BOOKLET 1 OF 2

TEAMCARE®

A CENTRAL STATES HEALTH PLAN

Delivering better healthcare over the long haul

8647 West Higgins Road • Chicago, IL 60631 • 800-TEAMCARE • MyTeamCare.org

Summary Plan Description

Allegiant Travel Company

Active Plan Benefit Booklet | Your Plan Benefits | Plan Year 2025

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

CustomerCare CENTER

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

TeamCare Partners

BlueCross BlueShield
bcbsil.com

Teladoc
teladoc.com/TeamCare
800-TELADOC

MinuteClinic
minuteclinic.com
866-389-2727

Caremark
caremark.com
888-483-2650

Lab Benefit
QuestSelect
questselect.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

Welcome to TeamCare!

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

You've received two booklets, and together they describe the benefits you are entitled to under your TeamCare plan.

Booklet 1 provides a summary of provisions that are unique to your plan options. It also includes a Plan Benefit Profile, which is a snapshot of all the different benefits, for Plan MI (Bundled - High), Plan N5 (Bundled - Standard), and Plan 5N (Medical Only).

BOOKLET 1 OF 2

Booklet 2 provides more detail on your benefits, including what is covered and what is not covered by your Plan.

BOOKLET 2 OF 2

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

The information in this booklet reflects your benefits as of January 1, 2025. Updated information is available throughout the year on **MyTeamCare.org**.

Sincerely,

Thomas C. Nyhan
Executive Director

Board of Trustees

Employee / Union Trustees	Employer Trustees
Charles A. Whobrey	Gary F. Caldwell
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ENROLL TODAY!!!

Don't Get Caught Without Coverage

Easy as 1, 2, 3...Welcome to TeamCare

1. Visit **MyTeamCare.org** and create your login and password.
2. Follow the step-by-step easy enrollment process to add your spouse and dependents.
3. Upload any requested documents like birth certificates or marriage certificates.

Let's compare your plan options for 2025:

More detailed information is included in the enclosed Plan Benefit Profiles.

	Plan MI Bundled - High		Plan N5 Bundled - Standard		Plan 5N Medical Only	
Plan Deductible (Annual)	$200 Individual	$500 Family	$500 Individual	$1,000 Family	$500 Individual	$1,000 Family
Medical Out-of-Pocket Limit (Annual)	$2,500 Individual	$5,000 Family	$4,000 Individual	$8,000 Family	$4,000 Individual	$8,000 Family
PPO Office Copay (Plan Deductible does not apply)	$20		$30		$30	
Co-insurance (After Plan Deductible)	80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.		75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.		75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Wellness Benefit	No-cost for in-network services.					
Telemedicine Benefit	No-cost for general medical, dermatology, and behavioral health visits through Teladoc.					
Lab Benefit	No-cost for outpatient lab services through QuestSelect.					
Imaging Benefit	No-cost for MRI, CT, and PET scans through USIN.					
MinuteClinic	No office-visit copay. Covered services include common illnesses and minor injuries.					
Prescription Benefit	25% copay for short-term prescription fills and non-maintenance medications. 20% copay for a 90-day supply of medication.					
Dental Benefit **The Dental Plan Benefit maximums are per person per calendar year.** ***Annual Dental Maximum does not apply to children under age 19**	Annual Dental Maximum*: $2,500 Annual Dental Deductible: None Preventive Services: 100% Diagnostic & Restorative: 85% Crown & Bridge Work: 70% Dentures (Full & Partial): 70% Lifetime Orthodontic Maximum (Child/Adult Child): $2,500 Orthodontic (Child/Adult Child): 50%		Annual Dental Maximum*: $1,500 Annual Dental Deductible: None Preventive Services: 100% Diagnostic & Restorative: 85% Crown & Bridge Work: 70% Dentures (Full & Partial): 70% Lifetime Orthodontic Maximum (Child/Adult Child): N/A Orthodontic (Child/Adult Child): N/A		N/A	
Vision Benefit ***Contacts are in lieu of glasses**	**If using an EyeMed provider:** Routine Eye Exam: $10 copay Frames: $0 copay (up to $150 allowance) Standard Lenses: $0 copay (per pair) Contacts*: $0 copay (up to $120 allowance) Once every **12** months		**If using an EyeMed provider:** Routine Eye Exam: $10 copay Frames: $0 copay (up to $150 allowance) Standard Lenses: $0 copay (per pair) Contacts*: $0 copay (up to $120 allowance) Once every **24** months		N/A	

2025 TeamCare Plan Costs

Note: Dental and Vision benefits are only available as part of Plans MI and N5.
You cannot elect Dental and Vision as stand-alone benefits.

		Allegiant Travel Company Bi-Weekly and Semi-Monthly Deductions 2 deductions per month			Allegiant Travel Flight Attendants Semi-Monthly Deductions 2 deductions per month	
Plan MI Bundled - High • Medical • Rx • Dental • Vision		Employee Cost Per Pay Period	Employer Cost Per Pay Period		Employee Cost Per Pay Period	Employer Cost Per Pay Period
	Employee Only	$104.29	$314.90		$103.81	$315.38
	Employee + Children	$231.60	$436.52		$165.45	$502.67
	Employee + Spouse	$276.07	$564.83		$208.24	$632.66
	Family	$360.73	$805.05		$288.69	$877.08
Plan N5 Bundled - Standard • Medical • Rx • Dental • Vision		Employee Cost Per Pay Period	Employer Cost Per Pay Period		Employee Cost Per Pay Period	Employer Cost Per Pay Period
	Employee Only	$80.98	$328.12		$101.31	$307.79
	Employee + Children	$188.95	$436.62		$154.92	$470.66
	Employee + Spouse	$251.53	$564.87		$202.17	$614.23
	Family	$325.15	$804.60		$279.77	$849.98
Plan 5N Medical Only • Medical • Rx		Employee Cost Per Pay Period	Employer Cost Per Pay Period		Employee Cost Per Pay Period	Employer Cost Per Pay Period
	Employee Only	$53.52	$324.65		$53.52	$324.65
	Employee + Children	$164.41	$424.06		$145.73	$442.74
	Employee + Spouse	$214.08	$571.34		$194.50	$590.92
	Family	$293.25	$804.94		$271.96	$826.23

TEAMCARE
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PLAN MI BENEFIT PROFILE

Coverage Period: Beginning on or after 01/01/2025

PLAN BENEFIT LIMIT (ANNUAL)	PLAN DEDUCTIBLE (ANNUAL)	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
None	$200 per Individual $500 per Family	$2,500 per Individual $5,000 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 Allowed Amount and the loss of TeamCare Family Protection Benefit.

