



**Delivering better healthcare over the long haul**

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

# Summary Plan Description

## Allegiant Travel Company and Sunseeker Resorts

Active Plan Benefit Booklet | Your Plan Benefits | Plan Year 2023





**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, 2023. Updated information is available throughout the year on **MyTeamCare.org**.

Sincerely,

Thomas C. Nyhan  
Executive Director

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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 2023:

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

	Plan MI Bundled - High		Plan N5 Bundled - Standard		Plan 5N Medical Only	
<b>PLAN DEDUCTIBLE (ANNUAL)</b>	\$200 Individual	\$500 Family	\$500 Individual	\$1,000 Family	\$500 Individual	\$1,000 Family
<b>MEDICAL OUT-OF-POCKET LIMIT (ANNUAL)</b>	\$2,500 Individual	\$5,000 Family	\$4,000 Individual	\$8,000 Family	\$4,000 Individual	\$8,000 Family
<b>PPO OFFICE COPAY (PLAN DEDUCTIBLE DOES NOT APPLY)</b>	\$20		\$30		\$30	
<b>CO-INSURANCE (AFTER PLAN DEDUCTIBLE)</b>	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.	
<b>WELLNESS BENEFIT</b>	No-cost for in-network services.					
<b>TELEMEDICINE BENEFIT</b>	No-cost for general medical, dermatology, and behavioral health visits through Teladoc.					
<b>LAB BENEFIT</b>	No-cost for outpatient lab services through QuestSelect.					
<b>IMAGING BENEFIT</b>	No-cost for MRI, CT, and PET scans through USIN.					
<b>MINUTECLINIC</b>	No office-visit copay. Covered services include common illnesses and minor injuries.					
<b>PRESCRIPTION BENEFIT</b>	25% copay for short-term prescription fills and non-maintenance medications. 20% copay for a 90-day supply of medication.					
<b>DENTAL BENEFIT</b>  <b>THE DENTAL PLAN BENEFIT MAXIMUMS ARE PER PERSON PER CALENDAR YEAR.</b>  <b>*ANNUAL DENTAL MAXIMUM DOES NOT APPLY TO CHILDREN UNDER AGE 19</b>	Annual Dental Maximum*:	\$2,500	Annual Dental Maximum*:	\$1,500	N/A	
	Annual Dental Deductible:	None	Annual Dental Deductible:	None		
	Preventive Services:	100%	Preventive Services:	100%		
	Diagnostic & Restorative:	85%	Diagnostic & Restorative:	85%		
	Crown & Bridge Work:	70%	Crown & Bridge Work:	70%		
	Dentures (Full & Partial):	70%	Dentures (Full & Partial):	70%		
	Lifetime Orthodontic Maximum (Child/Adult Child):	\$2,500	Lifetime Orthodontic Maximum (Child/Adult Child):	N/A		
	Orthodontic (Child/Adult Child):	50%	Orthodontic (Child/Adult Child):	N/A		
<b>VISION BENEFIT</b>  <b>*CONTACTS ARE IN LIEU OF GLASSES</b>	<b>If using an EyeMed provider:</b>		<b>If using an EyeMed provider:</b>		N/A	
	Routine Eye Exam:	\$10 copay	Routine Eye Exam:	\$10 copay		
	Frames: (up to \$150 allowance)	\$0 copay	Frames: (up to \$150 allowance)	\$0 copay		
	Standard Lenses: (per pair)	\$0 copay	Standard Lenses: (per pair)	\$0 copay		
	Contacts*: (up to \$120 allowance)	\$0 copay	Contacts*: (up to \$120 allowance)	\$0 copay		
	Once every <b>12</b> months		Once every <b>24</b> months			

## 2023 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.

		<b>Allegiant Travel Company</b> Bi-Weekly and Semi-Monthly Deductions		<b>Sunseeker Resorts</b> Weekly Deductions	
		2 deductions per month		4 deductions per month	
<b>Plan MI</b>  Bundled - High  • Medical • Rx • Dental • Vision		<b>Employee Cost Per Pay Period</b>	<b>Employer Cost Per Pay Period</b>	<b>Employee Cost Per Pay Period</b>	<b>Employer Cost Per Pay Period</b>
	Employee Only	\$93.70	\$281.15	\$46.85	\$140.57
	Employee + Children	\$208.09	\$389.36	\$104.05	\$194.68
	Employee + Spouse	\$248.04	\$503.91	\$124.02	\$251.95
	Family	\$324.11	\$718.35	\$162.06	\$359.16
<b>Plan N5</b>  Bundled - Standard  • Medical • Rx • Dental • Vision		<b>Employee Cost Per Pay Period</b>	<b>Employer Cost Per Pay Period</b>	<b>Employee Cost Per Pay Period</b>	<b>Employer Cost Per Pay Period</b>
	Employee Only	\$72.76	\$293.07	\$36.38	\$146.53
	Employee + Children	\$169.77	\$389.63	\$84.89	\$194.82
	Employee + Spouse	\$225.99	\$504.04	\$113.00	\$252.02
	Family	\$292.14	\$718.10	\$146.07	\$359.05
<b>Plan 5N</b>  Medical Only  • Medical • Rx		<b>Employee Cost Per Pay Period</b>	<b>Employer Cost Per Pay Period</b>	<b>Employee Cost Per Pay Period</b>	<b>Employer Cost Per Pay Period</b>
	Employee Only	51.64	\$286.52	\$25.82	\$143.26
	Employee + Children	\$147.72	\$378.50	\$73.86	\$189.25
	Employee + Spouse	\$198.43	\$503.90	\$99.22	\$251.95
	Family	\$263.47	\$718.54	\$131.74	\$359.27

