

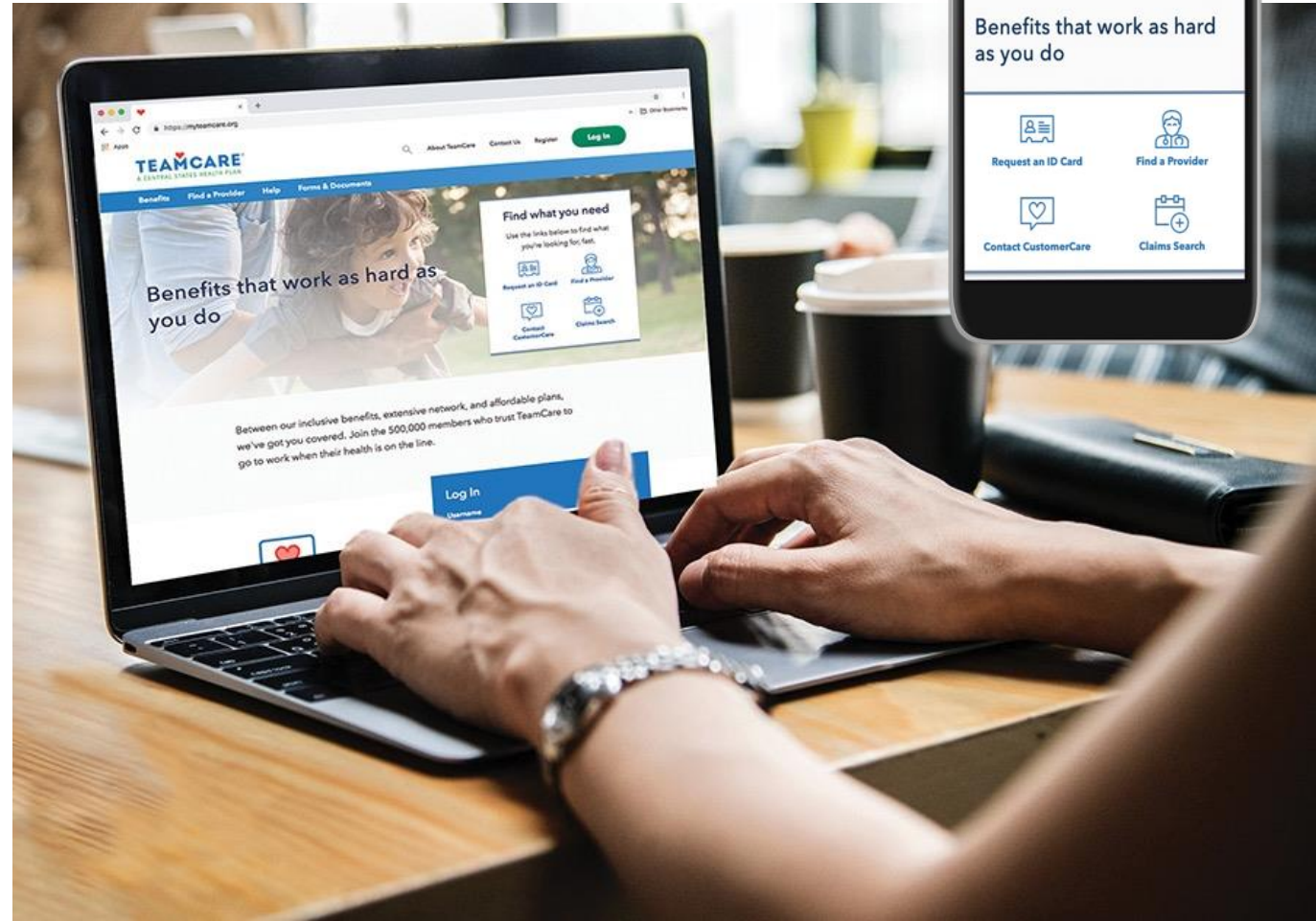
**TEAMCARE<sup>®</sup>**  **CENTRAL STATES  
PENSION FUND**