MEDICAL PLAN BENEFITS	*For further information, including a full Summary Plan Description (SPD), visit our website at MyTeamCare.org.*
TeamCare Wellness A TeamCare Physician must be used.	♦ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.
Teladoc Telemedicine Benefit Teladoc.com/TeamCare 800-TELADOC (835-2362)	♦ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, mental health, diabetes management and dermatology at no cost ($0 copay). Plan Deductible does not apply.
CVS MinuteClinic CVS.com/MinuteClinic 866-389-ASAP (2727)	♦ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost ($0 copay). Plan Deductible does not apply.
Hospital Expense Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Surgical and Maternity 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%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Lab Benefit questselect.com 800-646-7788	♦ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% provided the Physician submits the requisition through QuestSelect. If a Physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site. Plan Deductible does not apply. 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.
Advanced 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 (excludes x-rays) at 100% provided that the scans are scheduled directly through USIN. Plan deductible does not apply. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (includes 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	♦ Your Plan does not have a Hearing Aid Benefit.
Chiropractic Benefit	♦ After Plan Deductible, 50% of covered charges to a maximum $500 per person per calendar year. The Medical Out-of-Pocket Expense Limit does not apply.
Behavioral Health Benefits – Inpatient	♦ Facility: After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met. Physician: After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Behavioral Health Benefits – Outpatient	♦ $20 copayment for in-network office visit. Plan Deductible does not apply. Otherwise, after Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Major Medical Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.

TEAMCARE
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PLAN MI BENEFIT PROFILE

Coverage Period: Beginning on or after 01/01/2025

PRESCRIPTION BENEFIT

For more information or to find a participating pharmacy, call 888-483-2650 or visit **caremark.com**

Certain states have laws that may affect your Prescription Benefit. Visit **MyTeamCare.org/statelaws** for more information.

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.

Before the third fill of the same prescription at a Retail Pharmacy, long-term maintenance medications must be filled through the Maintenance Choice Network or the CVS/Caremark Mail Service Pharmacy or be subject to a 50% copayment. 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	$2,500*
Annual Dental Deductible	None
Preventive Services	100%
Diagnostic and Restorative	85%
Crown and Bridge Work	70%
Dentures (Full and Partial)	70%
Orthodontic (Child/Adult Child)	50%
Orthodontic Maximum (Child/Adult Child)	$2,500 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

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

MyTeamCare.org or 800-TEAMCARE

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

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

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

Additional Plan Provisions

Grandfathered Health Plan

Out-of-Pocket Expense Limit

The Out-of-Pocket Expense Limit is your portion of eligible covered medical expenses that you must pay after the Plan has paid its required percentage. Once your eligible out-of-pocket expenses reach the maximum (see Plan Benefit Profile), the Plan pays 100% of most covered charges for the rest of the calendar year.

The Out-of-Pocket Limit includes the balance of any Major Medical expenses that you must pay, including co-insurance amounts and balances from the outpatient diagnostic x-ray and laboratory charges. However, it excludes any non-covered expenses such as fees over the Reasonable and Customary limitation. The Out-of-Pocket Limit applies only to covered medical expenses payable under the Major Medical Benefit and does not apply to the Prescription Drug Benefit; the Hearing Aid Benefit; and Chiropractic, Dental or Vision Benefits.

Patient Protection and Affordable Care Act

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Research and Correspondence Department, TeamCare – A Central States Health Plan, P.O. Box 5126, Des Plaines, IL 60017-5126 or call TeamCare at 800-TEAMCARE (832-6227). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Women's Health & Cancer Rights