**PLAN BENEFIT LIMIT (ANNUAL)**

None

**PLAN DEDUCTIBLE (ANNUAL)**

\$200 per Individual  
\$500 per Family

**MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)**

\$2,500 per Individual  
\$5,000 per Family

**TEAMCARE PPO OFFICE VISIT**

\$20 copayment for in-network office visit  
(Plan Deductible does not apply)

**OUT-OF-NETWORK PENALTY**

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](http://MyTeamCare.org).*

**TeamCare Wellness**

A TeamCare Physician must be used.

◆ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.

**Teladoc Telemedicine Benefit**

Teladoc.com/TeamCare  
800-TELADOC (835-2362)

◆ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, dermatology and behavioral health at no cost (\$0 copay). Plan Deductible does not apply.

**CVS MinuteClinic**

CVS.com/MinuteClinic  
866-389-ASAP (2727)

◆ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost (\$0 copay). Plan Deductible does not apply.

**Hospital Expense Benefit**

◆ After Plan Deductible, 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% (Plan Deductible does not apply) provided the Physician submits the requisition through QuestSelect. If a Physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site.

If you do not use the TeamCare Lab Benefit, after Plan Deductible the outpatient lab benefit is 80%; then 100% after Medical Out-of-Pocket Expense Limit is met.

**Imaging Benefit**

To schedule a service call  
877-674-0674

◆ The TeamCare Imaging Benefit is a voluntary program that covers MRI, CT, and PET scans at 100% (Plan Deductible does not apply) provided that the scans are scheduled directly through USIN.

If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (including x-rays) is paid under Major Medical at 80%; then 100% after Medical Out-of-Pocket Expense Limit is met.

**Outpatient Cancer Treatment Benefit**

◆ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met for outpatient nuclear therapy, radiation therapy, chemotherapy, x-ray and lab procedures for the treatment of cancer. If treatment is provided in a doctor's office, a \$20 TeamCare office visit copayment is due.

**Hearing Aid Benefit**

◆ 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.

**PRESCRIPTION BENEFIT**

For more information call  
888-483-2650 or visit  
[caremark.com](http://caremark.com)

**RETAIL PHARMACY STORE:**

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

**MAINTENANCE CHOICE / MAIL SERVICE PHARMACY:**

20% copayment to a maximum copayment of \$200 per prescription for a 90-day supply of medication. Under Maintenance Choice, Member can receive a 90-day supply of medication at a local CVS pharmacy store.

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

TeamCare does not cover drugs or medicines on a formulary exclusion list compiled by CVS/Caremark. The formulary exclusion list is available at [MyTeamCare.org](http://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 TeamCareDental.

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](http://humanadentalnetwork.com).

**VISION BENEFITS**

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

TeamCareVision 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](http://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](http://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](http://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](http://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

