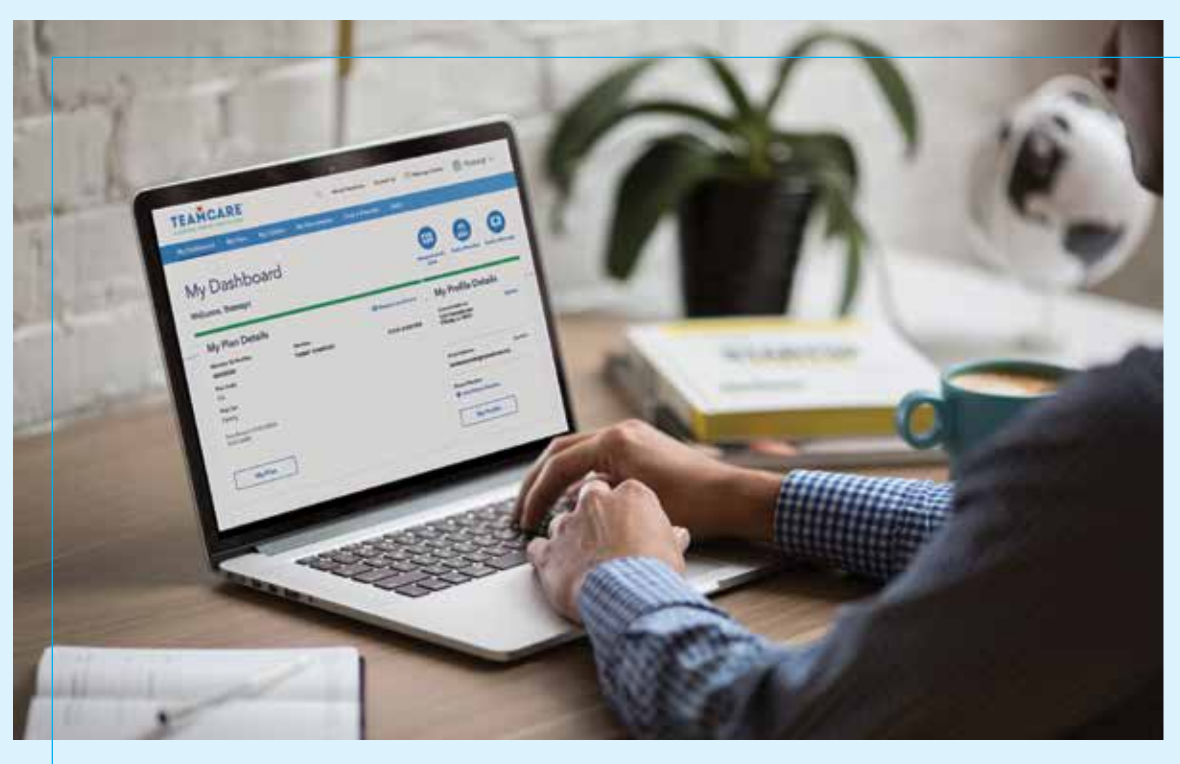
The information included here is a general overview of COBRA provisions. If you become eligible for continued coverage (that is, if you have a qualifying event) you'll be given more information that reflects your situation at the time. Eligibility for COBRA is triggered by a "qualifying event." The chart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

<table>
<tr><th>Event That Causes Loss of Coverage</th><th>Maximum Time Period for Making Self- Payments</th><th>Days From Event in Which TeamCare Must Be Notified</th><th>Election Period From Receipt of Notice</th><th>Initial Payment Due From Date of Election</th></tr>
<tr><td>Divorce or Legal Separation</td><td rowspan="2">36 months* for qualified dependents</td><td rowspan="2">60 days</td><td rowspan="2">60 days</td><td rowspan="2">45 days</td></tr>
<tr><td>Loss of Dependent Status</td></tr>
<tr><td colspan="5">*For these events and second qualifying events, it is the Participant's or Dependent's responsibility to notify TeamCare within 60 days of the event's occurrence.</td></tr>
</table>

How Do You Make COBRA Self-Payments?

TeamCare must be notified of the qualifying event within 60 days. TeamCare will then advise you of your Self-Payment options and the current Self-Payment rates. Once you receive the COBRA election notice, you'll have 60 days in which to elect to make Self-Payments. Finally, your initial Self-Payment must be received by TeamCare no later than 45 days from the date on which you made your election. Under no circumstances will TeamCare accept Self-Payments beyond this date.

The table outlines the qualifying events and the time period during which you and/or your qualified dependents can elect and begin making Self-Payments. When you receive a COBRA election notice you have the option to make Self-Payments for the same Benefit Plan that you had.