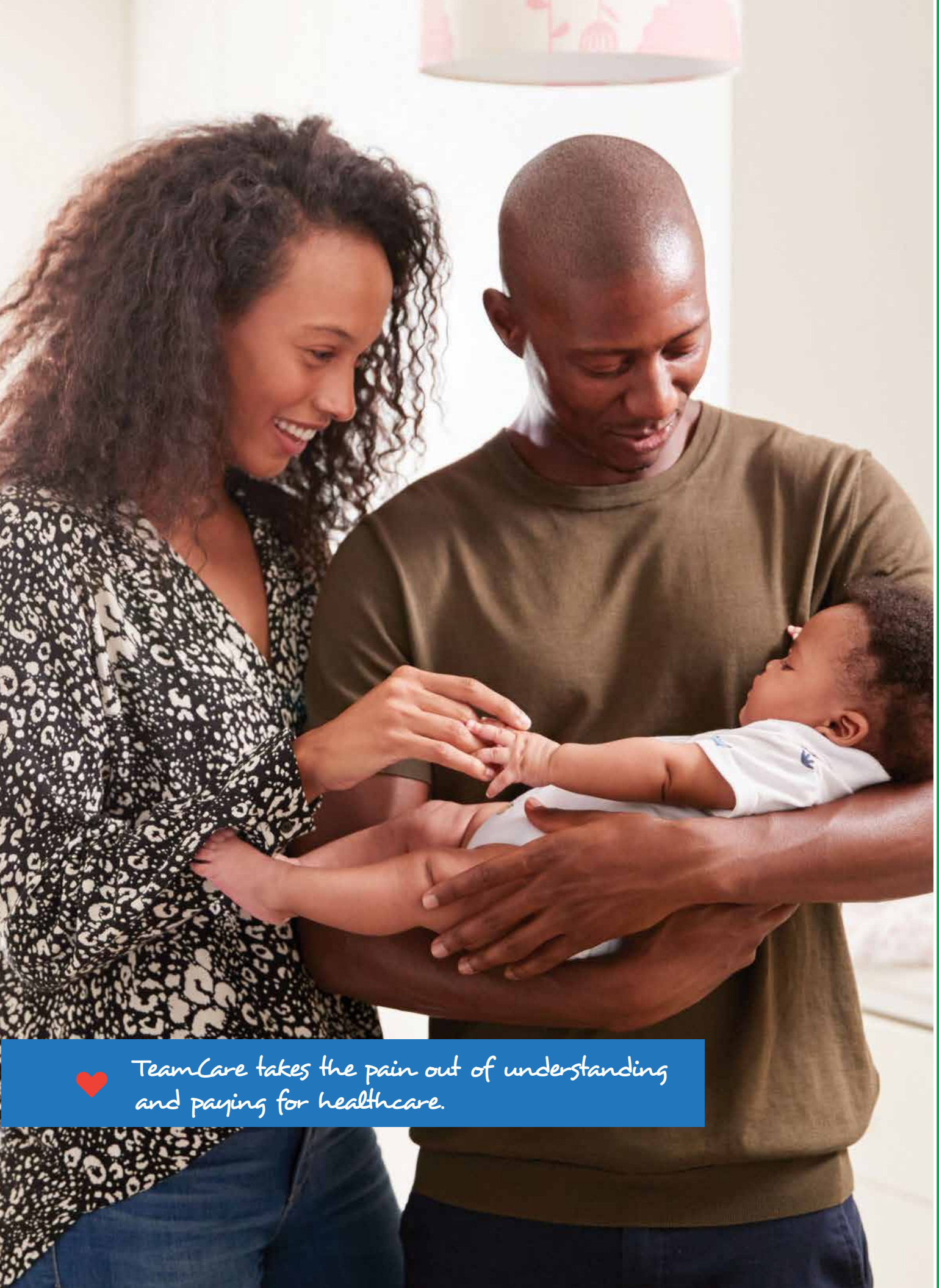
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

All stages of reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
Prostheses; and
Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance apply:

Plan Deductible:	$200 per Individual, $500 per Family
Medical Out-of-Pocket Expense Limit:	$2,500 per Individual, $5,000 per Family
Coinsurance:	20% after Deductible, 0% after Medical Out-of-Pocket Expense Limit is met.

If you would like more information on WHCRA benefits, call your Plan administrator at 800-TEAMCARE (832-6227) or visit MyTeamCare.org.



TeamCare takes the pain out of understanding and paying for healthcare.

Bundled - High: Medical Plan MI with Prescription, Dental, and Vision

TEAMCARE®
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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Central States Health & Welfare Fund – Plan MI
Coverage Period: 01/01/2025 - 12/31/2025
Coverage for: You and Your Covered Dependents | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to MyTeamCare.org or call 800-TEAMCARE (832-6227). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 800-TEAMCARE to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 per Individual, $500 per Family. Does not apply to in-network office visits and in-network prescription benefits.	Generally you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care; lab services through QuestSelect; advanced imaging services through USIN; and services requiring a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500 per Individual, $5,000 per Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Deductibles; in-network copayments; out-of-network penalty; chiropractic coinsurance; hearing aids; prescription drugs; dental & vision benefits; premiums; health care services this plan doesn't cover; and expenses not payable by the plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See MyTeamCare.org or call 800-TEAMCARE for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment per visit	30% coinsurance	Additional costs may be owed for medical services payable beyond the office visit (e.g. x-rays, injections, lab tests, etc.).
	Specialist visit	$20 copayment per visit		
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for bloodwork if through QuestSelect, otherwise 20% coinsurance.	30% coinsurance	For a QuestSelect provider, call QuestSelect Client Services at 800-646-7788 or visit questselect.com.
	Advanced Imaging (CT/PET scans, MRIs)	No charge if scheduled through USIN, otherwise 20% coinsurance.		For a USIN provider, you must schedule an appointment by calling 877-674-0674. Excludes x-rays.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition To find a participating pharmacy or more information about prescription drug coverage visit MyTeamCare.org or caremark.com Certain states have laws that may affect your Prescription Benefit. Visit MyTeamCare.org/statelaws for more information.	Generic drugs	25% coinsurance Retail 20% coinsurance Mail Order Member's maximum expense is $200 copayment per prescription. However, if a brand name prescription is purchased when a generic is available, you will be responsible for the cost difference plus any copayment and the $200 copayment maximum does not apply.	25% coinsurance of the allowed amount and Mail Order is not available. The $200 copayment maximum does not apply.	By the third fill, long-term maintenance medications must be filled through the Maintenance Choice Network / CVS/Caremark Mail Service Pharmacy, or be subject to a 50% copayment if filled through the Retail Pharmacy program. There are some non-preferred brand drugs that are excluded from coverage as determined by Caremark. For a list of these excluded drugs, visit our website at MyTeamCare.org. If you continue using one of these drugs after this date, you will be required to pay the full cost. Walmart and Amazon are not participating pharmacies.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	25% coinsurance Retail 20% coinsurance Mail Order $200 copayment	25% coinsurance of reasonable and customary charges and Mail Order is not available. The $200 copayment per prescription maximum does not apply.	If you use injectable medications, the plan provides a $1,000 per member per calendar year out-of-pocket maximum. Once the $1,000 out-of-pocket maximum is met, all in-network injectable medications will be paid by the Plan at 100%.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	Emergency care is paid the same as if in network. You may also be responsible for charges above allowed amounts.	If admitted, the emergency room services will be payable under the Hospital benefit. Additional costs may be owed for services payable beyond the urgent care visit (e.g. x-rays, lab).
	Emergency medical transportation	20% coinsurance		
	Urgent care	20% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	---------- None ----------
	Physician/surgeon fee	Physician fee: 20% coinsurance Surgeon fee: 20% coinsurance	Physician fee: 30% coinsurance Surgeon fee: 30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	$20 copayment for physician visit (deductible does not apply). Otherwise, 20% coinsurance.	30% coinsurance	---------- None ----------
	Inpatient Services	Facility Fee: 20% coinsurance Physician Fee: 20% coinsurance	Facility Fee: 30% coinsurance Physician Fee: 30% coinsurance	---------- None ----------
If you are pregnant	Office Visits	$20 copayment for initial visit	30% coinsurance	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests). Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services			