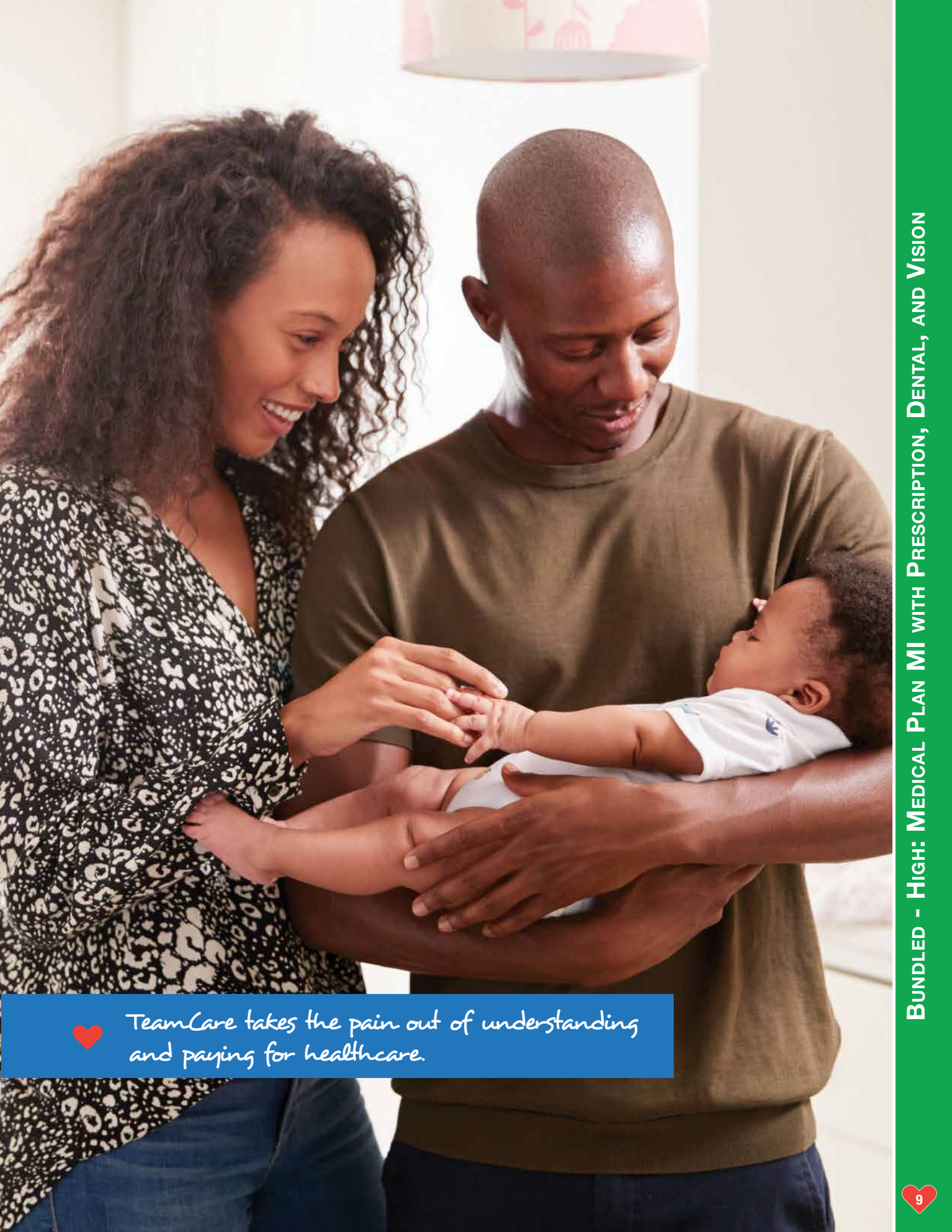
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician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



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




**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services  
**Central States Health & Welfare Fund – Plan MI**  
**Coverage Period: 01/01/2023 - 12/31/2023**

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

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

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a> per visit	30% <a href="#">coinsurance</a>	Additional costs may be owed for medical services payable beyond the office visit (e.g. x-rays, injections, lab tests, etc.).
	<a href="#">Specialist</a> visit	\$20 <a href="#">copayment</a> per visit		
If you have a test	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge if QuestSelect is used. Otherwise, 20% <a href="#">coinsurance</a> .	30% <a href="#">coinsurance</a>	For a QuestSelect provider, call QuestSelect Client Services at 800-646-7788 or visit <a href="#">questselect.com</a> .
	Imaging (CT/PET scans, MRIs)	No charge if scheduled through USIN. Otherwise, 20% <a href="#">coinsurance</a> .		For a USIN provider, you must schedule an appointment by calling 877-674-0674.



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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">MyTeamCare.org</a></p> <p>or</p> <p><a href="#">caremark.com</a></p>	Generic drugs	<p>25% <a href="#">coinsurance</a> Retail</p> <p>20% <a href="#">coinsurance</a> Mail Order</p> <p>Member's maximum expense is \$200 <a href="#">copayment</a> per prescription.</p> <p>However, if you purchase a brand name prescription when a generic is available, you are responsible for the cost difference plus any <a href="#">copayment</a> and the \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>	<p>25% <a href="#">coinsurance</a> of reasonable and customary charges and Mail Order is not available. The \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>	<p>By the third fill, maintenance medications must be filled through the Caremark Mail Order Program / Maintenance Choice or be subject to a 50% <a href="#">copayment</a> if filled through the Retail Card program.</p> <p>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 <a href="#">MyTeamCare.org</a>. If you continue using one of these drugs after this date, you will be required to pay the full cost.</p> <p>Walmart is not a participating pharmacy.</p> <p>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%.</p>
	Preferred brand drugs			
	Non-preferred brand drugs			
<p>If you have outpatient surgery</p>	<p><a href="#">Specialty drugs</a></p>	<p>25% <a href="#">coinsurance</a> Retail</p> <p>20% <a href="#">coinsurance</a> Mail Order</p> <p>\$200 <a href="#">copayment</a></p>	<p>25% <a href="#">coinsurance</a> of reasonable and customary charges and Mail Order is not available. The \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>	<p>Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).</p>
	<p>Facility fee (e.g., ambulatory surgery center)</p> <p>Physician/surgeon fees</p>	<p>20% <a href="#">coinsurance</a></p>	<p>30% <a href="#">coinsurance</a></p>	

