TEAMCARE®
A CENTRAL STATES HEALTH PLAN

CENTRAL STATES
PENSION FUND

UNION STEWARD HANDBOOK

— 2024 EDITION —

A Message For Union Stewards—

Thank you for serving as a Union leader at your worksite.

Your coworkers look to you for guidance, support and strength, and the Central States Funds appreciate the difference you make with your coworkers. To assist you, we have prepared the attached handbook that provides general benefit information on the Central States Health Fund—known as TeamCare; along with the Central States Pension Fund.

Please refer to your collective bargaining agreement to see which Fund(s) provide benefits to you and your coworkers.

You are the leader they look to for every day assistance and we hope the attached handbook provides you information on your benefits that will assist you and your coworkers.

We encourage you to read the information. We at TeamCare and Central States Pension Fund appreciate your role, and we hope that this handbook will be a useful reference to you.

About the Funds

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

CENTRAL STATES
PENSION FUND

In This Section:

NOTE: Although located in the same office complex, it is important to note that the Central States Health Fund (also known as TeamCare) and the Central States Pension Fund are two distinct and separate legal entities. Each individual Fund is governed by their own specific Trust Agreement and the assets and liabilities of each Fund are managed separately.

About The Central States Health Fund

The Central States Health Fund, also known as TeamCare, was founded in 1950, and 2025 will be our 75th anniversary of being one of the first non-profit labor health funds in the United States. Today, TeamCare covers the lives of over 560,000 members, from 1,100 different employers, making it the largest labor healthcare fund in the country. With a proud history, our members and their families have the financial security of high quality, affordable healthcare.

When the Central States Health Fund was established, the founding Trustees from both labor and management had one purpose in mind: to provide Teamster employees and their families with the best affordable healthcare. Over 70 years later, that goal remains the same—to bring you the excellent healthcare benefits you deserve—benefits that reflect the hard work you make happen every day.

Our Local Union partners are crucial to the success of TeamCare and we strive to provide you with information to make your job easier. We have a state-of-the-art website to help you understand all the health benefits, a dedicated CustomerCare line for local union officials to get information and answers, and an experienced Field Service Representative assigned to each Local Union to troubleshoot any member issue, educate your members, and be available to our local union partners when you need help.

About The Central States Pension Fund

The Central States Pension Fund is one of the nation's largest multiemployer Taft-Hartley defined benefit pension plans. With 360,000 participants, Central States has been a secure retirement choice for Teamster members who participate through a collective bargaining agreement between our union and employer partners.

Established in 1955 to provide a lifetime monthly retirement benefit to Teamster members, Central States has paid $85 billion in benefits to 650,000 retirees and beneficiaries.

Retirement benefits are funded by weekly contributions made by our 1,000 employer partners—negotiated under collective bargaining agreements with the Teamsters union.

As of 2023, Central States is 98.5% funded with a highly conservative investment strategy to reach full funding in coming years.

TeamCare By The Numbers

2023 Claims Processed

6.4 Million Medical Claims

3.9 Million Rx Claims

928,000 Dental Claims

205,000 Vision Claims

24,000 STD Claimants

$3.4 Billion Dollars
Benefits Paid by TeamCare in 2023

Low Admin Costs
Only **$.04** of Each Dollar Goes to Administrative Costs

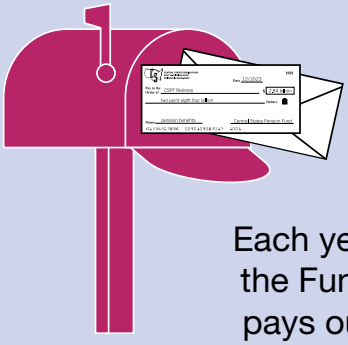
Pension Fund By The Numbers

$86 Billion Dollars

Paid in Benefits to

656,544
members & beneficiaries

From its inception in 1955 to December 2023



Each year the Fund pays out

$2.84 BILLION

Health Fund: TeamCare

In This Section:

TeamCare Partners

BlueCross BlueShield	**bcbsil.com**	**800-810-2583**
Caremark	**caremark.com**	**888-483-2650**
Teladoc Health	**teladochealth.com/TeamCare**	**800-835-2362**
QuestSelect	**questselect.com**	**800-646-7788**
USIN		**877-674-0674**
Humana Dental	**humanadentalnetwork.com**	**800-592-3112**
EyeMed Vision Care	**eyemed.com**	**866-723-0514**

Before We Get Started...

Healthcare is full of acronyms and terms. Below are some of the more frequently used acronyms and terms you should know:

ACA	Affordable Care Act (aka ObamaCare)
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act (healthcare self-payments)
DME	Durable Medical Equipment
EOB	Explanation of Benefit statement
FSA	Flexible Spending Account (Not offered by TeamCare)
HDHP	High Deductible Health Plan (Not offered by TeamCare)
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HSA	Health Spending Account (Not offered by TeamCare)
IMR	Independent Medical Review
OOP	Out-of-Pocket
PBM	Pharmacy Benefits Manager (Caremark)
PBP	Plan Benefit Profile
PCP	Primary Care Physician
PDB	Predetermination of Benefits
PPO	Preferred Provider Organization
SBC	Summary of Benefits and Coverages

Allowed Amount: In-network negotiated reimbursement fees for covered services. Network providers agree to accept the allowed amount as payment in full. Members are not billable (balance billing) for charges above the allowed amount.

Coinsurance/Cost-sharing: After the deductible is met (if any), it is the member's cost-sharing responsibility as outlined in the Plan Benefit Profile. For example, Plan C6 members have a 20% coinsurance for charges that apply to Major Medical expenses, and a 0% coinsurance for charges that apply to Surgery expenses.

Coordination of Benefits (COB): Industry process to determine which insurer pays first when two or more health insurance plans are responsible for paying the same medical claim. COB typically occurs when both the member and their spouse each have coverage. COB determines which plan pays primary (first) and which plan pays secondary.

Copayment: A flat dollar amount paid for an in-network covered benefit. Example: UPS members under Plan U1 have a $10 copayment for visit to a primary care doctor.

Deductible: The annual amount a member is responsible and must pay for covered services before TeamCare begins to pay as indicated in the Plan Benefit Profile. For example, a UPS member has a $100 per person deductible ($200 family max).

Explanation of Benefits (EOB): A benefit statement sent by TeamCare to the member that includes a summary of how TeamCare processed the claim, how much TeamCare paid on the charges, and what the member's responsibility may be (if any). It also contains the annual summary of the member's deductible and out-of-pocket (OOP) costs in the plan.

Formulary: Sometimes referred to as a "drug list," it is a list of drugs identified by Caremark that are covered by TeamCare. There are many different prescriptions that treat the same illness and the formulary list will identify those covered by TeamCare. More formulary information can be found at **MyTeamCare.org**.

Grandfathered Health Plan: As defined in the Affordable Care Act, a group health plan that was created—on or before March 23, 2010. Most of the TeamCare plans, including UPS, are grandfathered plans. Although TeamCare offers grandfathered health plans, certain provisions like dependent coverage to age 26, no-cost wellness, and other provisions are standard in our grandfathered plans.

In-Network Providers: A provider or health professional who has agreed to the provisions and reimbursement as outlined by the network. TeamCare has contracted with the following networks: BCBS, Caremark, USIN, Teladoc Health, QuestSelect, EyeMed Vision Care, and Humana Dental.

Open Enrollment Period (OEP): Period of time that TeamCare members under a "tiered plan" can make changes to their dependent coverage and/or choose from available plans (if applicable), for any reason. The OEP begins November 1st and lasts 3 weeks. Any changes go into effect the start of the next plan year.

Out-of-Network Providers: A provider or health professional not under contract with your insurance provider. Services with out-of-network providers will cost the member more money since there are no negotiated reimbursement rates and may cause the loss of their Family Protection benefit.

Out-of-Pocket (OOP) Limit: The maximum amount a member will be required to pay for covered services in a year, before the plan covers 100% of all costs. Out-of-pocket limits vary by plan and can be found on the Plan Benefit Profile.

Special Enrollment Event (also known as Life Event): Any event or occurrence such as death, birth, divorce, or loss of coverage that allows a TeamCare member under a "tiered plan" to change their dependent coverage and/or choose from available plans.

DISCLAIMER:
This document is intended as a summary to assist local unions. All information in this booklet is subject to the terms of the actual Health Plan Document and Pension Plan Document, which is the final written authority on all matters about the Plan. Only the Board of Trustees is authorized to interpret the Central States Health and Welfare Plan Document and Central States Pension Plan Document. No employer or union or any representative of any employer or union is authorized to interpret the Plan Documents. If there is a discrepancy between this document and Central States Health and Welfare Plan Document or Central States Pension Fund Plan Document, the Plan Document of the specific Fund will be the controlling document in determining benefits.

Plan Benefit Profile

The Plan Benefit Profile (PBP) will probably be the most utilized tool for members to understand their benefits. The PBP is a snapshot of a member's specific TeamCare Benefit coverage. The PBP can be downloaded from **MyTeamCare.org**.

For more detailed information about benefits, it can be found in the Summary Plan Description, also available at **MyTeamCare.org**.

Welcome Enrollment Packet

Enrolling a New Hire in TeamCare

There are over 1,100 participating employers in TeamCare who onboard approximately 500+ new hires each week. In some "peak" weeks, that number can be as high 2,000 new hires. TeamCare sends a personalized Welcome Enrollment Packet to each of the new hires joining TeamCare.

Most new hires have an initial 30-day probationary period before the employer begins reporting the first health and welfare contribution to TeamCare. When TeamCare becomes aware of a new hire, it is our job to make sure that our new member has a smooth transition and enrolls the family timely.

The TeamCare Welcome Enrollment Packet provides the member with all the information needed on their new plan of benefits, including:

- Detailed information on how to add family members through our online enrollment at **MyTeamCare.org**
- A paper enrollment form is also enclosed as an alternative to online enrollment
- A TeamCare highlight brochure of the benefits offered under their plan
- A Plan Benefit Profile and Plan booklets that provide information on their specific plan of benefits
- Temporary ID cards for member to use until receipt of their TeamCare Medical ID card and TeamCare Benefits ID card
- Life Insurance Beneficiary form (if member's plan offers life insurance)

The easiest and quickest way for a member to add their family members is through online enrollment at **MyTeamCare.org**. Members can add dependents, upload certificates/documents and follow the progress through the online enrollment. Please encourage your members to utilize this tool.