Bundled - High: Medical Plan MI with Prescription, Dental, and Vision

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care Rehabilitation services Habilitation services Skilled nursing care Durable medical equipment Hospice services	20% coinsurance	30% coinsurance	Charges for services that are not considered Standard Medical Care, Treatment, Services or Supplies are not covered. In addition, Maintenance Care is not covered.
If your child needs dental or eye care	Children's eye exam	$10 copayment under the TeamCare Vision program.	Routine eye exam is 20% of reasonable and customary allowance.	If your plan provides Vision coverage, it is provided to covered children through age 25 and only once every 12 months. Also, in lieu of glasses, contact lenses are covered to $120 maximum. For TeamCare Vision providers, contact EyeMed at 866-723-0514 or eyemed.com.
	Children's glasses	$0 copayment for Lenses, and $0 copayment for Frames. Standard lenses and frames up to $150 are included in the copayment. The member is responsible for any difference in cost.	TeamCare will pay a maximum of $75 for frames and $50 for standard lenses. Any charges above these maximums paid by TeamCare will be the responsibility of the member.	
	Children's dental check-up	No charge	TeamCare will pay 100% of reasonable and customary allowance. You would be responsible for charges above reasonable and customary.	If your plan provides Dental coverage, a Dental check-up is provided to covered children through age 25 only once every six months. For TeamCare Dental providers call 800-592-3112 or visit humanadentalnetwork.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Charges for medical services that are not considered Standard Medical Care, Treatment, Services or Supplies.
- Charges for stand-by surgeons.
- Cosmetic Surgery (except to the extent it's required due to an accidental bodily injury)

  Surgical procedures that are considered Cosmetic unless they're a result of an accidental injury include but are not limited to:
  - Augmentation mammoplasty (breast enlargement surgery), unless it is part of reconstruction following breast surgery due to cancer.
  - 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.
  - Otoplasty (plastic surgery on ears), sometimes referred to as "lop ears" or "cauliflower ears."
  - Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction.
  - Rhytidectomy (face lift), Dyschromia (tattoo removal), Genioplasty (chin augmentation).
- Hearing Aids
- Infertility Treatment: charges for services and drugs related to the treatment of infertility, including charges in connection with in-vitro fertilization, artificial insemination and reversal of prior sterilization
- Injury or illness that is work-related or covered by Worker's Compensation or an Occupational Disease Law
- Hospital confinements longer than accepted standards of medical practice.
- Long-Term Care
- Personal comfort items, state taxes or surcharges.
- Private Duty Nursing
- Reversal of sterilization procedures.
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Non-emergency care when traveling outside U.S.
- Routine Eye Care (Adult)
- Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 800-TEAMCARE (832-6227), you may also contact your state insurance department; the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Research and Correspondence Department, TeamCare – A Central States Health Plan, PO Box 5126, Des Plaines IL 60017-5126 or call 800-TEAMCARE (832-6227). In addition, you can contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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

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

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-832-6227

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-832-6227

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$20
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,780**

MM 200

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$120
Copayments	$120
Coinsurance	$860
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$40
Coinsurance	$360
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: MyTeamCare.org.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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PLAN N5 BENEFIT PROFILE

Coverage Period: Beginning on or after 01/01/2025

PLAN BENEFIT LIMIT (ANNUAL)	PLAN DEDUCTIBLE (ANNUAL)	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
None	$500 per Individual $1,000 per Family	$4,000 per Individual $8,000 per Family

TEAMCARE PPO OFFICE VISIT	OUT-OF-NETWORK PENALTY
$30 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 Allowed Amount and the loss of TeamCare Family Protection Benefit.

MEDICAL PLAN BENEFITS	*For further information, including a full Summary Plan Description (SPD), visit our website at MyTeamCare.org.*
TeamCare Wellness A TeamCare Physician must be used.	♦ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.
Teladoc Telemedicine Benefit Teladoc.com/TeamCare 800-TELADOC (835-2362)	♦ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, mental health, diabetes management and dermatology at no cost ($0 copay). Plan Deductible does not apply.
CVS MinuteClinic CVS.com/MinuteClinic 866-389-ASAP (2727)	♦ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost ($0 copay). Plan Deductible does not apply.
Hospital Expense Benefit	♦ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Surgical and Maternity Benefit	♦ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Ambulance Service Benefit	♦ After Plan Deductible, 75% of covered charges subject to medical necessity review; then 100% after Medical Out-of-Pocket Expense Limit is met.
Emergency Room Services	♦ $150 copay; then after Plan Deductible, 75%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Lab Benefit questselect.com 800-646-7788	♦ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% provided the Physician submits the requisition through QuestSelect. If a Physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site. Plan Deductible does not apply. If you do not use the TeamCare Lab Benefit, after Plan Deductible the outpatient lab benefit is 75%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Advanced 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 (excludes x-rays) at 100% provided that the scans are scheduled directly through USIN. Plan Deductible does not apply. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (includes x-rays) is paid under Major Medical at 75%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Outpatient Cancer Treatment Benefit	♦ After Plan Deductible, 75% 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 $30 TeamCare office visit copayment is due.
Hearing Aid Benefit	♦ Your Plan does not have a Hearing Aid Benefit.
Chiropractic Benefit	♦ After Plan Deductible, 50% of covered charges to a maximum $500 per person per calendar year.
Behavioral Health Benefits – Inpatient	♦ Facility: After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met. Physician: After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Behavioral Health Benefits – Outpatient	♦ $30 copayment for in-network office visit. Plan Deductible does not apply. Otherwise, after Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Major Medical Benefit	♦ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.