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	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	Emergency care is paid the same as if in network. You may also be responsible for charges above <a href="#">allowed amounts</a> .  30% <a href="#">coinsurance</a>	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).
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>		
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	----- None -----
	Physician/surgeon fee	Physician fee: 20% <a href="#">coinsurance</a> Surgeon fee: 20% <a href="#">coinsurance</a>	Physician fee: 30% <a href="#">coinsurance</a> Surgeon fee: 30% <a href="#">coinsurance</a>	----- None -----
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	\$20 <a href="#">copayment</a> for physician visit ( <a href="#">deductible</a> does not apply). Otherwise, 20% <a href="#">coinsurance</a> .	30% <a href="#">coinsurance</a>	----- None -----
	Inpatient Services	Facility Fee: 20% <a href="#">coinsurance</a> Physician Fee: 20% <a href="#">coinsurance</a>	Facility Fee: 30% <a href="#">coinsurance</a> Physician Fee: 30% <a href="#">coinsurance</a>	----- None -----
	Office Visits	\$20 <a href="#">copayment</a> for initial visit	30% <a href="#">coinsurance</a>	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 <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
If you are pregnant	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	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	<a href="#">Home health care</a>			Charges for services that are not considered Standard Medical Care, Treatment, Services or Supplies are not covered. In addition, Maintenance Care is not covered.
	<a href="#">Rehabilitation services</a>			
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>			
	<a href="#">Hospice services</a>			
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 <a href="#">eyemed.com</a> .
	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 <a href="#">humanadentalnetwork.com</a> .

**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](#).)**

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Charges for medical services that are not considered Standard Medical Care, Treatment, Services or Supplies.</li> <li>• Charges for stand-by surgeons.</li> <li>• Cosmetic Surgery (except to the extent it's required due to an accidental bodily injury)</li> <li>• Surgical procedures that are considered Cosmetic unless they're a result of an accidental injury include but are not limited to:             <ul style="list-style-type: none"> <li>▪ Augmentation mammoplasty (breast enlargement surgery), unless it is part of reconstruction following breast surgery due to cancer.</li> <li>▪ Blepharoplasty (repair of drooping eyelids), unless the droop restricts the field of vision as verified by an ophthalmologist.</li> <li>▪ Keratotomy or keratotomy—for diagnosis of myopia (nearsightedness) when the myopia is correctable by lenses.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Otoplasty (plastic surgery on ears), sometimes referred to as "lop ears" or "cauliflower ears."</li> <li>▪ Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction.</li> <li>▪ Rhytidectomy (face lift), Dyschromia (tattoo removal), Genioplasty (chin augmentation).</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Injury or illness that is work-related or covered by Worker's Compensation or an Occupational Disease Law</li> <li>• Hospital confinements longer than accepted standards of medical practice.</li> <li>• Long-Term Care</li> <li>• Personal comfort items, state taxes or surcharges.</li> <li>• Private Duty Nursing</li> <li>• Reversal of sterilization procedures.</li> <li>• Weight Loss Programs</li> </ul>
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic Care</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> </ul>
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**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](http://dol.gov/ebsa/healthreform); or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or [ccio.cms.gov](http://ccio.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](http://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](http://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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 800-832-6227

————— *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.* —————

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## 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	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$2,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,780</b>

MM 200

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.

### 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	
<a href="#">Deductibles</a>	\$120
<a href="#">Copayments</a>	\$120
<a href="#">Coinsurance</a>	\$860
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

### 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	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$360
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

<b>PLAN BENEFIT LIMIT (ANNUAL)</b>	None	<b>PLAN DEDUCTIBLE (ANNUAL)</b>	\$500 per Individual \$1,000 per Family	<b>MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)</b>	\$4,000 per Individual \$8,000 per Family
<b>TEAMCARE PPO OFFICE VISIT</b>	\$30 copayment for in-network office visit (Plan Deductible does not apply)				
<b>OUT-OF-NETWORK PENALTY</b>	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.				
<b>MEDICAL PLAN BENEFITS</b>	<i>For further information, including a full Summary Plan Description (SPD), visit our website at <a href="http://MyTeamCare.org">MyTeamCare.org</a>.</i>				
<b>TeamCare Wellness</b> A TeamCare Physician must be used.	◆ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.				
<b>Teladoc Telemedicine Benefit</b> Teladoc.com/TeamCare 800-TELADOC (835-2362)	◆ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, dermatology and behavioral health at no cost (\$0 copay). Plan Deductible does not apply.				
<b>CVS MinuteClinic</b> 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.				
<b>Hospital Expense Benefit</b>	◆ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.				
<b>Surgical and Maternity Benefit</b>	◆ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.				
<b>Ambulance Service Benefit</b>	◆ After Plan Deductible, 75% of covered charges subject to medical necessity review; then 100% after Medical Out-of-Pocket Expense Limit is met.				
<b>Emergency Room Services</b>	◆ \$150 copay; then after Plan Deductible, 75%; then 100% after Medical Out-of-Pocket Expense Limit is met.				
<b>Lab Benefit</b> questselect.com 800-646-7788	◆ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% (Plan Deductible does not apply) provided the Physician submits the requisition through QuestSelect. If a Physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site. 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.				
<b>Imaging Benefit</b> To schedule a service call 877-674-0674	◆ The TeamCare Imaging Benefit is a voluntary program that covers MRI, CT, and PET scans at 100% (Plan Deductible does not apply) provided that the scans are scheduled directly through USIN. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (including x-rays) is paid under Major Medical at 75%; then 100% after Medical Out-of-Pocket Expense Limit is met.				
<b>Outpatient Cancer Treatment Benefit</b>	◆ 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.				
<b>Hearing Aid Benefit</b>	◆ Your Plan does not have a Hearing Aid Benefit.				
<b>Chiropractic Benefit</b>	◆ After Plan Deductible, 50% of covered charges to a maximum \$500 per person per calendar year.				
<b>Behavioral Health Benefits – Inpatient</b>	◆ 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.				
<b>Behavioral Health Benefits – Outpatient</b>	◆ \$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.				
<b>Major Medical Benefit</b>	◆ After Plan Deductible, 75% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.				