Finally, in addition to the Welcome Enrollment Packet from TeamCare, the member will receive two other mailings with their ID cards:

- TeamCare PPO Medical ID card sent directly by the PPO network; and
- TeamCare Benefits ID card sent by our vendor that includes all information for ancillary benefits like Rx, Vision, Dental, etc.

ELIGIBILITY

Standard Reporting and Eligibility

All NMFA, NATA, and most "white paper contracts" fall into this category. An employer is required to accumulate work history data for each of their employees during the current month and then report it to Central States, and pay for it, by the 15th of the following month.

Weekly Contributions - The employer is required to remit a full Weekly contribution on behalf of any employee who works, or is compensated, for any portion of a week as required under the CBA. Standard establishing period applies, which means that any employee reported to TeamCare, that has not had eligibility with TeamCare in the last 52 weeks, will not be able to use their TeamCare benefits until after we have received the 8th Weekly contribution. Coverage begins on the member's 9th week of contributions.

For UPS Part-Time Employees

Under the UPS National Master Agreement, a newly hired UPS part-time employee becomes eligible for benefits on the tenth month after their initial hire date with UPS.

Hourly Plan

The Hourly Plan was developed to accommodate those members whose work opportunities were of a seasonal nature but during that seasonal period the amount of work performed was prodigious. The Hourly Plan requires the employer to remit a contribution for each hour worked. The added benefit to this type of reporting is that any hours that are reported on behalf of a member, in excess of the number of hours needed to provide eligibility, are saved in a bank for future use. Depending on the collective bargaining agreement, an employee may bank up to 12 months of future eligibility. Banked hours can be viewed at **MyTeamCare.org**.

The standard establishing rule does not apply to the Hourly Plan as eligibility is provided in monthly increments. Each plan has a set "hourly base" which is the minimum number of hours needed to provide eligibility in a given month.

- Eligibility for TeamCare Hourly Plan benefits is determined monthly.
- Eligibility is based on the hourly contribution requirement negotiated in the collective bargaining agreement—typically between 120 to 160 hours per month.
- Reported work hours in a calendar month, will provide coverage in the second month following the month worked. You always know when you have coverage.
- If you work the necessary number of hours in a month (as determined in your collective bargaining agreement), **you'll be eligible for benefit coverage in the second month following the month worked.**
- Surplus hours worked in a month are held in an "hourly bank" that will be applied to your future coverage.
- If the monthly hours worked and reported by the employer fall below the monthly hour eligibility requirement, TeamCare will deduct any necessary dollars from your "hourly bank" to meet the monthly hour eligibility requirement.

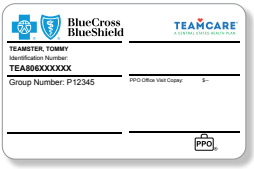
Example: Terry works for an employer that has a 160 hour monthly eligibility requirement. Terry works 180 hours in September 2024. The worked hours in September will be reported by the employer to TeamCare in October.

Because Terry met the 160 hour monthly eligibility requirement, Terry will have benefit coverage for the month of November; and 20 hours will be applied to his hourly bank to be used for future eligibility.

Which Card to Present

TeamCare PPO Medical ID Card

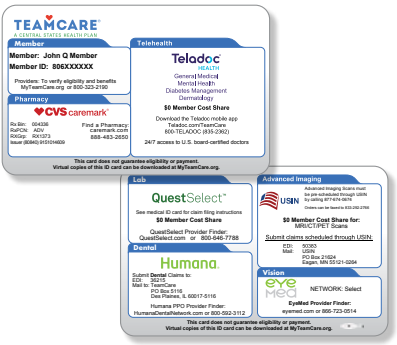
This card, with the BlueCross BlueShield, should be presented to any medical provider, mental health provider, or chiropractor. To check if a doctor, facility, or hospital participates in the network, call the phone number on the back of the card or visit the *Find A Provider* link at **MyTeamCare.org**.



TeamCare Benefits ID Card

Present this card to take advantage of your other great health benefits such as:

- Prescription: CVS Caremark
- Telehealth: Teladoc Health
- Dental: Humana Dental
- Vision: EyeMed Vision Care
- Advanced Imaging: USIN
- Lab Testing: QuestSelect

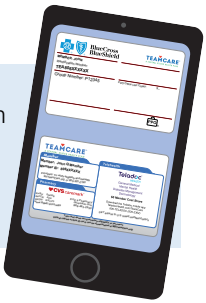


BCBS ID cards and TeamCare Benefits ID Cards are only issued in the member's name, but any covered dependents can use the cards.

A great tool for members is to download ID Cards directly to their smart phone from their dashboard at **MyTeamCare.org** or through the **MyTeamCare** app.

Download on the App Store

GET IT ON Google Play



Medical Benefit

TeamCare is a Preferred Provider organization (PPO), where members can enjoy the benefits of network-based healthcare. We offer the finest quality providers and facilities through the PPO network, BlueCross BlueShield. With 95% of all medical claims submitted by a TeamCare PPO provider—the quality and expansiveness of our TeamCare network speaks for itself.

Through TeamCare, members may seek care from any physician or hospital in the network. By seeking care from a network provider, they will receive higher, in-network benefits. In most cases, members may seek care from an out-of-network provider and still receive benefits. However, there is an out-of-network penalty that members will be responsible for and they will also have to file all claims.

MinuteClinic

$0 copay for convenient, affordable healthcare

MinuteClinic can treat and write prescriptions for common illnesses such as strep throat, pink eye, and ear, nose, and throat illness. It also provides a wide range of wellness services, such as flu shots, and offers routine lab tests.* There is no office visit copay when visiting the MinuteClinic.

*Lab fees and screenings may be billed separately. MinuteClinic services may vary by state.

Telehealth Benefit

Teladoc Health is a no-cost telehealth benefit

Members can call from home or on the road and speak to a U.S. board-certified and state-licensed doctor in all 50 states, 24/7/365. Teladoc Health offers visits for general medicine, dermatology, and behavioral health—conveniently and at no cost to the member!

Download the Teladoc Health app, visit **TeladocHealth.com/TeamCare**, or call **800-TELADOC**.

*Please remember to select TeamCare as your benefit provider when creating an account with Teladoc. If you do not see TeamCare as a benefit option during registration, please contact TeamCare at 800-TEAMCARE (832-6227).

Prescription Benefit

CVS caremark®

One of the most utilized TeamCare benefits is the Prescription Benefit. TeamCare partners with CVS/Caremark to manage both our Retail Pharmacy Program (for short-term fills) and the Caremark Maintenance Choice Program (for long-term maintenance medication fills). It is important to note that WalMart, Sam's Club, and Amazon/PillPack are not part of the TeamCare Prescription programs.

Retail Pharmacy Program (30 days or less)

The Retail Pharmacy Program allows the member to fill a short-term prescription at any of the 68,000+ pharmacies. These prescriptions are typically prescribed for less than a 30-day supply, such as an antibiotic.

Caremark Maintenance Choice Program/Mail Service Program (maintenance medications)

For long-term prescriptions that are taken on a regular basis for chronic conditions like high blood pressure, diabetes or high cholesterol, the TeamCare Prescription Benefit provides two easy and convenient ways to fill these prescriptions. A member can receive a 90-day supply of medication either at:

- Any CVS pharmacy or Kroeger pharmacy through the Maintenance Choice program; or
- Caremark Mail Service program or Costco mail service program

In simple terms, short-term fills can be filled at any in-network pharmacy like CVS, Walgreens, Rite-Aid, Albertsons, etc; while long-term fills (maintenance medications) can be filled either at a CVS pharmacy or through the mail-order program.

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

Helpful hint on Caremark Mail Service program: Registering for the mail service for the first time can be done easily online or by phone. Members can register at **caremark.com/mailservice** to fill a new prescription benefit or members can call 800-875-0867. Caremark will handle the rest.

Important Prescription Highlights:

- If a generic drug is available, the member must take the generic or be responsible for the cost difference plus any copayment.
- By the third fill, long-term maintenance medication must be filled through the Maintenance Choice or Mail Service program or be subject to a greater coinsurance.
- For injectable medications, TeamCare provides a $1,000 per member per calendar year out-of-pocket maximum, once this is met, all injectable medications will be paid at 100%.
- TeamCare does not cover medicines on a formulary exclusion list that is maintained by CVS/Caremark.

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

Outpatient Imaging Benefit

USIN

TeamCare partners with USIN to provide advanced imaging tests (MRI's, CT's and PET scans) all at no cost. These tests need to be scheduled directly through USIN by calling **877-674-0674**. USIN will set up an appointment at a time and location that is convenient for the member. All the member must do is present their Benefits ID card. Test results will be sent directly to the requesting provider.

*If there is not a USIN facility within 40 miles of the members home, TeamCare will make a network exception to have the test covered at 100%. To receive this exception the member must get approval from TeamCare prior to getting the test performed at a PPO facility.

Outpatient Lab Benefit

QuestSelect™

TeamCare offers covered members voluntary outpatient lab testing at no cost when performed through QuestSelect. Members can request their provider send the specimens to Quest directly or they can visit a QuestSelect collection site to have their specimen taken. Members must show their TeamCare Benefits ID card which lists their QuestSelect information.

For questions regarding this benefit, members can call QuestSelect Client Services at **800-646-7788**. Note: Physician must mark the specimen as QuestSelect or members will not be eligible.

Vision Benefit

In-Network Through EyeMed

TeamCare offers both in-network and out-of-network Vision benefits. TeamCare offers a voluntary network through the EyeMed Select network. The network has over 25,000 locations including national providers like Lenscrafters, Pearle Vision, or Target Optical; and local optometrists and ophthalmologists. Members that have vision benefits included in their plan receive the following in-network benefits once every 12 months*:

- One eye examination
- One set of frames up to $150 allowance
- One pair of eyeglass lenses
- Or, in lieu of glasses, contacts up to $120 allowance

Out-of-Network Vision Benefits

For non-EyeMed providers, TeamCare will reimburse the member for an exam, glasses or contacts once every 12 months*.