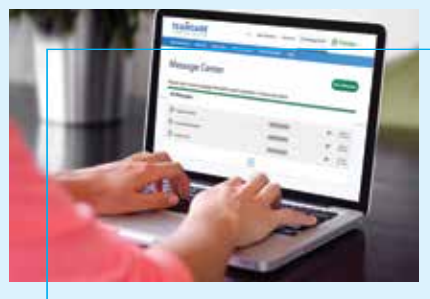


Get the information you need 24/7—MyTeamCare.org

Register for a web account today at **MyTeamCare.org**:

- Mobile and tablet-friendly
- Easy to navigate member dashboard
    - View a history of your recent health claims
    - Download PDFs of your Plan Benefit Profile, Plan Document, and Summary Plan Description
    - See your benefit maximums and what dates you are next eligible for services
    - See a breakdown of your deductible and out-of-pocket limits
- Interactive “How-To” guides for common tasks like adding dependents to your plan and updating your web account
- Download electronic ID cards
- Opt to go paperless

...and if you still need answers, you can contact our CustomerCare Center securely through the Message Center.



Coordination of Benefits

Coordination of Benefits takes place when you and your dependents are covered by your TeamCare plan and by another plan that provides group health benefits. This is common when both you and your spouse work, with each of you covered under the other person's group health insurance plan.

Coordination of Benefits also takes place when your injuries or your covered dependent's injuries result from a motor vehicle accident and motor vehicle no-fault or Personal Injury Protection (PIP) insurance benefits are available.

How Does It Work?

Coordination of Benefits provides complete payment of your allowable expenses **while preventing duplicate payment for the same service**. It can be a complex issue and you should always refer to your **Plan Document** for complete details of the Coordination of Benefits process.

How Coordination of Benefits Works with an HMO

In the case of coverage through an HMO, your TeamCare Plan will coordinate benefits as previously described, provided that the HMO rules and procedures are followed.

If charges are denied by the HMO for failure to follow its rules or failure to use an HMO provider, your TeamCare plan will also deny benefits.

TIP

Think of it this way: *You wouldn't expect to be paid twice by two auto insurance companies for the same claim. It works the same way for healthcare insurance—there are no duplicate payments.*

Coordination With No-Fault or Motor Vehicle Insurance Coverage

When the injury or illness results from a motor vehicle accident and motor vehicle no-fault, or personal injury protection insurance is available, that insurance has primary responsibility for the payment of claims related to the accident on you and your covered dependents.

What is "Primary Responsibility"?

When your TeamCare plan has primary responsibility, you or your covered dependents will receive full TeamCare benefits without regard to any coverage that you or your dependents have under another plan.

When the other plan has primary responsibility, it must first pay its full benefit. Your TeamCare plan will then pay any remaining covered expenses up to the amount that TeamCare would have paid if it had primary responsibility, unless payment is excluded by a provision of your TeamCare plan.

Please refer to your **Plan Document**, available at **MyTeamCare.org** to determine exactly how **Coordination of Benefits** affects you.

Subrogation is when TeamCare pays one of its members for care received and then makes its own claim against others who may have caused the loss, insured the loss, or contributed to the loss.

Subrogation and Reimbursement

Your TeamCare plan has a full right of subrogation and/or reimbursement each time you and/or one or more of your covered dependents receive benefit payments for any physical or mental condition or injury that was or may have been caused by any person. Your TeamCare plan's subrogation right to 100% reimbursement applies to all sources of recovery for all such injuries.

How Does It Work?

You and your covered dependents must fully cooperate with TeamCare and keep us informed of all facts about the causes of your injuries and all potential sources of recovery. If any injury is caused by a third party, you must provide all details to TeamCare as soon as possible.

Necessary details include:

- The date, time and place of your accident or injury
- Names, addresses and telephone numbers of all parties, witnesses, hospitals and medical providers
- A description of all motor vehicles in an accident
- The source of the police report (if any) or accident report
- Particulars of all liability insurance of all parties to the accident, as well as all other potential sources of recovery

You and your covered dependents have a continuing obligation to comply with all subrogation-related requests by TeamCare.

It is very important to respond to all TeamCare correspondence. Failure to cooperate with TeamCare may place your benefit payments in jeopardy. After an accident, TeamCare may postpone benefit payments until you meet the obligations outlined above. If you receive a monetary recovery without TeamCare's prior approval, we may decline future benefit payments for you until TeamCare's subrogation share is reimbursed.