# SUMMIT

2025

# AGENDA

- ✓ PLANS OFFERED
- ✓ HOW TO APPLY
- ✓ HOW TO QUALIFY
- ✓ ELIGIBILITY PERIODS
- ✓ BENEFITS OFFERED
- ✓ COST OF THE PLANS
- ✓ POSTPONING BENEFITS
- ✓ MEDICARE ADVANTAGE PLANS



# RETIREE HEALTH BENEFITS

## PRE-MEDICARE BENEFITS

RETIREE HEALTH PLAN R4

UPS RETIREE HEALTH PLANS

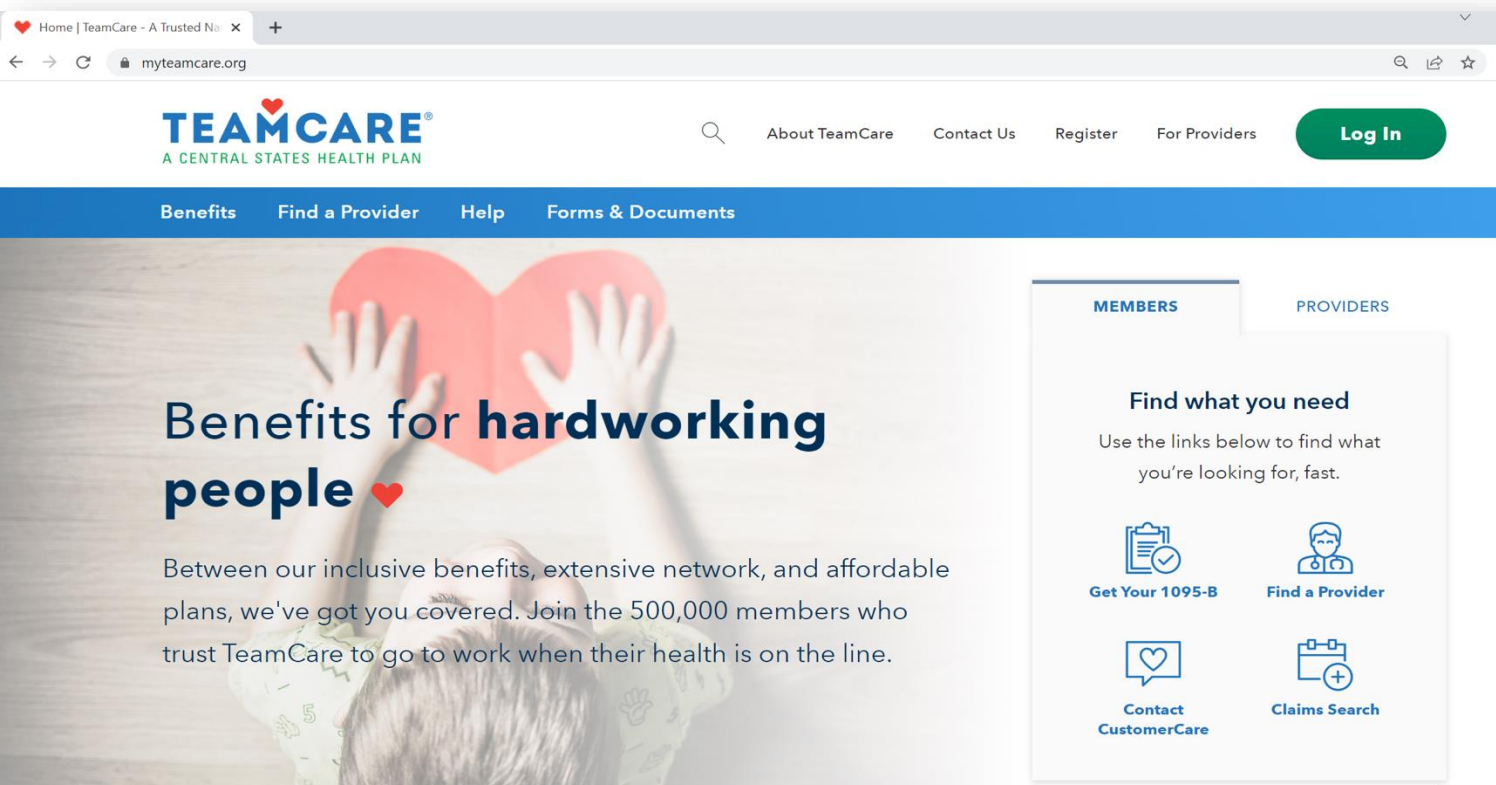
## MEDICARE BENEFITS

MEDICARE ADVANTAGE PLANS

401H PRESCRIPTION PLAN

# APPLYING FOR RETIREE HEALTH BENEFITS – R4

RETIREE HEALTH ELIGIBILITY IS REVIEWED WHEN A CSF PENSION APPLICATION IS RECEIVED



Speak with a Benefits Specialist

**1-800-TEAMCARE**

(1-800-832-6227)





Monday thru Friday  
8 a.m. to 5:30 p.m. CST

# UPS APPLICATION PROCESS

## 1. TEAMCARE IS NOTIFIED BY THESE PENSION PLANS

- ✓ CENTRAL STATES PENSION FUND
- ✓ UPS PENSION PLAN
- ✓ LOCAL 705 PENSION FUND
- ✓ LOCAL 710 PENSION FUND
- ✓ WESTERN PENNSYLVANIA FUND
- ✓ PHILADELPHIA AND VICINITY FUND
- ✓ TFORCE PENSION FUND