**PRESCRIPTION BENEFIT**

For more information call  
888-483-2650 or visit  
[caremark.com](http://caremark.com)

**RETAIL PHARMACY STORE:**

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

**MAINTENANCE CHOICE / MAIL SERVICE PHARMACY:**

20% copayment to a maximum copayment of \$200 per prescription for a 90-day supply of medication. Under Maintenance Choice, Member can receive a 90-day supply of medication at a local CVS pharmacy store.

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

TeamCare does not cover drugs or medicines on a formulary exclusion list compiled by CVS/Caremark. The formulary exclusion list is available at [MyTeamCare.org](http://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 TeamCareDental.

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](http://humanadentalnetwork.com).

**VISION BENEFITS**

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

TeamCareVision 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](http://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](http://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.



Delivering better healthcare over the long haul

## 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.




**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services  
 Central States Health & Welfare Fund – Plan N5  
 Coverage Period: 01/01/2023 - 12/31/2023  
 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](http://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](http://healthcare.gov/sbc-glossary) or call 800-TEAMCARE to request a copy.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>\$500 per Individual, \$1,000 per Family. Does not apply to <a href="#">in-network</a> office visits and <a href="#">in-network prescription</a> benefits.</p>	<p>Generally you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a>; lab services through QuestSelect; advanced imaging services through USIN; and services requiring a <a href="#">copayment</a> are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>\$4,000 per Individual, \$8,000 per Family for Medical, and \$5,100 per Individual and \$10,200 per Family for Prescription</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Out-of-network coinsurance</a>; hearing aids; <a href="#">prescription drugs</a>; dental and vision benefits; <a href="#">premiums</a>; health care services this <a href="#">plan</a> doesn't cover; and expenses not payable by the <a href="#">plan</a>.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

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

 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copayment</a> per visit	35% <a href="#">coinsurance</a>	Additional costs may be owed for medical services payable beyond the office visit (e.g. x-rays, injections, lab tests, etc.).
	<a href="#">Specialist</a> visit	\$30 <a href="#">copayment</a> per visit		
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge if QuestSelect is used. Otherwise, 25% <a href="#">coinsurance</a> .		For a QuestSelect provider, call QuestSelect Client Services at 800-646-7788 or visit <a href="#">questselect.com</a> .
	Imaging (CT/PET scans, MRIs)	No charge if scheduled through USIN. Otherwise, 25% <a href="#">coinsurance</a> .	35% <a href="#">coinsurance</a>	For a USIN provider, you must schedule an appointment by calling 877-674-0674.

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">MyTeamCare.org</a></p> <p>or</p> <p><a href="#">caremark.com</a></p>	Generic drugs	<p>25% <a href="#">coinsurance</a> Retail</p> <p>20% <a href="#">coinsurance</a> Mail Order</p> <p>Member's maximum expense is \$200 <a href="#">copayment</a> per prescription.</p> <p>However, if you purchase a brand name prescription when a generic is available, you are responsible for the cost difference plus any <a href="#">copayment</a> and the \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>	<p>25% <a href="#">coinsurance</a> of reasonable and customary charges and Mail Order is not available. The \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>	<p>By the third fill, maintenance medications must be filled through the Caremark Mail Order Program / Maintenance Choice or be subject to a 50% <a href="#">copayment</a> if filled through the Retail Card program.</p> <p>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 <a href="#">MyTeamCare.org</a>. If you continue using one of these drugs after this date, you will be required to pay the full cost.</p> <p>Walmart is not a participating pharmacy.</p> <p>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%.</p>
	Preferred brand drugs			
	Non-preferred brand drugs			
	<a href="#">Specialty drugs</a>	<p>25% <a href="#">coinsurance</a> Retail</p> <p>20% <a href="#">coinsurance</a> Mail Order</p> <p>\$200 <a href="#">copayment</a></p>	<p>25% <a href="#">coinsurance</a> of reasonable and customary charges and Mail Order is not available. The \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>	
If you have outpatient surgery	<p>Facility fee (e.g., ambulatory surgery center)</p> <p>Physician/surgeon fees</p>	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<p>Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).</p>