The maximum reimbursement is:

• Routine eye exam	$50.00
• Frames	$75.00
• Lenses	$50.00
• Bi and tri-focal lenses	$50.00
• Lenticular lenses	$60.00
• Contacts in lieu of glasses	$80.00

For out-of-network Vision claims, mail an itemized receipt to:

TeamCare
PO Box 5116
Des Plaines, IL 60017-5116

For more information call **866-723-0514** or visit **eyemed.com**.

**For MM500 plans, Vision Benefits are payable once every 24 months, and there is a $60 copay for progressive lenses. Refer to your plan benefit profile for your details.*

Dental Benefit

Humana.

Like the Vision benefits, TeamCare offers both in-network and out-of-network benefits. Members can choose any dentist they want, but TeamCare also offers a voluntary network through Humana Dental that allows members to maximize their dental benefit and with lower out-of-pocket expenses. Using an in-network dental provider protects the member from charges above the negotiated in-network discounted fee.

Key Dental Benefit Highlights:

- Dental exams and cleanings are allowed once every six months to date. At **MyTeamCare.org**, members can log in and view when they are eligible for their next dental exam, cleaning and/or x-rays.
- The annual dental maximum does not apply to dependent children under age 19.
- The orthodontic benefit is for dependent children up to age 26.
- Predetermination of benefits is available for charges of $500 or more. These can be submitted to TeamCare at the address below.
- Services provided by an in-network Humana Dental provider will be filed directly with TeamCare.
- Services provided by an out-of-network dental provider must be submitted to TeamCare by the provider or the member. Providers are encouraged to submit the claim electronically, members can submit claims to:

  TeamCare
  PO Box 5116
  Des Plaines, IL 60017-5116

- To find an in-network provider, visit **humanadentalnetwork.com** or call **800-592-3112** to find a Humana dental provider.

Short-Term Disability Benefit

If the member becomes disabled due to a non-work-related illness or injury and cannot work, most TeamCare plans offer Short-Term Disability Benefits to provide some income to help the member get through a rough time. The benefits and the number of weekly payments can be found in the Plan Benefit Profile.

To receive these benefits, the member must be disabled as a result of a non-work-related injury or illness or unable to work due to pregnancy, **and** must be receiving regular care from a doctor. Additionally, the member must be actively employed and covered by the Plan when disabled.

NOTE: Short-Term Disability Benefits are not payable for illnesses or injuries that are work related or are the result of surgical procedures not covered under the Plan.

Here are three very important steps to help ensure that the member's disability payment gets paid as quickly as possible:

1 **Visit** *Forms and Documents* link at **MyTeamCare.org** and download/print Short-Term Disability Claim Form-Initial Report of Disability. The form needs to be completed by your doctor, your supervisor/HR rep, signed, and returned to TeamCare. For members who work in NY, NJ, CA, and RI—See State Exceptions on next page.

2

For UPS members:	For TForce members:	For all other members:
Call **The Hartford** at **866-825-0186** to initiate your leave at UPS.	Email **tffleave@tforcefreight.com** or visit the TELUS Health Portal at **tforce.abilitiabsenceus.com** to initiate your leave.	Proceed to step 3.

3 Submit to TeamCare:

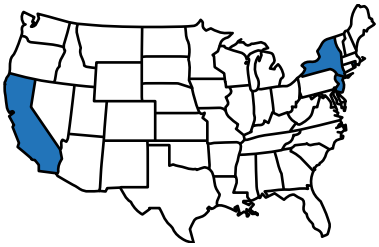
FASTEST: Online at Message Center at **MyTeamCare.org**

FASTER: Fax to (847) 518-9757

FAST: Mail to PO Box 5107
Des Plaines, IL 60017-5107

All Short-Term Disability checks are mailed to the members and a claim typically takes 7-10 days to process.

Short-Term Disability State Exceptions



Some states have their own short-term disability programs—meaning the benefit comes directly from the state.

Members Who Work in New York or New Jersey:

- **Non-UPS:** Submit claim directly through the TeamCare Message Center at **MyTeamCare.org** or to the address on the form.
- **UPS:** Submit a claim online through The Hartford at **abilityadvantage.thehartford.com** or by calling 866-825-0186.
- **TForce Freight:**
  - In New York, submit a claim with Prudential Insurance Company of America at **prudential.com/mybenefits**, by calling 877-367-7781, or by faxing 877-889-4885.
  - In New Jersey, submit a claim with the state by visiting **nj.gov/labor/myleavebenefits**, calling 609-292-7060, or faxing 609-984-4138. Once approved, members must send a copy of the statement to TeamCare.

All Members Who Work in California or Rhode Island:

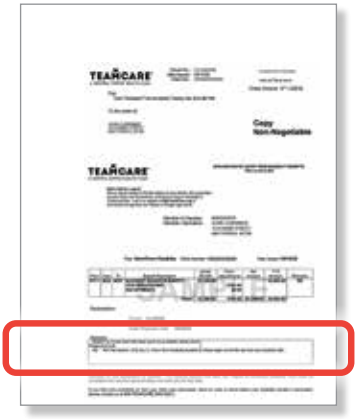
Your benefit comes directly from the state. Submit a claim through the state's short-term disability program:

- In California visit **edd.ca.gov**
- In Rhode Island visit **dlt.ri.gov/tdi**

For the above states, it is the member's responsibility to submit a copy of that claim to TeamCare (online, fax, or mail) to ensure there is continued coverage while the member is off on disability.

After Approval

Members should view the remarks box on the Explanation of Benefits attached to their Short-Term Disability checks. There members can find the auto-payment date, as well as any additional information requests from the Short-Term Disability department.



Short-Term Disability Questions Frequently Asked By Your Members

When does my Short-Term Disability Benefit (STD) begin?

To receive STD benefits, you must be disabled as a result of a non-work-related injury or illness or unable to work due to pregnancy and you must be receiving regular care from your doctor. You must complete the STD Initial Report of Disability which must be signed by your employer and your treating physician. Payments will begin:

- For an in injury, STD is typically paid from the date the doctor first determines you're disabled.
- For an illness or pregnancy, STD is typically payable from the 8th day after you become disabled.

In general, turnaround time is approximately 7-10 business days from receipt of a completed Disability form. To check the status of your claims, visit My Claims on your Dashboard at MyTeamCare.org. More detailed information is available in the Summary Plan Description.

Am I entitled to STD if I had an on-the-job accident?

No. STD is not payable for accidents or injuries that are covered under Workers' Compensation.

How many weeks of Short-Term Disability will I receive when I deliver my baby?

Typically, a normal vaginal delivery allows you six weeks of benefits. In the case of a surgery, you are allowed eight weeks. If you have complications either pre or post-delivery, we will need documentation from your doctor to approve additional STD.

Is there a different form to complete after my Initial Report of Disability?

Yes. You first apply for benefits on the STD Initial Report of Disability. During that same disability period, updates must be submitted on the Continued Report of Disability Form. Our Short-Term Disability Department will send the form in the mail when the update is needed.

When does my Short-Term Disability Benefit end?

STD ends when you are no longer disabled, retire or have received the maximum number of week's payable under your Plan.

Life Insurance Benefit

If Life Insurance is part of the Health and Welfare Package, TeamCare will pay Life Insurance Benefits on the member, the covered spouse, and any covered children under age 26. To file for benefits a "**Health Fund Notice of Claim for Death and Accidental Death Benefits**" must filled out and returned to TeamCare. This form can by be obtained at **MyTeamCare.org** under *Forms and Documents*.

Key Benefit Highlights:

- For benefits to be payable, the member must be covered by TeamCare on the date of death or within a 31-day grace period following their last day of coverage.
- All death claims must have a certified death certificate.
- Claims must be filed within 3 years.
- If member dies because of an accident, their beneficiary will receive the Accidental Death Benefit in additional to the Life Insurance Benefit.

If there is no beneficiary on file, TeamCare will pay the benefit in full in the following order:

1. Surviving spouse
2. Equal shares to the surviving children
3. Equal shares to the surviving parents
4. Equal shares to the surviving siblings
5. The estate

Beneficiaries can be changed anytime. A Life Insurance Designation Form can be obtained at **MyTeamCare.org** under *Forms and Documents*.

Family Protection Benefit

The Family Protection Benefit is a unique and unmatched benefit provided to TeamCare members and their families. In the event of the member's death, the Benefit provides TeamCare coverage to covered dependents for up to 5 years at no cost. To qualify, the member and covered dependents must have utilized in-network TeamCare medical providers for all non-emergency medical care during the two-year period (or less if TeamCare participation is less than 2 years) before the member's death.

Filing for the Family Protection Benefit

Once TeamCare receives the application for the Life Insurance benefit, TeamCare will review the family's eligibility for the Family Protection Benefit. A letter regarding the Life Insurance Benefit and Family Protection Benefit will be sent within a few weeks after receipt of the Life Insurance application.

If the member does not have a Life Insurance benefit under his plan (see Plan Benefit Profile), TeamCare must be notified and provided with a copy of the member's death certificate. When sending in the death certificate, please ensure that the member ID is also enclosed. This information can be faxed to the Life Insurance/Family Protection Department at **847-518-9786**.

Coverage under the Family Protection Benefit will end on the earliest of:

- 5 years from the member's death
- Coverage under another plan (including Medicare)
- Remarriage (NOTE: Children can continue to be covered unless other coverage is available)
- Child's 26th birthday or the date the child gains coverage under another plan

Retiree Health Plan Coverage

FOR EMPLOYERS THAT HAVE FUTURE RETIREE HEALTH PLAN COMPONENT

The Retiree Health Plan provides health coverage benefits until the member reaches age 65 or becomes eligible for Medicare benefits. Traditional medical expenses such as hospital, surgical, lab, diagnostic imaging, office visits, and prescription drugs, along with dental and vision benefits (effective 5/1/2022), are covered under the retiree health plan. Spouse coverage is also available under the retiree health plan. The level of retiree health plan benefits a member is eligible to receive and the applicable retiree health premiums will depend on the member's employer and the active plan of benefits the participant was enrolled in prior to retirement. The length of spousal coverage, the availability of dependent child coverage, and eligibility for any dental or vision benefits will vary depending on the participant's employer and active plan of benefits. Members can find specific details about their active and retiree health benefits by signing in to TeamCare's website **MyTeamCare.org**.

To qualify for retiree health coverage the member must meet the plan's TeamCare contribution requirement and the Pension Benefit/Union Service requirement.