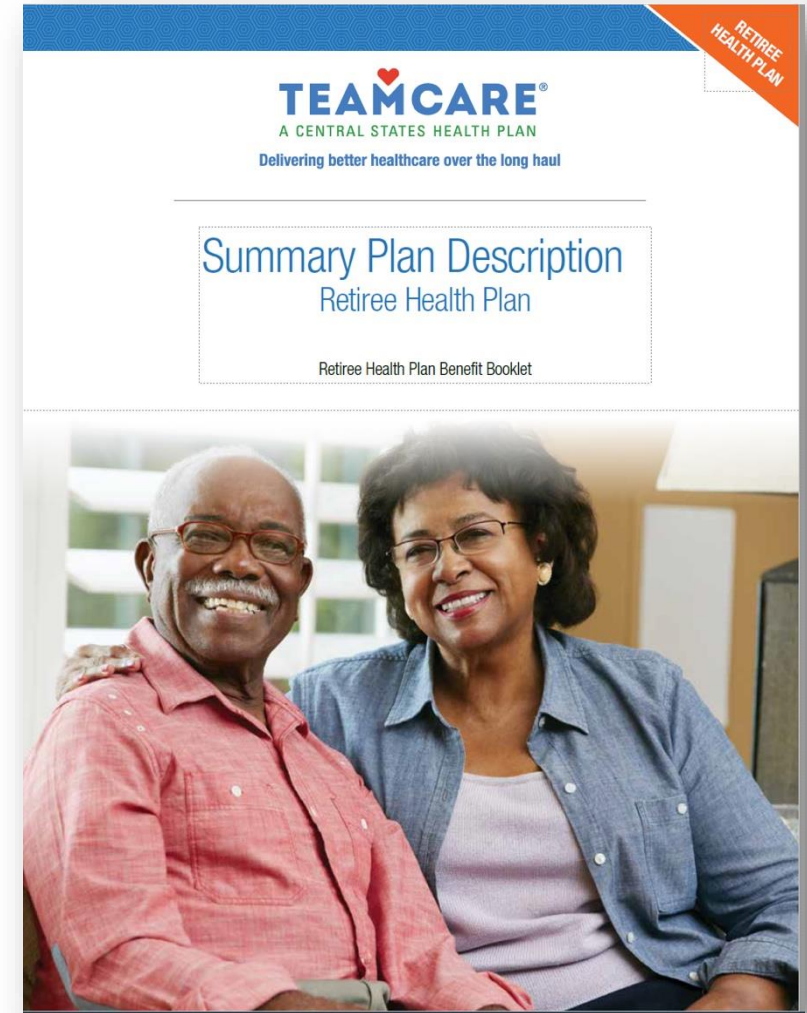
## 2. OTHER MEMBERS MUST SUBMIT PENSION AWARD LETTER

UPLOAD	 Message Center at MyTeamCare.org	MAIL	 TeamCare PO Box 5109 Des Plaines IL 60017-5109	FAX	 847-518-9752	CALL	 Questions? 800-TEAMCARE
--------	--	------	---	-----	---	------	---



# RETIREE HEALTH PLAN ELIGIBILITY REQUIREMENTS

1. “5 OUT OF THE LAST 5 YEARS” OR “7 OUT OF THE LAST 10 YEARS” RULE
2. 20 YEARS WORKED UNDER A TEAMSTERS COLLECTIVE BARGAINING AGREEMENT



# ELIGIBILITY PERIOD



## PLAN R4

- CAN BEGIN AT AGE 57
- MEMBERS ARE COVERED TO AGE 65
- SPOUSE COVERAGE CAN BE EXTENDED FOR UP TO 3 YEARS

## UPS RETIREE PLANS

- CAN BEGIN AT AGE 52 OR 55
- MEMBERS AND SPOUSES ARE COVERED TO AGE 65
- CHILDREN ARE COVERED TO AGE 19 AND UP TO 25 IF THEY ARE A FULL-TIME STUDENT

# RETIREE MEDICAL BENEFITS

## SUMMARY OF BENEFITS

ANNUAL MAXIMUM	\$350,000 PER PERSON
DEDUCTIBLE	\$100 / \$200
ANNUAL OUT OF POCKET	\$1,000 / \$2,000
MEDICAL OFFICE VISITS	\$20 COPAY
COINSURANCE	80%, UNTIL OOP IS MET
PRESCRIPTIONS	SAME AS ACTIVE PLAN
DENTAL	\$1,500 PER PERSON PER YEAR
VISION	SAME AS ACTIVE PLAN

TEAMCARE® A CENTRAL STATES HEALTH PLAN	
RETIREE PLAN R4 and RETIREE PLAN R6 BENEFIT PROFILE	
Coverage Period: Beginning on or after 03/01/2025	
<b>PLAN BENEFIT LIMIT (ANNUAL)</b> \$350,000 per Individual	<b>PLAN DEDUCTIBLE (ANNUAL)</b> \$100 per Individual
<b>TEAMCARE PPO OFFICE VISIT</b> \$20 copayment for in-network office visit; Plan Deductible does not apply.	<b>MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)</b> \$1,000 per Individual
<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> For further information, including a full Summary Plan Description (SPD), visit our website at <a href="http://MyTeamCare.org">MyTeamCare.org</a>	
<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. Your Plan provides coverage for Retiree and/or Spouse only.
<b>Teladoc Telemedicine Benefit</b> <a href="http://Teladoc.com/TeamCare">Teladoc.com/TeamCare</a> 800-TELADOC (835-2362)	Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, mental health, diabetes management, and dermatology at no cost (\$0 copay). Plan Deductible does not apply.
<b>CVS MinuteClinic</b> <a href="http://CVS.com/MinuteClinic">CVS.com/MinuteClinic</a> 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 vaccinations 7 days a week (hours vary) at no cost (\$0 copay). Plan Deductible does not apply.