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	<a href="#">Emergency room care</a>	\$150 copay; then 25% <a href="#">coinsurance</a>	Emergency care is paid the same as if in network. You may also be responsible for charges above <a href="#">allowed amounts</a> .	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).
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a>		
	<a href="#">Urgent care</a>	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	----- None -----
	Physician/surgeon fee	Physician fee: 25% <a href="#">coinsurance</a> Surgeon fee: 25% <a href="#">coinsurance</a>	Physician fee: 35% <a href="#">coinsurance</a> Surgeon fee: 35% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	\$30 <a href="#">copayment</a> for physician visit ( <a href="#">deductible</a> does not apply). Otherwise, 25% <a href="#">coinsurance</a> .	35% <a href="#">coinsurance</a>	----- None -----
	Inpatient Services	Facility Fee: 25% <a href="#">coinsurance</a> Physician Fee: 25% <a href="#">coinsurance</a>	Facility Fee: 35% <a href="#">coinsurance</a> Physician Fee: 35% <a href="#">coinsurance</a>	
	Office Visits	\$30 <a href="#">copayment</a> for initial visit	35% <a href="#">coinsurance</a>	
If you are pregnant	Childbirth/delivery professional services			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 <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	

# BUNDLED - STANDARD: MEDICAL PLAN N5 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	<a href="#">Home health care</a>			Charges for services that are not considered Standard Medical Care, Treatment, Services or Supplies are not covered. In addition, Maintenance Care is not covered.
	<a href="#">Rehabilitation services</a>			
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>			
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	
	<a href="#">Hospice services</a>			
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 <a href="#">eyemed.com</a> .
	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 responsible for charges above reasonable and customary.	

**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](#).)**

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Charges for medical services that are not considered Standard Medical Care, Treatment, Services or Supplies.</li> <li>• Charges for stand-by surgeons.</li> <li>• Cosmetic Surgery (except to the extent it's required due to an accidental bodily injury)</li> <li>• Surgical procedures that are considered Cosmetic unless they're a result of an accidental injury include but are not limited to:             <ul style="list-style-type: none"> <li>▪ Augmentation mammoplasty (breast enlargement surgery), unless it is part of reconstruction following breast surgery due to cancer.</li> <li>▪ Blepharoplasty (repair of drooping eyelids), unless the droop restricts the field of vision as verified by an ophthalmologist.</li> <li>▪ Keratectomy or keratotomy—for diagnosis of myopia (nearsightedness) when the myopia is correctable by lenses.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Otoplasty (plastic surgery on ears), sometimes referred to as "lop ears" or "cauliflower ears."</li> <li>▪ Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction.</li> <li>▪ Rhytidectomy (face lift), Dyschromia (tattoo removal), Genioplasty (chin augmentation).</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Injury or illness that is work-related or covered by Worker's Compensation or an Occupational Disease Law</li> <li>• Hospital confinements longer than accepted standards of medical practice.</li> <li>• Long-Term Care</li> <li>• Personal comfort items, state taxes or surcharges.</li> <li>• Reversal of sterilization procedures.</li> <li>• Weight Loss Programs</li> </ul>
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic Care</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside U.S.</li> <li>• Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> </ul>
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**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](http://dol.gov/ebsa/healthreform); or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or [cchio.cms.gov](http://cchio.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](http://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](http://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, kwijigo holne' 800-832-6227

\_\_\_\_\_ To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: OMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop 04-26-05, Baltimore, Maryland 21244-1850.

## 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	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$3,140
Limits or exclusions	
<b>The total Peg would pay is</b>	<b>\$3,730</b>

MM1500

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.

### 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	
<a href="#">Deductibles</a>	\$120
<a href="#">Copayments</a>	\$180
<a href="#">Coinsurance</a>	\$860
Limits or exclusions	
<b>The total Joe would pay is</b>	<b>\$1,180</b>

### 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	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$210
<a href="#">Coinsurance</a>	\$200
Limits or exclusions	
<b>The total Mia would pay is</b>	<b>\$910</b>

**PLAN BENEFIT LIMIT (ANNUAL)**

None

**PLAN DEDUCTIBLE (ANNUAL)**

\$500 per Individual  
\$1,000 per Family

**MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)**

\$4,000 per Individual  
\$8,000 per Family

**TEAMCARE PPO OFFICE VISIT**

\$30 copayment for in-network office visit  
(Plan Deductible does not apply)

**OUT-OF-NETWORK PENALTY**

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](http://MyTeamCare.org).*

**TeamCare Wellness**

A TeamCare Physician must be used.

- ◆ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.

**Teladoc Telemedicine Benefit**

Teladoc.com/TeamCare  
800-TELADOC (835-2362)

- ◆ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, dermatology and behavioral health at no cost (\$0 copay). Plan Deductible does not apply.