TeamCare Contribution Requirement:

As of the eligibility date, the member must have at least 40 weeks of active TeamCare contributions in a plan which includes retiree coverage in each of the last five years, or at least 40 weeks of active TeamCare contributions in at least seven out of the last 10 years immediately preceding the eligibility date. The eligibility date is the date the member retires; although in some cases, it can be the last date of active TeamCare contributions. The eligibility date is simply the date as of which the TeamCare contribution requirement is measured and may not be the same as the date coverage begins under the Retiree Health Plan.

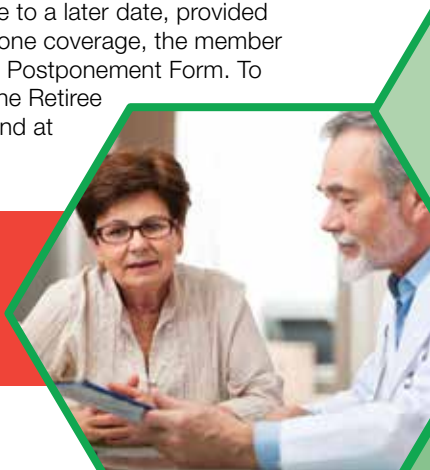
Pension Benefit/Union Service Requirement:

The member must be eligible to receive, at minimum, a pension benefit from the Central States Plan, The UPS/IBT Plan, or another Teamster Related Pension Plan based upon 20 years of service or must retire with at least 20 years of service under a recognized collective bargaining agreement negotiated by an affiliate of the Teamsters.

The Fund automatically determines eligibility for retiree health benefits when members apply for their retirement pension benefits with either the UPS/IBT plan or the Central States Pension Plan. To avoid any interruptions in health coverage, members who are eligible are automatically enrolled in the retiree health plan and any applicable retiree health premiums are deducted from their pension benefit checks. The Fund will mail a Retiree Health Election Form to each eligible member once approved. The member must then choose to remain enrolled, decline, or postpone the retiree health coverage by completing the Retiree Health Election Form and returning it to the Fund. If a member declines or postpones retiree health coverage within the specified timeframe any collected retiree health premiums will be refunded back to the member.

Either the member or the member's spouse may independently elect on a one-time basis to postpone retiree health plan coverage to a later date, provided there is other health insurance coverage. To postpone coverage, the member must complete and submit the Retiree Health Plan Postponement Form. To reactivate coverage, the member must complete the Retiree Health Plan Reinstatement. Both forms can be found at **MyTeamCare.org**.

The Retiree Health Plan is NOT a supplement to Medicare. It is the member's responsibility to notify TeamCare if he/she (or covered dependent) is eligible for Medicare to prevent an overpayment.



Cost of Retiree Health Plan Coverage

The Board of Trustees reviews the monthly premiums required for Retiree Health Plan coverage at the end of each year. Through the Health Fund's strong performance, the Board of Trustees has maintained annual increases well below industry standards. Local Union partners and retirees are notified each year when rates change. The following chart contains rates for 2024:

Non-UPS Retirees (Plan R4):

Retiree's Age at Retirement	Contribution Rate Per Person		
	2024	2023	Increase
62-64	$100	$100	$0
61	$256	$253	$3
60	$363	$359	$4
59	$447	$442	$5
58	$513	$508	$5
57	$581	$575	$6

*TForce employees: Contact TeamCare for eligibility and rate information prior to retirement.

UPS Retirees (Plan RU/RV):

2019-2024		
UPS Retirees	Member	Member+Family
	$200	$400

Under the terms of the collective bargaining agreement, the Retiree Health Plan premiums will remain $200 for one-person and $400 for family coverage for the duration of the agreement.

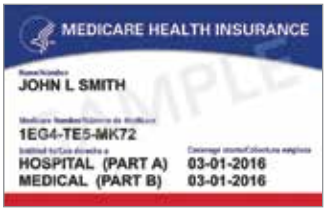
Use this QR code or visit **MyTeamCare.org/Summit-Resources** to get the most up to date Retiree Health Plan contribution rates.

Medicare Advantage Plan Benefits

TeamCare, in partnership with Humana Inc., offers Medicare eligible retirees the option of enrolling in a Medicare Advantage health plan which was designed just for Teamster retirees and provides a plan of medical and prescription benefits greater than original Medicare. The plans combine Medicare Part A (hospital benefits), Part B (physician and other medical services) and Part D (prescription drug) into one complete benefits package.

Additionally, the plans offer extra benefits such as access to fitness centers, vision and dental discounts, emergency coverage worldwide, and Humana Active Outlook®, which is a health program and magazine.

Members and their spouses who wish to participate in these programs must be enrolled in Medicare Part B prior to enrolling in any Medicare Advantage Plan available through Humana. Part B covers physicians and other medical services and requires a separate premium paid to Medicare. The Part B premium is deducted from the enrollee's Social Security benefit check.



TeamCare Advantage Plan

The TeamCare Advantage Plan is available to qualifying members for free and any premium payments are covered by the Fund. To qualify for the TeamCare Advantage Plan the member must:

- have qualified for coverage under the Retiree Health Plan,
- be eligible to receive a retirement or disability benefit from the Central States Pension Plan,
- had Plan C6 coverage under the Active Health Plan as of his/her date of retirement date, and
- be at least 63 years of age as of his/her date of retirement

The TeamCare Advantage Plan is available for a 2, 4, and 6 year coverage period if retiring at age 63, 64, and 65 respectively. The coverage period begins when the member reaches age 65 or an earlier date of Medicare entitlement, but no earlier than the first day of the month following the member's retirement.

The Fund determines eligibility for the TeamCare Advantage Plan when members retire and apply for pension benefits with the Central States Pension Plan. The Fund then notifies Humana of any qualifying members. Humana will then mail an enrollment application to qualifying members as their coverage period approaches. **This plan is not available to UPS members.**

TeamCare Gold Plan

The TeamCare Gold Plan is available to Teamster retirees who are not eligible for the TeamCare Advantage Plan, whose coverage period under the TeamCare Advantage Plan ends, or who decline the TeamCare Advantage Plan. The TeamCare Gold Plan's premiums are the responsibility of the member and are priced below the market value for similar Humana plans in the member's area. Humana will offer enrollment to the TeamCare Gold Plan to Teamster retirees as their qualifying age approaches.

Use this QR code or visit **MyTeamCare.org/Summit-Resources** to view more details about these Medicare Advantage Plans.

Age 65 Prescription Drug Benefit

The Age 65 Prescription Drug Benefit (NATA 65) applies only to retirees who receive pension benefits from the Central States Pension Plan and have established Benefit Class 18+. The benefit provides a 20% copayment by the member or spouse at the time of prescription purchase with the remaining 80% to be paid by the Pension Fund. The maximum benefit is $1,000 per calendar year for the member and $1,000 per calendar year for the spouse.

To qualify for the Age 65 Prescription Drug Benefit the member must be receiving a pension benefit from the Central States Pension Plan, have at least 20 years of contributory credit service, and the member's employer must be submitting contributions to the plan at Benefit Class 18+ levels when the member retires. The recipient of the benefit (member or spouse) must be age 65 or older.

When the member becomes eligible for the Age 65 Retiree Prescription Drug Benefit, he or she will receive a new prescription card and an informational package explaining the details of the plan and the benefits, and must notify TeamCare.

Appeals Process

Step One Appeal

A TeamCare member or healthcare provider may file an appeal when there is a disagreement with the decision based on benefits. Appeals must be received within 180 days from the date the healthcare benefit was denied, reduced, or terminated.

TeamCare will mail the Step One appeal decision within 30 days of receiving the request.

Step Two Appeal

If the first appeal is denied, a second and final appeal may be submitted by completing the appeal notification that was sent with the first decision. The final appeal must be received within 180 days from the date that the first appeal was denied.

The Step Two Appeal review is conducted by either the Trustee Appellate Review Committee or the Staff Final Review Committee and a final decision will be communicated to the members within 30 days of receiving the request.

If a member is still dissatisfied with TeamCare's decision at the conclusion of the Step Two Appeal, they have the right to file suit in state or Federal court pursuant to Section 502(a) of the Employee Retirement Income Security Act.

How to File an Appeal

Visit **MyTeamCare.org/help/appeal-a-claim** and select "Print and complete the form". Once logged in, the member can download the Claims Appeal Form. The member can also call the CustomerCare Center at **800-TEAMCARE** to request a form be sent to them.

An Appeal Must Include:

- Member's name and address
- Member's identification number
- Claim number, if known
- Patient's name
- Relationship of patient to plan member
- The date of loss for which the claim was made
- Exact reason of dissatisfaction of claim handling
- Documents and records to support your position

Ways to Submit The Appeal:					
ONLINE	Logging in at **MyTeamCare.org** and select the Message Center	FAX	847-518-9794	MAIL	TeamCare A Central States Health Plan PO Box 5126 Des Plaines, IL 60017-5126

COBRA Self-Payment Rights

COBRA, which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, is a federal law that provides members and dependents notification when their health plan coverage has ceased. It also allows them to make self-payments for a period of time to continue their health plan coverage.

If a member loses health plan coverage due to a reduction in hours or termination of employment, a notification will be sent by TeamCare in writing with the option of continuing coverage for up to 24 months. NOTE: COBRA only requires 18 months, but TeamCare provides the option for an extra 6 months.

Under COBRA, the member can choose:

- Either the full plan of coverage that the member's employer provided; or
- In some cases as determined by plan, a lower alternative “core” coverage (same as active coverage but only includes the medical and prescription portions of this coverage).
- Also, if a dependent loses coverage due to a divorce or the member's death, healthcare coverage may be continued for up to 36 months at one of the plans offered.

In most cases, TeamCare is made aware of coverage ending through the employer’s reporting. In those cases, TeamCare will send a COBRA letter with details outlining payment options and the time frame the payments are due to TeamCare.

Important Time Frame And COBRA Information

- Under COBRA regulations, a member has up to 60 days to notify TeamCare of their election to make COBRA self-payments.
- The member then has 45 more days to make payments to TeamCare.
- Once COBRA self-payments begin, they must be made continuously in order to continue to receive coverage.
- Once COBRA payments begin, a member has the right to discontinue making payments or reduce coverage in the future.
- TeamCare makes every effort to notify a member as soon as possible when there has been a loss of health plan coverage. If a member believes a COBRA letter should have been sent, please call 800-TEAMCARE (832-6227).