<b>Hospital Expense Benefit</b>	After Plan Deductible, 80% of semi-private room rate with no maximum day limit; then 100% after Medical Out-of-Pocket Expense Limit is met.
<b>Surgical and Obstetrical Benefit</b>	After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
<b>Ambulance Service Benefit</b>	After Plan Deductible, 80% of covered charges subject to medical necessity review; then 100% after Medical Out-of-Pocket Expense Limit is met.
<b>Emergency Room Services</b>	After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
<b>Lab Benefit</b> <a href="http://questselect.com">questselect.com</a> 800-646-7788	The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% provided the physician submits the requisition through QuestSelect. If a physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site. Plan Deductible does not apply. If you do not use the TeamCare Lab Benefit, after Plan Deductible the outpatient lab benefit is 80%; then 100% after Medical Out-of-Pocket Expense Limit is met.
<b>Advanced 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 (excludes x-rays) at 100% provided that the scans are scheduled directly through USIN. Plan Deductible does not apply. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (includes 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.) is 80%; then 100% after Medical Out-of-Pocket Expense Limit is met.
<b>Outpatient Cancer Treatment Benefit</b>	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.
<b>Hearing Aid Benefit</b>	After Plan Deductible, 100% of covered charges to a maximum of \$3,000 per ear (\$6,000 total) every 36 months. The Medical Out-of-Pocket Expense Limit does not apply.
<b>Chiropractic Benefit</b>	After Plan Deductible, 70% of covered charges to a maximum 24 visits per person per calendar year. The Out-of-Pocket Expense Limit does not apply.
<b>Behavioral Health Benefits – Inpatient</b>	After Plan Deductible, 80% of covered charges to a maximum 21 days per person per calendar year; maximum 42 days per person Lifetime. The Medical Out-of-Pocket Expense Limit does not apply.
<b>Behavioral Health Benefits – Outpatient</b>	After Plan Deductible, 80% of covered charges to a maximum 30 visits per person per calendar year. The Medical Out-of-Pocket Expense Limit does not apply.
<b>Major Medical Benefit</b>	After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.