TEAMCARE
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PLAN N5 BENEFIT PROFILE

Coverage Period: Beginning on or after 01/01/2025

PRESCRIPTION BENEFIT

For more information or to find a participating pharmacy, call 888-483-2650 or visit **caremark.com**

Certain states have laws that may affect your Prescription Benefit. Visit **MyTeamCare.org/statelaws** for more information.

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.

Before the third fill of the same prescription at a Retail Pharmacy, long-term maintenance medications must be filled through the Maintenance Choice Network or the CVS/Caremark Mail Service Pharmacy or be subject to a 50% copayment. 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	85%
Crown and Bridge Work	70%
Dentures (Full and Partial)	70%
Orthodontic (Child/Adult Child)	N/A
Orthodontic Maximum (Child/Adult Child)	N/A

** 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 24 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 75% once every 12 months.*

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

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

MyTeamCare.org or 800-TEAMCARE

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

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

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Additional Plan Provisions

Non-Grandfathered Health Plan

Out-of-Pocket Expense Limit

The Out-of-Pocket Expense Limit is your portion of eligible covered medical expenses that you must pay after the Plan has paid its required percentage. Once your eligible out-of-pocket expenses reach the maximum (see Plan Benefit Profile), the Plan pays 100% of most covered charges for the rest of the calendar year.

The Out-of-Pocket Limit includes the balance of any Major Medical expenses that you must pay, including your deductibles, copayments, and your coinsurance amounts including any balances from the outpatient diagnostic x-ray and laboratory charges. However, it excludes any non-covered expenses such as fees over the Reasonable and Customary limitation. The Out-of-Pocket Limit applies only to covered medical expenses payable under the Major Medical Benefit and does not apply to the Prescription Drug Benefit; the Hearing Aid Benefit; and Dental or Vision Benefits.

Additional Appeal Rights

EXTERNAL REVIEW

If you are dissatisfied with the decision of the second level review, you may file a request for an external review of the second level appeal adverse determination. The instructions for initiating external review will be contained in your notice of the Plan's decision on Step Two Appeal. You have four months from the date you receive the Plan's adverse decision on Step Two Appeal.

Only an adverse decision that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) are eligible for external review.

After receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether the claim is eligible for external review. The Plan will advise the claimant if the request is not eligible for external review. If the claim is eligible for external review, the Plan will assign an Independent Review Organization (IRO) to conduct the external review. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

EXPEDITED EXTERNAL APPEAL

A claimant may request an expedited external review at the time the claimant receives an adverse benefit determination if:

- The adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of an expedited internal appeal under the law would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
- The claimant has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or
- If the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or
- If the final internal adverse benefit determination concerns a health care item or service for which the claimant received emergency services but has not been discharged from a facility.

Upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements for standard external review. The Plan will send a notice to the claimant of its eligibility determination. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Women's Health & Cancer Rights

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

All stages of reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
Prostheses; and
Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance apply:

Plan Deductible:	$500 per Individual, $1,000 per Family
Medical Out-of-Pocket Expense Limit:	$4,000 per Individual, $8,000 per Family
Coinsurance:	25% after Deductible, 0% after Medical Out-of-Pocket Expense Limit is met.

If you would like more information on WHCRA benefits, call your Plan administrator at 800-TEAMCARE (832-6227) or visit MyTeamCare.org.