**CVS MinuteClinic**

CVS.com/MinuteClinic  
866-389-ASAP (2727)

- ◆ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost (\$0 copay). Plan Deductible does not apply.

**Hospital Expense Benefit**

- ◆ After Plan Deductible, 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% (Plan Deductible does not apply) provided the Physician submits the requisition through QuestSelect. If a Physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site. 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.

**Imaging Benefit**

To schedule a service call  
877-674-0674

- ◆ The TeamCare Imaging Benefit is a voluntary program that covers MRI, CT, and PET scans at 100% (Plan Deductible does not apply) provided that the scans are scheduled directly through USIN. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (including x-rays) is paid under Major Medical at 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.

**PRESCRIPTION BENEFIT**

For more information call  
888-483-2650 or visit  
[caremark.com](http://caremark.com)

**RETAIL PHARMACY STORE:**

25% copayment for short-term prescription fills and non-maintenance medications to a maximum co-payment of \$200 per prescription.

**MAINTENANCE CHOICE / MAIL SERVICE PHARMACY:**

20% copayment to a maximum co-payment of \$200 per prescription for a 90-day supply of medication. Under Maintenance Choice, Member can receive a 90-day supply of medication at a local CVS pharmacy store.

After the second fill of the same prescription, long-term maintenance medications must be filled through Maintenance Choice or CVS/Caremark Mail Service Pharmacy or be subject to a 50% co-payment if filled through the Retail Pharmacy Program.

On both Retail and Mail Order, if a generic equivalent is available, the Member must take the generic or be responsible for the cost difference plus any copayment and the per prescription maximum does not apply. Plan Deductible does not apply. The Medical Out-of-Pocket Expense Limit does not apply.

TeamCare does not cover drugs or medicines on a formulary exclusion list compiled by CVS/Caremark. The formulary exclusion list is available at [MyTeamCare.org](http://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](http://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](http://MyTeamCare.org).




**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services  
**Central States Health & Welfare Fund – Plan 5N**  
**Coverage Period: 01/01/2023 - 12/31/2023**  
**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](http://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](http://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 <a href="#">in-network</a> office visits and <a href="#">in-network prescription</a> benefits.	Generally you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your deductible?	Yes. <a href="#">Preventive care</a> ; lab services through QuestSelect; advanced imaging services through USIN; and services requiring a <a href="#">copayment</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the out-of-pocket limit for this plan?	\$4,000 per Individual, \$8,000 per Family for Medical, and \$5,100 per Individual and \$10,200 per Family for Prescription <a href="#">Out-of-network coinsurance</a> ; hearing aids; <a href="#">prescription drugs</a> ; dental and vision benefits; <a href="#">premiums</a> ; health care services this <a href="#">plan</a> doesn't cover; and expenses not payable by the <a href="#">plan</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the out-of-pocket limit?		Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

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

 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copayment</a> per visit	35% <a href="#">coinsurance</a>	Additional costs may be owed for medical services payable beyond the office visit (e.g. x-rays, injections, lab tests, etc.).
	<a href="#">Specialist</a> visit	\$30 <a href="#">copayment</a> per visit		
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge if QuestSelect is used. Otherwise, 25% <a href="#">coinsurance</a> .		For a QuestSelect provider, call QuestSelect Client Services at 800-646-7788 or visit <a href="#">questselect.com</a> .
	Imaging (CT/PET scans, MRIs)	No charge if scheduled through USIN. Otherwise, 25% <a href="#">coinsurance</a> .	35% <a href="#">coinsurance</a>	For a USIN provider, you must schedule an appointment by calling 877-674-0674.

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">MyTeamCare.org</a></p> <p>or</p> <p><a href="#">caremark.com</a></p>	Generic drugs	<p>25% <a href="#">coinsurance</a> Retail</p> <p>20% <a href="#">coinsurance</a> Mail Order</p>	<p>25% <a href="#">coinsurance</a> of reasonable and customary charges and Mail Order is not available. The \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>	<p>By the third fill, maintenance medications must be filled through the Caremark Mail Order Program / Maintenance Choice or be subject to a 50% <a href="#">copayment</a> if filled through the Retail Card program.</p> <p>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 <a href="#">MyTeamCare.org</a>. If you continue using one of these drugs after this date, you will be required to pay the full cost.</p> <p>Walmart is not a participating pharmacy.</p>
	Preferred brand drugs	<p>Member's maximum expense is \$200 <a href="#">copayment</a> per prescription.</p> <p>However, if you purchase a brand name prescription when a generic is available, you are responsible for the cost difference plus any <a href="#">copayment</a> and the \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>		
	Non-preferred brand drugs			
<p><b>If you have outpatient surgery</b></p>	<a href="#">Specialty drugs</a>	<p>25% <a href="#">coinsurance</a> Retail</p> <p>20% <a href="#">coinsurance</a> Mail Order</p> <p>\$200 <a href="#">copayment</a></p>	<p>25% <a href="#">coinsurance</a> of reasonable and customary charges and Mail Order is not available. The \$200 <a href="#">copayment</a> per prescription maximum does not apply.</p>	<p>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%.</p>
	<p>Facility fee (e.g., ambulatory surgery center)</p> <p>Physician/surgeon fees</p>	<p>25% <a href="#">coinsurance</a></p>	<p>35% <a href="#">coinsurance</a></p>	<p>Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).</p>