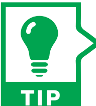
TeamCare is entitled to full reimbursement from your settlement, or other recovery, and of all benefit payments for care and treatment of injuries.

- Full reimbursement is not reduced by any attorneys' fees or other costs you incur in obtaining your settlement or other recovery.
- Full reimbursement is also not reduced by the fact you may not have been "made whole" by your monetary recovery—because of permanent injuries, loss of future earnings, hardship, etc.

TeamCare's right to a 100% reimbursement, prior to any amount you may recover, is an essential funding provision of your benefit plan. However, TeamCare will consider a settlement and will compromise on the amount owed in appropriate cases.

Workers' Compensation

You are not entitled to payment on a claim for any charge incurred for any treatment or service of an illness or injury which is sustained as a result of **any** occupation or enterprise for wage or profit, or any illness or injury of any type covered under any applicable Workers' Compensation Act or similar law.



Think of it this way: *TeamCare pays benefits for illnesses and injuries that are not work-related. Workers' Compensation covers those that are. TeamCare can recover any claims that are paid that are found to be work-related.*

Your TeamCare Medical Benefits do not replace Workers' Compensation Benefits. TeamCare has a full right of subrogation and/or reimbursement for any payment on a claim for the treatment of any work-related illness or injury.

The most important thing to remember is **DO NOT WAIT**. Often there are time limits on how long you can take to file a claim—and if you miss the time limit, you may not be able to file at all.

Workers' compensation is a form of insurance required from employers that provides compensation for workers who are injured at work or contract an occupational disease.

Assignment of Benefits

Usually, the provider of medical services will require you to assign benefits directly to them. When you assign benefits to your provider, you are authorizing TeamCare to issue the benefit payment directly to that provider. If we do not issue payment to the provider, we will mail you a benefit check for the amount payable on the submitted claim and it is your responsibility to pay the provider for services rendered.

Appeals Process

TeamCare has established a two-step process for appeal when you disagree with the payment of your claim. It is intended to give you the opportunity for two separate fair and impartial reviews.

- At all times during the appeal process, you have the right to submit any written comments, documents, records and other information you choose.
- All of your comments, documents, records and other information will be considered and will be included in the record of your appeal.
- In addition, at any time during your appeal, TeamCare, upon your request and free of charge, will send you copies of all documents, records, and other information possessed by us and relevant to your claim and your appeal.

You may waive any time limit for TeamCare's decision on your Step One Appeal or Step Two Appeal, and notice of the decision. The limits may also be extended if you do not submit the requested information necessary to decide your appeal. Depending on your TeamCare plan, additional appeals rights may be available to you. Please refer to your **Plan Document** for additional information.

For appeals involving a medically urgent situation, you may request an expedited appeal. Medically urgent generally means a situation in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience severe pain that cannot be adequately controlled while you wait for a decision. You and your physician will be notified of the decision as expeditiously as possible based on the medical exigencies of your situation.

Step One Appeal

If you are notified that your claim was denied, in whole or in part, and you disagree with the decision, you may have your claim reviewed as a **Step One Appeal**. You can submit your appeal and a written request for review to:

- The Message Center at **MyTeamCare.org** or
- By mail to:

  Research & Correspondence
  TeamCare, A Central States Health Plan
  P.O. Box 5126
  Des Plaines, IL 60017-5126

The TeamCare Research and Correspondence Department must receive your written request for review within 180 days after you receive the claim settlement.

Scan this QR with your smartphone or visit MyTeamCare.org/Help/Appeal-A-Claim for more details on filing an appeal.

Your written request for review must contain all of the following:

- TeamCare member's name and address
- TeamCare member's identification number
- Claim number (if known)
- Patient's name
- Relationship of patient to TeamCare member (husband, wife, son, daughter or self)
- The date of loss for which the claim was made
- Exact reason you are dissatisfied with the handling of your claim

TeamCare will mail you the Step One Appeal decision within 30 days after it receives your request for review. There will be a delay, however, if your request did not contain all of the required information. TeamCare will do more than just inform you of its decision—the notice sent to you will contain additional information. If your claim is again denied in whole or in part, the notice will provide:

- The exact reason why your claim was denied
- A reference to the section of your TeamCare plan document on which the denial was based
- An explanation of the process for a second step of review

If additional information is required, the notice will provide:

- A listing of additional information needed, if any, that might help approve your claim
- An explanation of why additional information may be necessary

*When additional information is requested, be sure to send it to the TeamCare Research and Correspondence Department either by mail or through the Message Center at **MyTeamCare.org** as soon as possible. When the information is received from the Step One Appeal process, your claim will be reviewed again and a final decision will be mailed to you.*

Step Two Appeal

To initiate a second and final review, you need to complete and return the appeal notification form sent to you by the TeamCare Research and Correspondence Department to:

- The Message Center at **MyTeamCare.org** or
- By mail to:

  Research & Correspondence
  TeamCare, A Central States Health Plan
  P.O. Box 5126
  Des Plaines, IL 60017-5126

You must submit this form within 180 days after you receive the decision of the Step One Appeal.