COBRA Questions Frequently Asked By Your Members

When and how must first COBRA self-payments be made?

If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election (this is the date the election notice is post marked, if mailed). Failure to do so results in the loss of all COBRA rights under TeamCare. You are responsible for making sure that the amount of your first payment is correct. The amount of your first payment must be sufficient to pay for the coverage elected from the initial loss of coverage date through the current week if coverage is to be maintained into the future.

Can a member make COBRA payments in advance?

Yes. In fact, paying before the due date will ensure that the member has no lapse in coverage or disruption to service occurs.

Does TeamCare accept electronic fund transfers or what forms of payment are accepted?

At this time, TeamCare accepts personal check, cashier's check, and money order. We do not accept credit cards. Please reference your Unique Member Identification Number (UMI) on your payment. Payments should be sent to:

Self-Payments Department
TeamCare—A Central States Health Plan
Dept 10291
Palatine IL 60055-0291

TeamCare Questions Frequently Asked By Your Members

Do I need a referral to see a specialist?

TeamCare does not require a referral for claim payment. NOTE: Using an out-of-network specialist will affect claim payment and other benefits like the Family Protection Benefit.

How do I request additional ID Cards?

Log in at **MyTeamCare.org** and click on "Request an ID Card" in your Dashboard. You can request new TeamCare Medical ID Cards and TeamCare Benefits ID Cards to be mailed to you, as well as view digital versions.

Am I eligible for benefits if I need treatment outside the United States?

Yes. You are eligible for services covered under TeamCare when treatment is received outside the United States. Treatment received must be considered Standard Medical Care, Services, or Supplies.

I just got married/had a baby. What do I do?

Contact TeamCare via your Message Center or at 800-TEAMCARE to request an Enrollment Form. You have sixty (60) days from the date of the to complete the Enrollment Form and return it to TeamCare.

My spouse lost her/his job and insurance. How can I have them added to my Plan? What documents do you need?

Contact TeamCare to request an Enrollment Form. A Letter of Credible Coverage (or other proof of termination of coverage) must be attached from your spouse's insurance company stating the last date of coverage. These documents must be submitted to TeamCare within sixty (60) days of the involuntary loss of coverage.

Are dental implants covered?

For plans that include a dental benefit: As of 01/01/2018, dental implants are covered under your dental benefits up to the annual dental maximum (if applicable).

When does coverage end for my adult child?

Coverage for an adult child ends when:

- Your coverage ends
- The adult child reaches age 26
- The adult child enters the military

Children who are mentally or permanently physically disabled may be eligible for some benefits after the age of 26.

Can I see my life insurance beneficiary online? How can I make a change?

This information is not available online. You can contact us for a copy of the Designation of Beneficiary Form we have on file. To change your beneficiary, you must submit an updated form. New Life Insurance Beneficiary Designation Forms are available at **MyTeamCare.org**

I am scheduled to have surgery soon. Who should call TeamCare, my doctor or me?

Providers can check eligibility on-line or by calling to verify eligibility and plan coverage. If your doctor is part of a PPO network, the doctor may also need to pre-certify certain procedures. The appropriate phone numbers and requirements are shown on your TeamCare Medical ID card.

How do I obtain copies of my Explanation of Benefits (EOB)?

Please visit **MyTeamCare.org**. Click on the “Claim Search” button. After signing in, the Explanation of Benefits (EOB) are located in the “Recent Claims” section.

Use this QR code or visit **MyTeamCare.org/Summit-Resources** to view more FAQs.

COMMUNICATIONS

In This Section:

CustomerCare
CENTER

Monday through Friday, 8:00am - 5:30pm CST

MyTeamCare.org

Members: 800-TEAMCARE
Locals: 800-323-2130
Providers: 800-323-2190

MyCentralStatesPension.org **800-323-5000**

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

HIPAA Privacy

Subscribers, family members and natural parents have specific rights under the HIPAA regulations relating to their protected health information (PHI) or that of their minor children that is stored by Central States TeamCare. Below is a summary of HIPAA forms available on the TeamCare website that must be used by subscribers, family members or natural parent to exercise these rights.

Health & Welfare Fund - HIPAA Privacy Forms:

Authorization to Allow Use and Disclosure of PHI: This form must be used by a subscriber, spouse, or adult child to direct who can access their PHI or that of the minor children. Access to PHI of a minor child by a natural parent not covered under the plan can be granted by submitting copies of birth certificates and court documents with custody directives or by the subscriber completing the form and providing authorization.

Request to Restrict Use and Disclosure of PHI: This form must be used to limit who can access their PHI or make changes to their record or to add a password that is required to be given when calls are received at Central States TeamCare.

Alternate Payee Request form: This form must be used by a spouse, adult child, or natural parent to provide an address that is different than the subscriber's address to be used for explanation of benefits statements on processed claims and correspondence from the Health & Welfare Fund. The form details the additional documents or requirements that should also be submitted.

Request a Copy of Health & Welfare Information: This form can be used to request copies of information maintained in the Central States TeamCare records.

The completed and signed forms can be submitted through the Message Center at MyTeamCare.org, by mail at the address on the form, by fax to (847) 518-9789, or by email to privacyofficer@centralstates.org.

NOTE: If subscribers, family members, or natural parents move, they will need to complete a new form so we have the most current address and contact information.

Other Documents:

Notice of Privacy Practices: This document is also available through the Central States TeamCare website and describes how PHI may be used and disclosed, rights under the regulations and how Subscribers, family members and natural parents can access this information.

Submitting Other Documents:

Power of Attorney, Guardian, Conservator documents: These documents are recorded within the Central States TeamCare records. They can be submitted through the message center on the TeamCare website, by mail, by fax (847) 518 -9789 or by email to privacyofficer@centralstates.org. **For Pension only members**, send these to the attention of the Pension Department, through the Pension Fund website, mail or by fax to (847) 518-9752.

MyTeamCare.org

Our website has mobile functionality and enhanced features for our members, local unions, employers and providers.

Some highlights of the website:

- "How-To" guides on common tasks like adding dependents to your plan, applying for Short-Term Disability and updating your web account
- Interactive digital ID cards
- Enhanced CustomerCare support tools
- FAQ's section
- Easy-to-navigate member dashboard
- Also available on the **MyTeamCare** app

MyCentralStatesPension.org

These are some of main functions the members can utilize on **MyCentralStatesPension.org**.

What Is My Pension?
The Benefit Estimator is available to calculate your pension, so you know what to expect at retirement.

I Want To Apply For Benefits
Start the process of applying for Retirement, Disability, or Survivor Benefits.

My Pension Check
View pension check schedules, get set up for direct deposit, and verify your income.

Online Help
FAQs, Forms and Documents, QDRO, Reemployment—get your questions answered here.

Also available:

- Plan Benefits
- Tax Calculator
- Pension Message Center
- Pension Work History
- Pension Applications

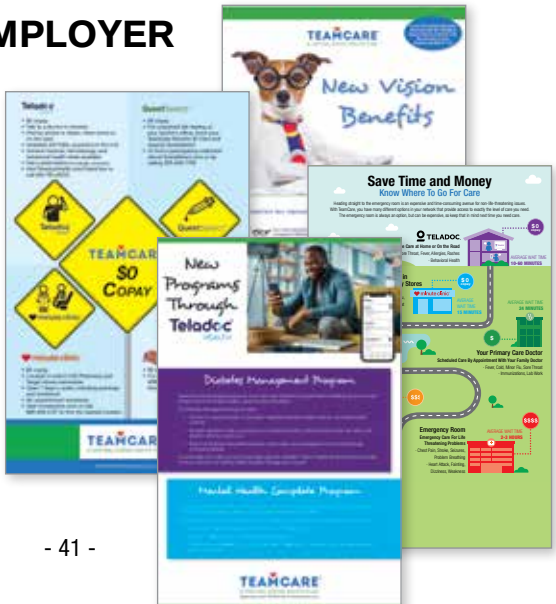
TeamCare Connections

TeamCare Connections is a quarterly health and wellness newsletter. Connections provides benefit updates, health tips, member stories, and ways to save money by using TeamCare partners, such as MinuteClinic, Humana Dental, and EyeMed.

Members can update their mailing address on **MyTeamCare.org** as well as sign up to receive an email version of TeamCare Connections to their inbox.

Local Union/Employer Posters

From time to time, TeamCare will provide Local Unions with posters. These posters highlight important information or benefit tips for your members. We appreciate the help of our Local Union parters in hanging the posters at your union hall and/or participating employers.



Contact Your TEAMCARE® Partners

BlueCross BlueShield
bcbsil.com
800-810-2583

Teladoc Health
teladochealth.com/TeamCare
800-TELADOC

Caremark
caremark.com
888-483-2650

QuestSelect (Lab Benefit)
questselect.com
800-646-7788

USIN (Imaging Benefit)
877-674-0674

Humana Dental
humanadentalnetwork.com
800-592-3112

EyeMed Vision Care
eyemed.com
866-723-0514

Message Center at MyTeamCare.org • 800-TEAMCARE

In This Section:

UPS

Summary of TeamCare UPS Plans:

PLAN	UPS
U1	FT UPS PACKAGE
U2	FT UPS PACKAGE (PRIOR C6)
U3	PT UPS PACKAGE
UW	FT UPS WORLDPORT

Weekly Coverage

UPS will make a health plan contribution to TeamCare for every week in which a member receives any form of compensation. “Compensation” is broadly defined and includes actual work as well as vacation, paid time off, sick leave, paid holiday, personal day, FMLA leave, and workers’ compensation as stated in the collective bargaining agreement.

Weekly Coverage

UPS will make a health plan contribution to TeamCare for every week in which a member receives any form of compensation. “Compensation” is broadly defined and includes actual work as well as vacation, paid time off, sick leave, paid holiday, personal day, FMLA leave, and workers’ compensation as stated in the collective bargaining agreement.

Short-Term Disability

- In addition to filing a short-term disability claim with TeamCare (signed by the member, employer, and doctor):
  - UPS members must also call The Hartford at **866-825-0186** or **abilityadvantage.thehartford.com**. A medical note supporting your leave must be provided to The Hartford either by mail or through **abilityadvantage.thehartford.com**. General questions about your leave from UPS can be directed to The Hartford.
- A UPS employee who works in New Jersey, New York, Rhode Island or California will have their STD benefit by the state. In NY and NJ, a member must submit your claim through The Hartford and send a copy to TeamCare; while in CA and RI, the member must file the claim with the state:

  California: edd.ca.gov Rhode Island: dlt.ri.gov/tdi

A copy of the claim filed with the state must also be sent to TeamCare.