Bundled - Standard: Medical Plan N5 with Prescription, Dental, and Vision

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Central States Health & Welfare Fund – Plan N5
Coverage Period: 01/01/2025 - 12/31/2025
Coverage for: You and Your Covered Dependents | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to MyTeamCare.org or call 800-TEAMCARE (832-6227). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 800-TEAMCARE to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 per Individual, $1,000 per Family. Does not apply to in-network office visits and in-network prescription benefits.	Generally you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care; lab services through QuestSelect; advanced imaging services through USIN; and services requiring a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 per Individual, $8,000 per Family for Medical, and $5,200 per Individual and $10,400 per Family for Prescription	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Out-of-network coinsurance; hearing aids; prescription drugs; dental and vision benefits; premiums; health care services this plan doesn't cover; and expenses not payable by the plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See MyTeamCare.org or call 800-TEAMCARE for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment per visit	35% coinsurance	Additional costs may be owed for medical services payable beyond the office visit (e.g. x-rays, injections, lab tests, etc.).
	Specialist visit	$30 copayment per visit		
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for bloodwork if through QuestSelect, otherwise 25% coinsurance.	35% coinsurance	For a QuestSelect provider, call QuestSelect Client Services at 800-646-7788 or visit questselect.com.
	Advanced Imaging (CT/PET scans, MRIs)	No charge if scheduled through USIN, otherwise 25% coinsurance.		For a USIN provider, you must schedule an appointment by calling 877-674-0674. Excludes x-rays.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition To find a participating pharmacy or more information about prescription drug coverage visit MyTeamCare.org or caremark.com Certain states have laws that may affect your Prescription Benefit. Visit MyTeamCare.org/statelaws for more information.	Generic drugs	25% coinsurance Retail 20% coinsurance Mail Order Member's maximum expense is $200 copayment per prescription. However, if a brand name prescription is purchased when a generic is available, you will be responsible for the cost difference plus any copayment and the $200 copayment maximum does not apply.	25% coinsurance of the allowed amount and Mail Order is not available. The $200 copayment maximum does not apply.	By the third fill, long-term maintenance medications must be filled through the Maintenance Choice Network / CVS/Caremark Mail Service Pharmacy, or be subject to a 50% copayment if filled through the Retail Pharmacy program. There are some non-preferred brand drugs that are excluded from coverage as determined by Caremark. For a list of these excluded drugs, visit our website at MyTeamCare.org. If you continue using one of these drugs after this date, you will be required to pay the full cost. Walmart and Amazon are not participating pharmacies.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	25% coinsurance Retail 20% coinsurance Mail Order $200 copayment	25% coinsurance of reasonable and customary charges and Mail Order is not available. The $200 copayment per prescription maximum does not apply.	If you use injectable medications, the plan provides a $1,000 per member per calendar year out-of-pocket maximum. Once the $1,000 out-of-pocket maximum is met, all in-network injectable medications will be paid by the Plan at 100%.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	35% coinsurance	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay; then 25% coinsurance	Emergency care is paid the same as if in network. You may also be responsible for charges above allowed amounts.	If admitted, the emergency room services will be payable under the Hospital benefit. Additional costs may be owed for services payable beyond the urgent care visit (e.g. x-rays, lab).
	Emergency medical transportation	25% coinsurance		
	Urgent care	25% coinsurance	35% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	35% coinsurance	---------- None ----------
	Physician/surgeon fee	Physician fee: 25% coinsurance Surgeon fee: 25% coinsurance	Physician fee: 35% coinsurance Surgeon fee: 35% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	$30 copayment for physician visit (deductible does not apply). Otherwise, 25% coinsurance.	35% coinsurance	---------- None ----------
	Inpatient Services	Facility Fee: 25% coinsurance Physician Fee: 25% coinsurance	Facility Fee: 35% coinsurance Physician Fee: 35% coinsurance	---------- None ----------
If you are pregnant	Office Visits	$30 copayment for initial visit	35% coinsurance	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests). Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery professional services	25% coinsurance	35% coinsurance	
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care Rehabilitation services Habilitation services Skilled nursing care Durable medical equipment Hospice services	25% coinsurance	35% coinsurance	Charges for services that are not considered Standard Medical Care, Treatment, Services or Supplies are not covered. In addition, Maintenance Care is not covered.
If your child needs dental or eye care	Children's eye exam	$10 copayment under the TeamCare Vision program.	Routine eye exam is 25% of reasonable and customary allowance.	If your plan provides Vision coverage, it is provided to covered children through age 25 and only once every 24 months. Also, in lieu of glasses, contact lenses are covered to $120 maximum. For TeamCare Vision providers, contact EyeMed at 866-723-0514 or eyemed.com.
	Children's glasses	$0 copayment for Lenses, and $0 copayment for Frames. Standard lenses and frames up to $150 are included in the copayment. The member is responsible for any difference in cost.	TeamCare will pay a maximum of $75 for frames and $50 for standard lenses. Any charges above these maximums paid by TeamCare will be the responsibility of the member.	
	Children's dental check-up	No charge	TeamCare will pay 100% of reasonable and customary allowance. You would be responsible for charges above reasonable and customary.	If your plan provides Dental coverage, a Dental check-up is provided to covered children through age 25 only once every six months. For TeamCare Dental providers call 800-592-3112 or visit humanadentalnetwork.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Charges for medical services that are not considered Standard Medical Care, Treatment, Services or Supplies.
- Charges for stand-by surgeons.
- Cosmetic Surgery (except to the extent it's required due to an accidental bodily injury)

  Surgical procedures that are considered Cosmetic unless they're a result of an accidental injury include but are not limited to:
  - Augmentation mammoplasty (breast enlargement surgery), unless it is part of reconstruction following breast surgery due to cancer.
  - 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.
  - Otoplasty (plastic surgery on ears), sometimes referred to as "lop ears" or "cauliflower ears."
  - Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction.
  - Rhytidectomy (face lift), Dyschromia (tattoo removal), Genioplasty (chin augmentation).
- Hearing Aids
- Infertility Treatment: charges for services and drugs related to the treatment of infertility, including charges in connection with in-vitro fertilization, artificial insemination and reversal of prior sterilization
- Injury or illness that is work-related or covered by Worker's Compensation or an Occupational Disease Law
- Hospital confinements longer than accepted standards of medical practice.
- Long-Term Care
- Personal comfort items, state taxes or surcharges.
- Reversal of sterilization procedures.
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Non-emergency care when traveling outside U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 800-TEAMCARE (832-6227), you may also contact your state insurance department; the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Research and Correspondence Department, TeamCare – A Central States Health Plan, PO Box 5126, Des Plaines IL 60017-5126 or call 800-TEAMCARE (832-6227). In addition, you can contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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

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

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 800-832-6227

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-832-6227

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$30
Coinsurance	$3,140
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,730**

MM500

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$180
Coinsurance	$860
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,180**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$210
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$910**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: MyTeamCare.org.

The plan would be responsible for the other costs of these EXAMPLE covered services.

TEAMCARE
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PLAN 5N BENEFIT PROFILE

Coverage Period: Beginning on or after 01/01/2025

PLAN BENEFIT LIMIT (ANNUAL)	PLAN DEDUCTIBLE (ANNUAL)	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
None	$500 per Individual $1,000 per Family	$4,000 per Individual $8,000 per Family

TEAMCARE PPO OFFICE VISIT	OUT-OF-NETWORK PENALTY
$30 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 Allowed Amount and the loss of TeamCare Family Protection Benefit.