- In addition to the form, you and your authorized representative may submit written issues and comments regarding your case.
- You have the right to obtain copies of any documents or files that apply to your claim. They will be mailed to you if you request them in writing.

If your second and final appeal is denied, a decision will be mailed to you within 30 days after your appeal notification form was received. This decision will also contain:

- The exact reason your claim was again denied.
- A reference to the section of your TeamCare plan document on which the refusal was based.
- An explanation of your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

Based on the nature of the appeal, the Step Two Appeal review will be conducted by either the Trustee Appellate Review Committee or the Staff Final Review Committee.

Your TeamCare plan assigns the members of the Trustee Appellate Review Committee (and the Staff Final Review Committee, in appeals assigned to it) with the discretionary and final authority in deciding your Step Two Appeal, including decisions upon claims for benefits and including Trustee decisions interpreting your TeamCare plan.

If you are dissatisfied with TeamCare's decision at the conclusion of your Step Two Appeal, you have the right to file suit in state or federal court pursuant to Section 502 of the Employee Retirement Income Security Act. Before filing suit, however, you must complete your Step Two Appeal and receive the TeamCare's final decision. You must submit any appeal in a timely manner. TeamCare must receive the written request for review within 180 days after the claim has been processed.

Plan Administration

Your TeamCare plan is administered by the Trustees of the Central States, Southeast and Southwest Areas Health and Welfare Fund. The Board of Trustees is the only group with the authority to change or interpret any part of this TeamCare plan. No agent or union representative or employee of TeamCare acting alone has this authority.

Amendments to the TeamCare Plan and Termination

The provisions of this TeamCare plan may be amended from time to time as deemed necessary by the Trustees. Amendments may include increases, modifications, reductions or the elimination of certain benefits. Copies of all amendments are included in the records and minutes of the Trustees' meetings. This TeamCare plan may be terminated under circumstances specified in the TeamCare plan document. In the event of plan termination, all benefits will terminate.

Information Required by the Employee Retirement Income Security Act of 1974 (ERISA)

This booklet describes the comprehensive health benefits available to you as a TeamCare member. The TeamCare plan administrator is:

TeamCare, A Central States Health Plan
P.O. Box 5126
Des Plaines, IL 60017-5126

Telephone: (847) 518-9800

Your participation in TeamCare is determined by your Collective Bargaining Agreement and by the eligibility rules listed in this booklet. Your Collective Bargaining Agreement is the contract between your employer and your union which requires your employer to contribute to TeamCare on your behalf. The amount of employer contributions is actuarially determined.

Within 30 days of receipt of your written inquiry, TeamCare will verify whether any employer or employee organization participates in this TeamCare plan. Also, you may obtain your own copy of the Collective Bargaining Agreement that applies to you by making a written request to your union. If the union denies this request for any reason and you notify TeamCare, in writing. TeamCare will provide you with a copy of the agreement that applies to you.

To obtain this information from TeamCare, send a written request to:

TeamCare, A Central States Health Plan
P.O. Box 5126
Des Plaines, IL 60017-5126

Statement of ERISA Rights

As a TeamCare member in the Central States, Southeast and Southwest Areas Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all TeamCare members shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at your TeamCare plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing your plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by your plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to your plan administrator, copies of documents governing the operation of your plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of your TeamCare plan's annual financial report. Your TeamCare plan administrator is required by law to furnish each TeamCare member with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under your plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing your plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for TeamCare members, 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 you and other TeamCare members and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from your 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 your 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 your 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 your 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 your plan, you should contact your plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue 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 Employee Benefits Security Administration.

Legislated Benefits Coverage

Health Insurance Portability And Accountability Act (HIPAA)

This law became applicable to TeamCare on July 1, 1997. TeamCare, however, did not need to amend its benefit coverage provisions because it already complied with the HIPAA requirement that plans not apply any preexisting medical condition exclusion or otherwise discriminate against covered individuals as to eligibility and coverage on the basis of any health-status factors.