# 2025 RETIREE HEALTH PLAN MONTHLY COST PER PERSON

RETIREE'S AGE AT RETIREMENT	MONTHLY COST PER PERSON
62+	\$100
61	\$264
60	\$374
59	\$461
58	\$529
57	\$599



**2025 MONTHLY RETIREE HEALTH PLAN CONTRIBUTION RATES FOR UPS RETIREES**



**FOR ALL UPS RETIREES:**

**\$200 FOR ONE PERSON /\$400 PER FAMILY**

# POSTPONING BENEFITS

## MEMBER OR SPOUSE MAY ELECT A ONE-TIME POSTPONEMENT OF RETIREE HEALTH PLAN TO A LATER DATE

- AT RETIREMENT OR AFTER COVERAGE HAS BEGUN
- ORIGINAL ELIGIBILITY PERIODS STILL APPLY
- MUST HAVE OTHER INSURANCE AND PROVIDE DOCUMENTATION WHEN REINSTATING COVERAGE



**TEAMCARE**  
A CENTRAL STATES HEALTH PLAN

**RETIREE HEALTH PLAN POSTPONEMENT FORM**

MEMBER NAME: \_\_\_\_\_ MEMBER ID: 8 0 6 \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

You and your family (if applicable) may elect on a one-time basis to voluntarily postpone Retiree Health Plan coverage to a later date provided there is other insurance coverage in effect. If you are on the TeamCare Retiree Health Plan and wish to voluntarily postpone your coverage to a later date, please complete this form.  
You must submit proof of your other insurance to qualify for postponement of your TeamCare Retiree Health Plan coverage.

**I WANT TO VOLUNTARILY WAIVE RETIREE HEALTH PLAN COVERAGE AND POSTPONE COVERAGE TO A LATER DATE.**  
Check one box (A, B, C or D) below:

A. ☐ POSTPONE MYSELF ONLY, effective: \_\_\_\_\_  
B. ☐ POSTPONE MYSELF AND MY SPOUSE, effective: \_\_\_\_\_  
C. ☐ POSTPONE MY SPOUSE ONLY, effective: \_\_\_\_\_  
D. ☐ POSTPONE MY DEPENDENT CHILDREN ONLY (UPS RU/RV Plans), effective: \_\_\_\_\_

**NOTE:**

- Eligibility for Medicare coverage makes you ineligible for Retiree Health Plan coverage from TeamCare even if you decline Part B. You will be held responsible for reimbursing TeamCare for any claims paid after the Medicare eligibility date. Under no circumstances may you voluntarily postpone Retiree Health Plan coverage beyond your normal Medicare eligibility date (age 65 at present).
- Coverage will be terminated, effective the 1st of the month following receipt of the postponement or termination request.