MEDICAL PLAN BENEFITS	*For further information, including a full Summary Plan Description (SPD), visit our website at MyTeamCare.org.*
TeamCare Wellness A TeamCare Physician must be used.	♦ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.
Teladoc Telemedicine Benefit Teladoc.com/TeamCare 800-TELADOC (835-2362)	♦ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, mental health, diabetes management and dermatology at no cost ($0 copay). Plan Deductible does not apply.
CVS MinuteClinic CVS.com/MinuteClinic 866-389-ASAP (2727)	♦ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost ($0 copay). Plan Deductible does not apply.
Hospital Expense Benefit	♦ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Surgical and Maternity Benefit	♦ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Ambulance Service Benefit	♦ After Plan Deductible, 75% of covered charges subject to medical necessity review; then 100% after Medical Out-of-Pocket Expense Limit is met.
Emergency Room Services	♦ $150 copay; then after Plan Deductible, 75%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Lab Benefit questselect.com 800-646-7788	♦ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% provided the Physician submits the requisition through QuestSelect. If a Physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site. Plan Deductible does not apply. If you do not use the TeamCare Lab Benefit, after Plan Deductible the outpatient lab benefit is 75%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Advanced 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 (excludes x-rays) at 100% provided that the scans are scheduled directly through USIN. Plan Deductible does not apply. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (includes x-rays) is paid under Major Medical at 75%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Outpatient Cancer Treatment Benefit	♦ After Plan Deductible, 75% 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 $30 TeamCare office visit copayment is due.
Hearing Aid Benefit	♦ Your Plan does not have a Hearing Aid Benefit.
Chiropractic Benefit	♦ After Plan Deductible, 50% of covered charges to a maximum $500 per person per calendar year.
Behavioral Health Benefits – Inpatient	♦ Facility: After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met. Physician: After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Behavioral Health Benefits – Outpatient	♦ $30 copayment for in-network office visit. Plan Deductible does not apply. Otherwise, after Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Major Medical Benefit	♦ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.

TEAMCARE
A CENTRAL STATES HEALTH PLAN

PLAN 5N BENEFIT PROFILE

Coverage Period: Beginning on or after 01/01/2025

PRESCRIPTION BENEFIT

For more information or to find a participating pharmacy, call 888-483-2650 or visit **caremark.com**

Certain states have laws that may affect your Prescription Benefit. Visit **MyTeamCare.org/statelaws** for more information.

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.

Before the third fill of the same prescription at a Retail Pharmacy, long-term maintenance medications must be filled through the Maintenance Choice Network or the CVS/Caremark Mail Service Pharmacy or be subject to a 50% copayment.

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

Your Plan does not have Dental Benefits.

VISION BENEFITS

Your Plan does not have Vision Benefits.

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

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

MyTeamCare.org or 800-TEAMCARE

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

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

Additional Plan Provisions

Non-Grandfathered Health Plan

Out-of-Pocket Expense Limit

The Out-of-Pocket Expense Limit is your portion of eligible covered medical expenses that you must pay after the Plan has paid its required percentage. Once your eligible out-of-pocket expenses reach the maximum (see Plan Benefit Profile), the Plan pays 100% of most covered charges for the rest of the calendar year.

The Out-of-Pocket Limit includes the balance of any Major Medical expenses that you must pay, including your deductibles, copayments, and your coinsurance amounts including any balances from the outpatient diagnostic x-ray and laboratory charges. However, it excludes any non-covered expenses such as fees over the Reasonable and Customary limitation. The Out-of-Pocket Limit applies only to covered medical expenses payable under the Major Medical Benefit and does not apply to the Prescription Drug Benefit; the Hearing Aid Benefit; and Dental or Vision Benefits.

Additional Appeal Rights

EXTERNAL REVIEW

If you are dissatisfied with the decision of the second level review, you may file a request for an external review of the second level appeal adverse determination. The instructions for initiating external review will be contained in your notice of the Plan's decision on Step Two Appeal. You have four months from the date you receive the Plan's adverse decision on Step Two Appeal.

Only an adverse decision that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) are eligible for external review.

After receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether the claim is eligible for external review. The Plan will advise the claimant if the request is not eligible for external review. If the claim is eligible for external review, the Plan will assign an Independent Review Organization (IRO) to conduct the external review. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

EXPEDITED EXTERNAL APPEAL

A claimant may request an expedited external review at the time the claimant receives an adverse benefit determination if:

- The adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of an expedited internal appeal under the law would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

- The claimant has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or

- If the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or

- If the final internal adverse benefit determination concerns a health care item or service for which the claimant received emergency services but has not been discharged from a facility.

Upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements for standard external review. The Plan will send a notice to the claimant of its eligibility determination. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Women's Health & Cancer Rights

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

All stages of reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
Prostheses; and
Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance apply:

Plan Deductible:	$500 per Individual, $1,000 per Family
Medical Out-of-Pocket Expense Limit:	$4,000 per Individual, $8,000 per Family
Coinsurance:	25% after Deductible, 0% after Medical Out-of-Pocket Expense Limit is met.

If you would like more information on WHCRA benefits, call your Plan administrator at 800-TEAMCARE (832-6227) or visit MyTeamCare.org.