Women's Health And Cancer Rights Act

TeamCare complies with this law's requirements which can be summarized as follows:

- Every covered individual and beneficiary who, due to cancer, receives coverage for a mastectomy from TeamCare, and who elects breast reconstruction as part of that coverage, shall be provided coverage for such reconstructive surgery in a manner determined in consultation between her and her attending physician.
- This coverage will include reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- The deductible and/or copayment applicable to reconstructive breast surgery can be found in Book 1.
- Out-of-pocket limits and reasonable and customary limitations, to the extent applicable, are also the same as other plan coverage limitations.

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 your plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notices Addendum

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under your TeamCare Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the TeamCare Plan and under federal law, you should review the Summary Plan Description or contact the TeamCare Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of TeamCare Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the TeamCare Plan is lost because of the qualifying event. Under the TeamCare Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the TeamCare Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the TeamCare Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the TeamCare Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the TeamCare Plan as a "dependent child."

When is COBRA continuation coverage available?

The TeamCare Plan will offer COBRA continuation coverage to qualified beneficiaries only after the TeamCare Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the TeamCare Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the TeamCare Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Self-Payments Department
TeamCare, A Central States Health Plan
P.O. Box 5108
Des Plaines, IL 60017-5108

How is COBRA continuation coverage provided?

Once the TeamCare Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 24 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 24-month period of COBRA continuation coverage can be extended:

Disability extension of 24-month period of COBRA continuation coverage

If you or anyone in your family covered under the TeamCare Plan is determined by Social Security to be disabled and you notify the TeamCare Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 5 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 24-month period of COBRA continuation coverage. You must notify the TeamCare Plan Administrator of the determination within sixty (60) days of the determination and before the end of the initial twenty-four (24)-month period of Continuation Coverage. See your TeamCare Plan Document for details about when this extension might terminate.

Second qualifying event extension of 24-month period of continuation coverage

If your family experiences another qualifying event during the 24 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 12 additional months of COBRA continuation coverage, for a maximum of 36 months, if the TeamCare Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the TeamCare Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the TeamCare Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **HealthCare.gov**.

If you have questions:

Questions concerning your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws

affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit DOL.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **HealthCare.gov**.

Keep your TeamCare Plan informed of address changes

To protect your family's rights, let the TeamCare Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the TeamCare Plan Administrator.

TeamCare Plan contact information

Self-Payments Department
TeamCare, A Central States Health Plan
P.O. Box 5108
Des Plaines, IL 60017-5108

Central States, Southeast and Southwest Areas Health and Welfare Fund
Notice of Privacy Practices

Effective October 1, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Information
Your Rights
Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Depending on where you live, there may also be state or other laws that require greater limits on disclosures.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

- Unless you tell us otherwise, in writing, we will share information with a spouse or with a parent of an adult child if that information is relevant to their involvement in the health care of the individual or the payment of claims
- Unless you tell us otherwise, in writing, we often share limited information about your medical claims (such as the date of service, payment amount, and payment date) with your local union for their use in assisting you with claim payment

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will *never* share your information for marketing purposes unless you give us written permission

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
  Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact us for Further Information

- **Mail:**
  Privacy Officer
  TeamCare, A Central States Health Plan
  P.O. Box 5125
  Des Plaines, IL 60017-5125
- **Internet:**
  MyTeamCare.org
- **E-mail:**
  PrivacyOfficer@CentralStates.org
- **Telephone:**
  847-939-2500

Notes

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE PLAN
is a jointly administered, defined benefit employee benefit plan.

EXECUTIVE DIRECTOR
Thomas C. Nyhan

ADDRESS OF ADMINISTRATIVE OFFICE
8647 West Higgins Road
Chicago, IL 60631

ADDRESS FOR CORRESPONDENCE
P.O. Box 5126
Des Plaines, IL 60017-5126

TELEPHONE NUMBER
847-518-9800

TEAMCARE CUSTOMERCARE CENTER
800-TEAMCARE (800-832-6227)

WEBSITE
MyTeamCare.org

EMPLOYER IDENTIFICATION
36-2154936

PLAN NUMBER
501

PLAN YEAR
January 1 through December 31

The agent for service of legal process is Thomas C. Nyhan, Executive Director, Central States, Southeast and Southwest Areas Health and Welfare Fund, at the Administrative Office address.

IMPORTANT

Para obtener asistencia en Español, llame al
800-832-6227

Kung kailangan ninyo ang tulong sa Tagalog tumawag
800-832-6227

如果需要中文的帮助，请拨打这个号码
800-832-6227

Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’
800-832-6227

8647 West Higgins Road
Chicago, IL 60631

ADDRESS SERVICE REQUESTED

Questions? We're here to help!

Call us at 800-TEAMCARE (800-832-6227) or visit MyTeamCare.org.

August 2020