MEMBER SIGNATURE: \_\_\_\_\_

Return the completed form to:

Message Center at MyTeamCare.org  
TeamCare PO Box 5109 Des Plaines IL 60017-5109  
847-519-9752  
800-TEAMCARE

# TForce Members

- COVERAGE UNDER ENHANCED UPS RETIREE PLAN WAS EXTENDED FROM 2021 THROUGH 2024
- TRANSITION TO RETIREE PLAN R4 STARTED ON 1/1/2025

ELIGIBILITY RULES	RETIREMENT DATE BETWEEN 8/1/2023- 12/31/2024 No CHANGES	RETIREMENT DATE BETWEEN 1/1/2025-12/31/2025 CHANGES LISTED BELOW	RETIREMENT DATE BETWEEN 1/1/2026-7/31/2028 CHANGES LISTED BELOW
	<b>“5 OUT OF 5 RULE” OR “7 OUT OF 10 RULE”</b> 40 WEEKS OF TEAMCARE PLAN CONTRIBUTIONS IN EACH OF THE 52-WEEK PERIODS PRECEDING THE RETIREMENT DATE		
AGE REQUIREMENT	55	55	57
YEARS OF SERVICE	10-YRS WITH OVERNITE/UPS FRT/TFORCE OR 20 YRS UNDER TEAMSTER CBA	10-YRS WITH OVERNITE/UPS FRT/TFORCE OR 20 YRS UNDER TEAMSTER CBA	20-YRS WITH OVERNITE/UPS FRT/TFORCE OR 20 YRS UNDER TEAMSTER CBA
CHILD COVERAGE	YES: AGE 19; OR 25 IF STUDENT	NONE	NONE
YOUNGER SPOUSE COVERAGE	UNTIL SPOUSE’S AGE 65 OR MEDICARE (WHICHEVER OCCURS FIRST)	MAXIMUM OF 3 YRS FROM RETIREE’S 65 <sup>TH</sup> BIRTHDAY OR MEDICARE (WHICHEVER OCCURS FIRST)	MAXIMUM OF 3 YRS FROM RETIREE’S 65 <sup>TH</sup> BIRTHDAY OR MEDICARE (WHICHEVER OCCURS FIRST)
RETIREE COST	\$200 SINGLE \$400 FAMILY	62-64: \$100 SINGLE \$200 W/SPOUSE 61*: \$264 SINGLE \$528 W/SPOUSE 55-60*: \$400 SINGLE \$800 W/SPOUSE <small>* TO BE DETERMINED BUT WON’T EXCEED AMOUNTS</small>	RATES AS ESTABLISHED BY BOARD OF TRUSTEES
NOTES	ALL RULES AND REQUIREMENTS STAY THE SAME AS PREVIOUS CBA.	RETIREEES GET RETIREE PLAN R4. RATES REMAIN UNCHANGED UNTIL AGE 65 OR MEDICARE ELIGIBILITY.	TFORCE HAS THE SAME RETIREE PLAN REQUIREMENTS AND COST AS ALL NON- UPS EMPLOYERS.

# MEDICARE ADVANTAGE PLANS

## TEAMCARE ADVANTAGE PLAN

## TEAMCARE GOLD PLAN

1. COMBINES MEDICARE PART A (HOSPITAL), PART B (PHYSICIAN AND MEDICAL SERVICES), AND PART D (PRESCRIPTION DRUG) INTO ONE PACKAGE
2. HUMANA WILL SEND INFORMATION PACKETS AND ENROLLMENT FORMS

**Humana®**



# Questions?