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Central States Health & Welfare Fund – Plan 5N
Coverage Period: 01/01/2025 - 12/31/2025
Coverage for: You and Your Covered Dependents | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to MyTeamCare.org or call 800-TEAMCARE (832-6227). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 800-TEAMCARE to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 per Individual, $1,000 per Family. Does not apply to in-network office visits and in-network prescription benefits.	Generally you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care; lab services through QuestSelect; advanced imaging services through USIN; and services requiring a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 per Individual, $8,000 per Family for Medical, and $5,200 per Individual and $10,400 per Family for Prescription	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Out-of-network coinsurance; hearing aids; prescription drugs; dental and vision benefits; premiums; health care services this plan doesn't cover; and expenses not payable by the plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See MyTeamCare.org or call 800-TEAMCARE for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment per visit	35% coinsurance	Additional costs may be owed for medical services payable beyond the office visit (e.g. x-rays, injections, lab tests, etc.).
	Specialist visit	$30 copayment per visit		
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for bloodwork if through QuestSelect, otherwise 25% coinsurance.	35% coinsurance	For a QuestSelect provider, call QuestSelect Client Services at 800-646-7788 or visit questselect.com.
	Advanced Imaging (CT/PET scans, MRIs)	No charge if scheduled through USIN, otherwise 25% coinsurance.		For a USIN provider, you must schedule an appointment by calling 877-674-0674. Excludes x-rays.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition To find a participating pharmacy or more information about prescription drug coverage visit MyTeamCare.org or caremark.com Certain states have laws that may affect your Prescription Benefit. Visit MyTeamCare.org/statelaws for more information.	Generic drugs	25% coinsurance Retail 20% coinsurance Mail Order Member's maximum expense is $200 copayment per prescription. However, if a brand name prescription is purchased when a generic is available, you will be responsible for the cost difference plus any copayment and the $200 copayment maximum does not apply.	25% coinsurance of the allowed amount and Mail Order is not available. The $200 copayment maximum does not apply.	By the third fill, long-term maintenance medications must be filled through the Maintenance Choice Network / CVS/Caremark Mail Service Pharmacy, or be subject to a 50% copayment if filled through the Retail Pharmacy program. There are some non-preferred brand drugs that are excluded from coverage as determined by Caremark. For a list of these excluded drugs, visit our website at MyTeamCare.org. If you continue using one of these drugs after this date, you will be required to pay the full cost. Walmart and Amazon are not participating pharmacies.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	25% coinsurance Retail 20% coinsurance Mail Order $200 copayment	25% coinsurance of reasonable and customary charges and Mail Order is not available. The $200 copayment per prescription maximum does not apply.	If you use injectable medications, the plan provides a $1,000 per member per calendar year out-of-pocket maximum. Once the $1,000 out-of-pocket maximum is met, all in-network injectable medications will be paid by the Plan at 100%.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	35% coinsurance	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay; then 25% coinsurance	Emergency care is paid the same as if in network. You may also be responsible for charges above allowed amounts.	If admitted, the emergency room services will be payable under the Hospital benefit. Additional costs may be owed for services payable beyond the urgent care visit (e.g. x-rays, lab).
	Emergency medical transportation	25% coinsurance		
	Urgent care	25% coinsurance	35% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	35% coinsurance	---------- None ----------
	Physician/surgeon fee	Physician fee: 25% coinsurance Surgeon fee: 25% coinsurance	Physician fee: 35% coinsurance Surgeon fee: 35% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	$30 copayment for physician visit (deductible does not apply). Otherwise, 25% coinsurance.	35% coinsurance	---------- None ----------
	Inpatient Services	Facility Fee: 25% coinsurance Physician Fee: 25% coinsurance	Facility Fee: 35% coinsurance Physician Fee: 35% coinsurance	---------- None ----------
If you are pregnant	Office Visits	$30 copayment for initial visit	35% coinsurance	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests). Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery professional services	25% coinsurance	35% coinsurance	
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care Rehabilitation services Habilitation services Skilled nursing care Durable medical equipment Hospice services	25% coinsurance	35% coinsurance	Charges for services that are not considered Standard Medical Care, Treatment, Services or Supplies are not covered. In addition, Maintenance Care is not covered.
If your child needs dental or eye care	Children's eye exam	Routine eye exam is 25% of reasonable and customary allowance.	Routine eye exam is 25% of reasonable and customary allowance.	If your plan provides Vision coverage, it is provided to covered children through age 25 and only once every 12 months. For TeamCare Vision providers, contact EyeMed at 866-723-0514 or eyemed.com.
	Children's glasses	Your Plan does not provide coverage for Glasses for children.	Your Plan does not provide coverage for Glasses for children.	
	Children's dental check-up	Your Plan does not provide Dental coverage for children.	Your Plan does not provide Dental coverage for children.	If your plan provides Dental coverage, a Dental check-up is provided to covered children through age 25 only once every six months. For TeamCare Dental providers call 800-592-3112 or visit humanadentalnetwork.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Charges for medical services that are not considered Standard Medical Care, Treatment, Services or Supplies.
- Charges for stand-by surgeons.
- Cosmetic Surgery (except to the extent it's required due to an accidental bodily injury)

  Surgical procedures that are considered Cosmetic unless they're a result of an accidental injury include but are not limited to:
  - Augmentation mammoplasty (breast enlargement surgery), unless it is part of reconstruction following breast surgery due to cancer.
  - 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.
  - Otoplasty (plastic surgery on ears), sometimes referred to as "lop ears" or "cauliflower ears."
  - Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction.
  - Rhytidectomy (face lift), Dyschromia (tattoo removal), Genioplasty (chin augmentation).
- Dental Care (Adult)
- 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" in the Summary Plan Description).
- Hearing Aids
- Infertility Treatment: charges for services and drugs related to the treatment of infertility, including charges in connection with in-vitro fertilization, artificial insemination and reversal of prior sterilization
- Injury or illness that is work-related or covered by Worker's Compensation or an Occupational Disease Law
- Hospital confinements longer than accepted standards of medical practice.
- Long-Term Care
- Personal comfort items, state taxes or surcharges.
- Reversal of sterilization procedures.
- Routine Eye Care (Adult)
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Non-emergency care when traveling outside U.S.
- Private Duty Nursing
- Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 800-TEAMCARE (832-6227), you may also contact your state insurance department; the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Research and Correspondence Department, TeamCare – A Central States Health Plan, PO Box 5126, Des Plaines IL 60017-5126 or call 800-TEAMCARE (832-6227). In addition, you can contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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

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

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-832-6227

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-832-6227

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$30
Coinsurance	$3,140
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,730**

MM500

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$180
Coinsurance	$860
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,180**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$210
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$910**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: MyTeamCare.org.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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

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Chicago, IL 60631

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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

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800-832-6227

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TEAMCARE®

A CENTRAL STATES HEALTH PLAN

Delivering better healthcare over the long haul

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October 2024