Long-Term Disability

- UPS Plan U1 & U2 – Eligible for the Extension of Benefits once the LTD ends (13 week and Major Medical Extension).
- UPS Plan U3 – Not eligible for the LTD; eligible for the Extension of Benefits (13 week and Major Medical Extension).
- Kaiser Plans – Eligible for 1 year of LTD coverage if approved by The Hartford’s LTD Plan. No coverage under TeamCare for Basic or Major Medical Extension.
- LTD benefits are handled through The Hartford. Questions regarding the benefit can be directed to The Hartford at **866-825-0186** or at **abilityadvantage.thehartford.com**.

Pension

In This Section:

Additional Pension Topics And Resources

The Fund's website **MyCentralStatesPension.org** contains additional information on a variety of other pension topics:

- How-To Guides on submitting applications for benefits and appeals
- Help with Divorce Situations (QDRO Model Orders and Procedures)
- FAQs on Earning and Losing Credits, Breaks in Service, Vesting, Guardianships and POAs
- Frequently Used Forms (Tax Forms, Direct Deposit Forms, Employment Affidavits, Reemployment Forms, Appeal Forms, Benefit Application Forms, Joint and Survivor Option Forms)
- Important Documents (Summary Plan Description, Plan Documents, Trust Agreement, and Independent Special Counsel Reports)

Retirement Benefits

To qualify for a retirement benefit from the plan a member must have at least 5 years of vesting service (10 years prior to 1999). The plan's normal age of retirement is age 65, but some members with 20 years of service might be able to receive their full retirement benefit as early as age 62. The earliest age a member may retire and begin receiving benefits from the plan is age 57.

The decision to retire is an important decision and members should consider the following when making their retirement decision:

1. Understand the amount of pension benefits he or she is eligible to receive.
2. Understand the impact that age at retirement has on the amount of pension benefits the member is eligible to receive.
3. Be aware there is a 12-month limit to the amount of retroactive benefits a member can receive counted from the date a complete benefit application is filed with the plan.
4. Understand the impact of retirement on health insurance coverage.
5. Understand the plan's restrictions on reemployment, particularly if the member is planning to supplement their retirement income by working.
6. Be aware that in order to collect retirement benefits a member must first permanently end their employment (resign) with a contributing employer or any employment which would be restricted under the plan's reemployment rules.
7. Be aware that benefits may be reduced after retirement, if the employer discontinues participation in the plan.

Members are encouraged to obtain a benefit estimate prior to retirement. The best way to determine eligibility for retirement benefits is to use the benefit estimator available on the Fund's website: **MyCentralStatesPension.org**. The benefit estimator allows members to obtain an estimate of their current retirement benefits and to also project their retirement benefits into the future.

Members can apply for benefits by completing the application for retirement benefits, which can be downloaded from **MyCentralStatesPension.org**. Additional documents that should be submitted with the benefits application include birth certificates, marriage certificates, and divorce decrees. Members should allow 90 days after submitting their benefit application for plan benefits to be processed.

Use this QR Code or visit **MyTeamCare.org/Summit-Resources** to view the Application for Retirement Pension Benefits.

Reemployment Restrictions

There are very specific rules regarding employment while receiving a pension. A member should always seek approval from the Fund before accepting a job. Any employment that is not approved by the Fund may result in recovery of any overpaid Retirement Benefits.

A member must notify the Fund prior to beginning any employment and provide the following information: name of employer, location, job duties, job title, type of industry, and number of hours worked per month. If a member begins working in Restricted Reemployment and has not notified us, the Fund reserves the right to recover any overpaid pension benefits or Retiree Health Plan claims.

Work That Is Not Permitted

- Work in the Core Teamster Industries (either in a union or non-union capacity)
    - Trucking and Freight
    - Small Package and Parcel Delivery
    - Car Haul
    - Tank Haul
    - Warehouse
    - Food Processing or Distribution (including Grocery, Dairy, Bakery, Brewery and Soft Drink)
    - Building Material and Construction
    - Labor Organization
- Work for a contributing employer
- Work in any position covered by a Teamster contract

Work that is outside the Core Teamster Industries, which is not for a contributing employer, and work that is not in a position covered by a Teamster contract may still be restricted and limited to 80 hours per month up to age 60 if it is:

- Work in the same industry in which the participant earned contributory service with the plan
- Work in the same job classification as other plan participants within 100 miles

Work That Is Generally Exempt From Reemployment Restrictions:

- Government employment provided the federal, state, or local agency is not a contributing employer or former contributing employer
- Work for a charitable organization provided the organization is not engaged in substantial commercial activities
- Work after age 65 for less than 40 hours per month
- Work after age 65 that is not in the same trade or craft with which the participant earned contributory service with the plan
- Work after the participant has applied and been approved by the plan for the Post-Age 65 Exemption to the Reemployment Rules
    - This exemption applies to retirees who have reached age 65 and who immediately prior to reaching age 65 or later have received 12 consecutive months of pension benefits without engaging in Restricted Reemployment. The exemption is effective after the end of the 12-month period.

Retirement Payment Options And Death Benefits After Retirement

The member must choose a payment option at retirement, which affects the amount of the member's monthly retirement benefit. Depending on the payment option chosen, death benefits may be available to the member's spouse or other beneficiary after retirement.

With Joint and Survivor Option Coverage

The Joint and Survivor Option provides a spouse with a lifetime benefit after the member's death. The member can choose between a 50% Surviving Spouse Option or a 75% Surviving Spouse Option. If the Joint and Surviving Option is elected, the member's monthly retirement benefit is reduced using an adjustment factor which is dependent on the member's age and the spouse's age at retirement. After the member's death, the spouse will receive either 50% or 75% of the member's reduced benefit for her or his lifetime. If the member's spouse dies first, the member's monthly benefit can be restored to the amount he or she would have received without the Joint and Survivor Option. To restore the benefit, the member must first supply the plan with a copy of the death certificate.

Without Joint and Survivor Option Coverage

If the Joint and Survivor Option is declined, and the member retires with less than 20 years of service or if the member is only eligible for a Contribution-Based Pension at retirement, then no survivor or death benefits of any kind will be payable after the member's death.

If the Joint and Survivor Option is declined, and the member qualifies for Twenty-Year Service Pension, Deferred Pension, or Contributory-Credit Pension at retirement (even if the member receives a Contribution-Based Pension because the amount may have been greater) then one of the following death benefits will be payable:

- If the member is married, established benefit class 4 or greater, and dies before receiving 60 months of payments, the balance of the 60 payments is payable to a surviving spouse
- If the member is not married and the member dies before receiving 60 months of payments a $1,000 Lump Sum Death benefit is payable to the first of the following:
    - The member's dependent children
    - The member's non-dependent children
    - The member's parents
    - The member's brothers and sisters
- If the member's benefit class is less than 4, a $1,000 Lump Sum Death Benefit is payable to the first of the following:
    - The member's spouse
    - The member's dependent children
    - The member's non-dependent children
    - The member's parents
    - The member's brothers and sisters
    - The member's estate

Death Benefits Prior To Retirement

The plan provides for the following death benefits in the event the member dies prior to collecting retirement benefits from the plan:

50% Surviving Spouse Benefit

This is a lifetime monthly benefit payable to a surviving spouse beginning with the month following the date a member would have reached age 57 or the month following a member's death, if later.

60-Month Benefit

This is a monthly benefit payable to a surviving spouse or, if none, to dependent children beginning with the month following the date a member would have reached age 57 or the month following a member's death, if later. Although the monthly amount of this benefit is greater than the 50% Surviving Spouse Benefit, it ends after 60 months of benefits have been paid or, if earlier, upon the death of the surviving spouse or dependent children. If there is more than one dependent child, the monthly benefit is divided equally among them. The 60-month benefit is only payable if the member meets certain service and benefit class requirements and the death occurs within a specified timeframe from when the member last worked for a contributing employer.

Lump Sum Death Benefit

As an alternative to the 50% Surviving Spouse Benefit or the 60-Month Benefit, the Lump Sum Death Benefit provides a surviving spouse or other eligible payee with a one-time payment of $2,000, $4,000, or $10,000* (Benefit Class 18/18+ only) depending on the contribution levels and the applicable benefit class established by the member. The Lump Sum Death benefit is payable if the death occurs before three or more consecutive one-year breaks (worked less than 10 weeks in one calendar year), if the member had attained 10 or more years of credit, and if the plan's minimum pension contribution requirement is met.

The Lump Sum Death Benefit is payable to the first of the eligible payees in the order listed below:

- Spouse
- Dependent children
- Non-dependent children
- Parents
- Brothers and sisters
- Estate

The 60-month benefit and the Lump Sum Death Benefit are not payable if the member's adjustable benefits have been eliminated under the Rehabilitation Plan (see Rehabilitation Plan). The Application For Survivor Benefits is available on our website **MyCentralStatesPension.org**

*Unlike the $2,000 and $4,000 Lump Sum Death Benefit, the Benefit Class 18/18+ $10,000 Lump Sum Death Benefit is payable in addition to either the 60-Month Benefit or the 50% Surviving Spouse Benefit.

Use this QR code or visit **MyTeamCare.org/Summit-Resources** to view the Application for Survivor Benefits.

Disability Benefits (Pension)

A member will be eligible for monthly disability benefits if he or she becomes totally and permanently disabled before their 62nd birthday and before three or more consecutive one-year breaks (worked less than 10 weeks in one calendar year) and have 10 or more years of credit as of the date of disability.

Members can only receive one form of benefit from the plan at a time. If a member is eligible for both a disability benefit and a retirement benefit, the member must choose which one of the benefits he or she wants to receive. A member receiving disability benefits can switch to a retirement pension upon reaching age 65, the plan's normal retirement age.

The Application For Disability Benefit is available on our website **MyCentralStatesPension.org**. The Fund will accept the Social Security Administration disability award letter or certificate as evidence of total and permanent disability. A copy of the award/certificate should be submitted with the application.

Once approved, the Fund will periodically request evidence of continuing disability. Any type of work for gain is prohibited while receiving disability benefits under the Fund's restricted reemployment rules.