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	<a href="#">Emergency room care</a>	\$150 copay; then 25% <a href="#">coinsurance</a>	Emergency care is paid the same as if in network. You may also be responsible for charges above <a href="#">allowed amounts</a> .	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).
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a>		
	<a href="#">Urgent care</a>	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	----- None -----
	Physician/surgeon fee	Physician fee: 25% <a href="#">coinsurance</a> Surgeon fee: 25% <a href="#">coinsurance</a>	Physician fee: 35% <a href="#">coinsurance</a> Surgeon fee: 35% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	\$30 <a href="#">copayment</a> for physician visit ( <a href="#">deductible</a> does not apply). Otherwise, 25% <a href="#">coinsurance</a> .	35% <a href="#">coinsurance</a>	----- None -----
	Inpatient Services	Facility Fee: 25% <a href="#">coinsurance</a> Physician Fee: 25% <a href="#">coinsurance</a>	Facility Fee: 35% <a href="#">coinsurance</a> Physician Fee: 35% <a href="#">coinsurance</a>	
	Office Visits	\$30 <a href="#">copayment</a> for initial visit	35% <a href="#">coinsurance</a>	
If you are pregnant	Childbirth/delivery professional services			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 <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	

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	<a href="#">Home health care</a>			Charges for services that are not considered Standard Medical Care, Treatment, Services or Supplies are not covered. In addition, Maintenance Care is not covered.
	<a href="#">Rehabilitation services</a>			
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>			
	<a href="#">Hospice services</a>			
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 <a href="#">eyemed.com</a> . 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 <a href="#">humanadentalnetwork.com</a> .
	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.	

**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](#).)**

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Charges for medical services that are not considered Standard Medical Care, Treatment, Services or Supplies.</li> <li>• Charges for stand-by surgeons.</li> <li>• Cosmetic Surgery (except to the extent it's required due to an accidental bodily injury)</li> <li>• Surgical procedures that are considered Cosmetic unless they're a result of an accidental injury include but are not limited to:             <ul style="list-style-type: none"> <li>▪ Augmentation mammoplasty (breast enlargement surgery), unless it is part of reconstruction following breast surgery due to cancer.</li> <li>▪ Blepharoplasty (repair of drooping eyelids), unless the droop restricts the field of vision as verified by an ophthalmologist.</li> <li>▪ Keratectomy or keratotomy—for diagnosis of myopia (nearsightedness) when the myopia is correctable by lenses.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Otoplasty (plastic surgery on ears), sometimes referred to as "lop ears" or "cauliflower ears."</li> <li>▪ Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction.</li> <li>▪ Rhytidectomy (face lift), Dyschromia (tattoo removal), Genioplasty (chin augmentation).</li> <li>• Dental Care (Adult)</li> <li>• 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).</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Injury or illness that is work-related or covered by Worker's Compensation or an Occupational Disease Law</li> <li>• Hospital confinements longer than accepted standards of medical practice.</li> <li>• Long-Term Care</li> <li>• Personal comfort items, state taxes or surcharges.</li> <li>• Reversal of sterilization procedures.</li> <li>• Routine Eye Care (Adult)</li> <li>• Weight Loss Programs</li> </ul>
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside U.S.</li> <li>• Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care</li> </ul>
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**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](http://dol.gov/ebsa/healthreform); or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or [cchio.cms.gov](http://cchio.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](http://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](http://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, kwijigo hoine' 800-832-6227

————— *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.* —————

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: OMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$3,140
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,730</b>

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	
<a href="#">Deductibles</a>	\$120
<a href="#">Copayments</a>	\$180
<a href="#">Coinsurance</a>	\$860
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,180</b>

### 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	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$210
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$910</b>

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.





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

**EXECUTIVE DIRECTOR**  
Thomas C. Nyhan

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

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

**TELEPHONE NUMBER**  
847-518-9800

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

**WEBSITE**  
[MyTeamCare.org](http://MyTeamCare.org)

**EMPLOYER IDENTIFICATION**  
36-2154936

**PLAN NUMBER**  
501

**PLAN YEAR**  
January 1 through December 31

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

**IMPORTANT**

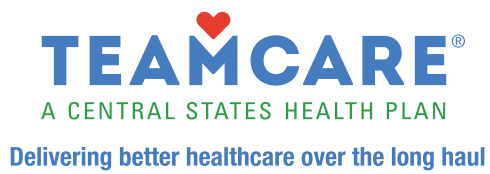
**Para obtener asistencia en Español, llame al**  
800-832-6227

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

如果需要中文的帮助，请拨打这个号码  
800-832-6227

**Dinek'ehgo shika at'ohwol ninisingo,  
kwijjigo holne'**  
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October 2022