Rehabilitation Plan & Adjustable Benefits

Under the Pension Protection Act a pension plan is required to adopt a rehabilitation plan if the pension plan is in critical status. The Pension Fund was certified to be in critical status and established a rehabilitation plan in 2008. The rehabilitation plan requires contribution levels to be increased according to published schedules. If the required contribution levels are not remitted or if the bargaining unit withdraws from the plan, then members are subject to the loss of their adjustable benefits. Adjustable benefits include:

(1) the Twenty Year Service Pension;

(2) the Early Retirement Pension;

(3) the Contribution-Based Pension (to the extent such benefit is available prior to age 65);

(4) the Contributory Credit Pension;

(5) the 25-And-Out Pension;

(6) the 30-And-Out Pension;

(7) the Vested Pension (to the extent such benefit is available prior to age 65);

(8) the Deferred Pension;

(9) the Twenty-Year Deferred Pension;

(10) Monthly Disability Benefits (not yet in pay status);

(11) Lump Sum Disability Benefits;

(12) the 60 Month Survivor Benefit (not yet in pay status);

(13) the Disability Death Benefit;

(14) the Lump Sum Death Benefit;

(15) the Benefit Class 18/18+ Death Benefit; and

(16) Partial Pensions

In addition to the loss of benefits described above, the Contribution-Based Pension monthly benefit payable at age 65 shall be reduced to an actuarially equivalent benefit with a minimum retirement age of 57 in accordance with the following schedule:

Age	65	64	63	62	61	60	59	58	57
Actuarial Equivalence	100%	90%	81%	74%	67%	61%	55%	50%	46%

UPS Employees

As a result of the withdrawal of UPS from the Central States Pension Plan and the creation of the UPS/IBT Plan, the Central States Pension Plan no longer processes retirement benefit claims for UPS employees. Instead, the Central States Pension Plan works together with the UPS/IBT Plan to provide members a total retirement benefit based on the member's years of service in both plans.

Regardless of age, UPS employees must file the appropriate forms with the UPS/IBT Plan to receive any benefits or to take any other action under the Central States Pension Plan. All forms required to take any action under the Central States Pension Plan or the UPS/IBT Plan may be obtained as indicated below.

- by telephone at 1-800-643-4442, or
- by e-mail at retirementdept@UPS.com, or
- by mail at the following address:
  UPS/IBT Full-Time Employee Pension Plan
  55 Glenlake Parkway NE
  Atlanta, Georgia 30328

Appeals

In the event a member disagrees with a benefit determination made by the Pension Fund, he or she can submit an appeal and have their benefit determination re-evaluated by a committee. Appeals should be submitted as quickly as possible after the original benefit determination. Appeal Forms can be found at **MyCentralStatesPension.org**.

Pension Fund: Withdrawal Liability

Things to Consider Before Negotiating a Withdrawal

To help ensure that pension funds have enough assets to pay for promised benefits, the Multiemployer Pension Plan Amendments Act of 1980 (MPPAA) imposed liabilities on employers which terminate participation in pension plans. The Central States, Southeast and Southwest Areas Pension Plan is a defined benefit plan. It pays pre-defined benefits based on certain age and service requirements; it is not a defined contribution plan which simply repays the amounts contributed plus or minus investment returns. Some of the reasons why defined benefit plans have unfunded liability include participants retiring earlier and drawing benefits longer, investments not meeting expectations, and negotiated benefit increases.

The cost of benefits is shared by all participating employers. If an employer withdraws from a pension plan before the plan's owed benefits are fully funded, the law requires that the withdrawing employer pay its pro-rata share of the unfunded vested benefits liability. This amount is known as the employer's withdrawal liability.

The employer's withdrawal liability is imposed when an employer completely ceases contributions to a pension plan. An employer that has not ceased operations in full, but discontinues a portion of its operations and continues to contribute on behalf of other employees, would typically not be assessed withdrawal liability. However, a portion of the employer's liability may be owed if contributions have ceased for a portion of its employees because the collective bargaining agreement no longer requires pension plan participation due to decertification or bargaining out of the plan, or if formerly covered work has been transferred to others who are not participants in the Fund. Also, in certain situations, a decline in business can trigger employer withdrawal liability (including a decline in the workforce of 70% or more over 3 years).

An employer or local union may contact the Central States Pension Fund to request a withdrawal liability estimate by writing the Fund's "Withdrawal Liability Department".

Rehabilitation Plan Withdrawal ("RPW"):

Effective on and after March 26, 2008, Appendix M (Rehabilitation Plan) was added to the Pension Plan. As denoted within the Plan Document, "a Rehabilitation Plan Withdrawal occurs on the date a Contributing Employer is no longer required to make Employer Contributions to the Pension Fund under one or more of its Collective Bargaining Agreements as a result of actions by members of a Bargaining Unit (or its representatives) or the Contributing Employer." Should the Pension Fund determine that an RPW has occurred the members shall have their Adjustable Benefits eliminated or reduced as outlined in the Plan Document. If the representative of the members would like further details on the potential elimination or reduction of benefits for a specific bargaining group, you may contact your Field Service Representative.

By using this QR Code or visiting **MyTeamCare.org/Summit-Resources**, the parties can review the Pension Fund's Plan Document, which contains Appendix M.

Pension Questions Frequently Asked By Your Members

How much is my pension worth?

Upon request, the Fund will advise you of your accrued benefit as of your normal retirement age (age 65) or any other age you request. A Pension Benefit Estimator is also available at **MyCentralStatesPension.org**.

Can I get a lump sum?

No, this is not permitted under the plan.

What should I do if I am considering going back to work after I have retired?

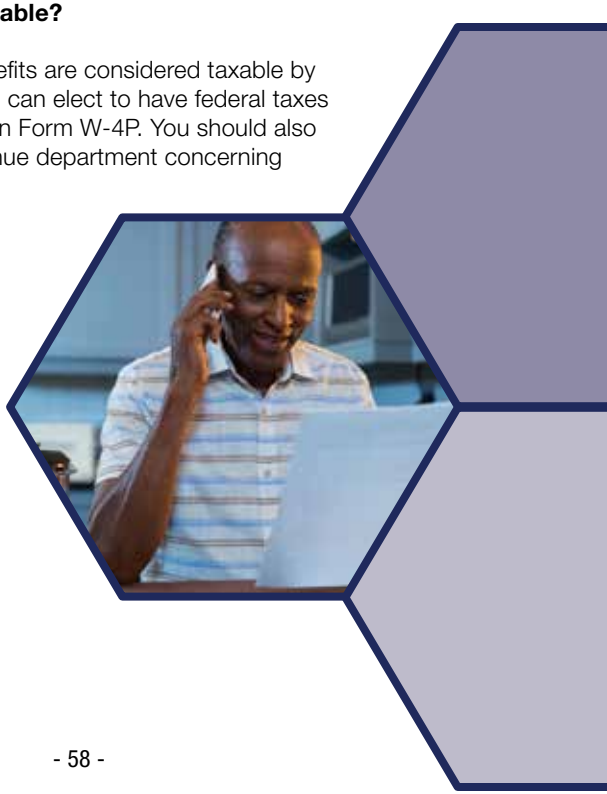
You must notify the Fund prior to beginning any employment and provide the following information: name of your employer, location, job duties, job title, type of industry, and number of hours worked per month. If you begin working in Restricted Employment and have not notified us, the Fund reserves the right to recover any overpaid pension benefits or Retiree Health Plan claims.

Are my retirement benefits taxable?

Yes. Your monthly retirement benefits are considered taxable by the Internal Revenue Service. You can elect to have federal taxes withheld by completing an election Form W-4P. You should also check with your state tax or revenue department concerning retirement benefit tax liability.

Does the Fund withhold state or local taxes?

Central States is not required to withhold state or local taxes. If your state or local tax authority requires that you pay taxes on your Central States benefits, you may need to make payments to them directly. If you have questions regarding state or local taxes contact your state or local tax authorities.



I want to retire; How do I get started?

You will need to complete an application for Retirement Benefits, which can be found at **MyCentralStatesPension.org** along with instructions. Submit your application at least 90 days prior to your retirement date.

I am getting divorced. Does that affect my pension?

Under the law your pension may or may not be assigned in a divorce settlement. If any part of your pension is assigned, you will need to submit a Qualified Domestic Relations Order (QDRO) which gives the alternate payee their assigned share of your pension. Additional details are available at **MyCentralStatesPension.org**. You can also contact the QDRO department at 800-323-2152, ext. 3876 or QDROmail@centralstates.org.

If I elected JSO coverage at retirement and then I get divorced, is my JSO canceled?

Divorce after retirement does not cancel the Joint and Surviving Spouse Option (JSO) election. To do this your spouse must execute a written waiver of any right to and interest in the JSO.This waiver must be incorporated into a court approved property settlement agreement that is part of a judgment or order entered by a court. Additional details are available by calling the QDRO department at 800-323-2152, ext. 3876 or at **MyCentralStatesPension.org**.

Use this QR code or visit **MyTeamCare.org/Summit-Resources** to view more FAQs.

CENTRAL STATES PENSION FUND

Working Toward Your Retirement

The financial security you'll have in the future, begins today.

A rewarding retirement just doesn't happen. Through weekly pension contributions negotiated by the union and paid entirely by the employer to the Central States Pension Fund, your hard work is rewarded with a monthly lifetime retirement benefit that you can never outlive.

Over the last 65 years, the Central States Pension Fund has paid out over $80 billion in pension benefits to over 650,000 retired Teamsters and their families.

Earning a pension benefit...

The amount of your retirement pension benefit is determined by the length of your service and the contributions paid by your employer on your behalf. With as little as **5 years** in the plan, you will be eligible for a monthly lifetime pension benefit from the Pension Fund at the normal retirement age of 65.

However, the more you work, the higher your benefit will be. Your pension grows with you. Also, the more years you have in the Pension Fund, the earlier you can retire without an age reduction in your benefit.

Let's look at two examples on how your pension benefit is calculated:

Example 1: Larry	
Age He Started:	55
Retirement Age:	65
Years Worked:	10
Employer Contribution:	$135 per week ($7,020 per year)
Accrual:	1% ($70.20 per year)
Base Pension:	$702 per month

This is only a conservative estimate. Most employers are under the Primary Schedule which requires annual pension contribution increases of 4% each year—helping Larry's pension grow to $845.78 per month.

Since Larry is retiring at 65, there is no age reduction on his benefit. He does have the option to take a reduced pension to provide a monthly benefit to his spouse in the event of his death.

Example 2: Jerry	
Age He Started:	32
Retirement Age:	62
Years Worked:	30
Employer Contribution:	$68.40 per work day ($17,784 per year)
Accrual:	1% ($177.84 per year)
Base Pension:	$5,335 per month

When a participant has 20 or more years, pension benefits are payable in full without an age reduction factor at age 62—not age 65. However, if Jerry was age 60 when he retired, there would be an age reduction on his base pension. Since "age-60 Jerry" will be receiving his benefit longer than "age-62 Jerry", there is a 6% per year age reduction factor applied for each year under the normal retirement age.

If Jerry lives to age 80, he will have received over $1.1 million in benefits from the Pension Fund.

It's never too early to plan.

By visiting **MyCentralStatesPension.org**, you can see exactly what your pension is worth today. You can also project what your pension will be in the future. The Benefit Estimator projects your future pension benefits, along with the survivor options for your spouse.

If there is a discrepancy between this summary and the Pension Plan Document, the Pension Plan Document will be the controlling document in determining the benefit.

Key Numbers to Know:

5 Number of years of vesting service required for the Plan

1 Percentage your employer's contribution will be multiplied by* (for post 2003 contributions)

65 The Plan's normal retirement age (assuming you have met the 5 year vesting requirement)

20 Years of Credit that will allow you to retire early at...

62 Age you can retire after getting 20 years of Credit

57 The earliest age you can retire and receive partial benefit payments

6 Percentage per year your payments will reduced if you retire before your 62nd or 65th birthday

If you were previously employed by another employer that participated in the Central States Pension Fund and had contributions prior to 2003, you may have different percentages. Please visit **MyCentralStatesPension.org and use the Benefit Estimator.*

Frequently Asked Questions

In This Section:

When will my coverage begin?

Generally, you are eligible for benefits:

- After eight weeks of contributions on your behalf have been received by TeamCare within a 52-week period, or
- Immediately, if you meet one of these conditions:
  - You come into the TeamCare plan as part of a new group that has been accepted for immediate coverage.
  - You leave your employer as a covered TeamCare member and return to covered employment with any other TeamCare plan employer within 52 weeks after your previous coverage ended.

How do I register for an account online?

Once you have received your welcome packet in the mail, visit **MyTeamCare.org** and click the Register link at the top of the page. You will need to enter your Member ID number, the last four digits of your Social Security Number, your date of birth, and zip code. You will then create a username and password.

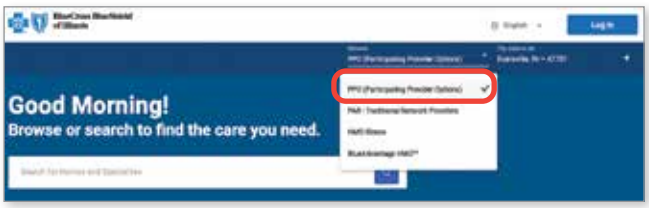
If you are a new member, you will be directed to the Enrollment page. Note: You will not be able to view your Dashboard until after your effective date of coverage. If you are a current member, you will be directed to your Dashboard.

You will also be asked if you would like to opt for Electronic Delivery of Documents and if you would like to grant dependent access.

How do I find an in-network medical provider?

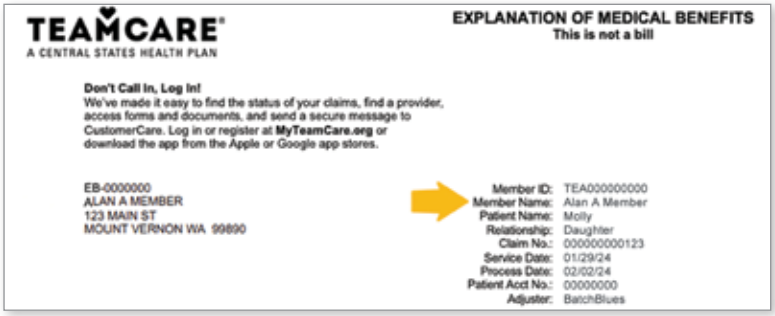
Visit **MyTeamCare.org**, click *Find A Provider*, and on the following screen click the link to the BCBS website. From there, choose PPO (Participating Provider Options) and enter your location.

If you are checking to see if your existing provider is in the network, search by the doctor's name, not by the medical group's name.



How do I read this EOB?

After your claim is processed, you'll receive an Explanation of Benefits (EOB) that details what was paid and, if a claim was denied, the reason why. An EOB is not a bill! It's a good idea to review your EOB carefully and compare it to the billing statement from your provider.



TEAMCARE
A CENTRAL STATES HEALTH PLAN

EXPLANATION OF MEDICAL BENEFITS
This is not a bill

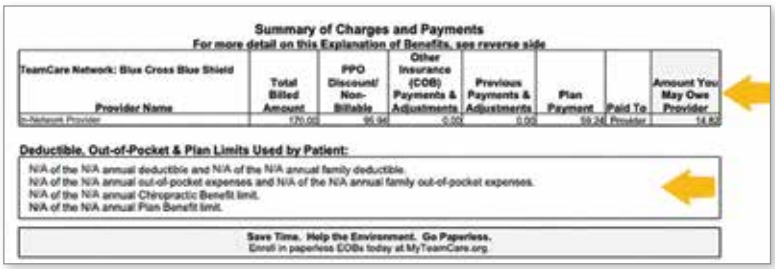
Don't Call In, Log In!
We've made it easy to find the status of your claims, find a provider, access forms and documents, and send a secure message to CustomerCare. Log in or register at **MyTeamCare.org** or download the app from the Apple or Google app stores.

EB-0000000
ALAN A MEMBER
123 MAIN ST
MOUNT VERNON WA 99890

Member ID:	TEA000000000
Member Name:	Alan A Member
Patient Name:	Molly
Relationship:	Daughter
Claim No.:	000000000123
Service Date:	01/29/24
Process Date:	02/02/24
Patient Acct No.:	00000000
Adjuster:	BatchBlues

1. In this section you'll see who was treated, and the service date(s). You'll also find an assigned claim number to use when referencing your claim, and the time that status was updated.

   To the left you'll find Member Information concerning the covered person.



Summary of Charges and Payments
For more detail on this Explanation of Benefits, see reverse side

TeamCare Network: Blue Cross Blue Shield Provider Name	Total Billed Amount	PPO Discount/ Non-Billable	Other Insurance (COB) Payments & Adjustments	Previous Payments & Adjustments	Plan Payment	Paid To	Amount You May Owe Provider
In-Network Provider	170.00	95.94	0.00	0.00	59.24	Provider	14.82

Deductible, Out-of-Pocket & Plan Limits Used by Patient:

N/A of the N/A annual deductible and N/A of the N/A annual family deductible.
N/A of the N/A annual out-of-pocket expenses and N/A of the N/A annual family out-of-pocket expenses.
N/A of the N/A annual Chiropractic Benefit limit.
N/A of the N/A annual Plan Benefit limit.

Save Time. Help the Environment. Go Paperless.
Enroll in paperless EOBs today at MyTeamCare.org

2. This is where TeamCare helps you get a complete view of your charges in detail. You'll find the total billed amount, any amount discounted by TeamCare, and the amount paid for by TeamCare according to your plan's coverage. In the final box, you'll see the amount you may still have to pay to the provider.

   The next section details the amount this claim has contributed to your annual deductible and out-of-pocket limit.

APPEAL PROCEDURES

You are entitled to appeal this benefit determination if you do not agree with the decision concerning your benefit claim. If you choose to file an appeal, you must file a written appeal and send it to TeamCare within 180 days from your original benefits determination. You may file an appeal by printing and completing the form which is available on TeamCare's website (MyTeamCare.org) or you may contact TeamCare by letter. If you file your appeal by letter, this letter must contain: (1) member's name and address; (2) member's identification number; (3) patient's name; (4) claim number(s); (5) appellant's name; and (6) EXACT reason(s) you are dissatisfied.

TeamCare has a two-step appeals process. If your first appeal is denied, you have the right to file a second and final appeal. If you choose to file a second level appeal, you must file your second appeal within 180 days from the day you are notified that your first appeal was denied. If your second and final appeal is denied you will have the right to bring suit under Section 502(a) of ERISA in an attempt to recover benefits due under the terms of the Plan, enforce rights under the terms of the Plan, or to clarify rights to future benefits under the terms of the Plan.

An internal rule or guideline may have been relied upon in making your benefit determination. If so, a copy of such rule or guideline will be provided free of charge to you upon written request. Your benefit determination may have been based on a determination that the treatment was not medically necessary or on a determination that the treatment constituted experimental treatment. If so, an explanation of the scientific or clinical judgment for this determination will be provided to you free of charge upon written request.

IMPORTANT NOTICE: The above deadlines for appeals have been extended due to the COVID-19 outbreak. The deadlines are now subject to a deadline that ends as of the earlier of: (a) 1 year from the date the deadline would have occurred on or after March 1, 2020, absent the extension relief; or (b) 60 days after the announced end of the COVID-19 National Emergency. On the applicable date, any deadlines for appeals with periods that were extended will resume. In no case will the extension of time exceed 1 year. For further information on this topic, please visit MyTeamCare.org/covid-19-extension or call us at 800-TEAMCARE (832-6227).

Requests for appeals, explanations, or guidelines should be directed to: Research and Correspondence Department
TeamCare – A Central States Health Plan
PO Box 5126
Des Plaines IL 60017-5126

3. If you suspect any billing or coverage errors you have two ways to take action. You can contact your healthcare provider directly, or complete and submit an appeals form by mail or through the Message Center within 180 days. To download an appeals form and learn more about appealing a claim, visit **MyTeamCare.org**.

I went to the doctor, and received a bill, how do I know I'm being charged correctly?

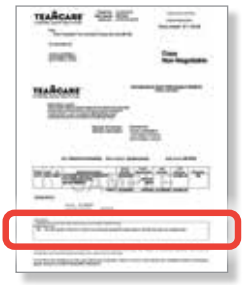
Your proof as to what you will owe for any service will be listed on your EOB.

If you are being billed for more than what is listed on your TeamCare EOB, you should call the doctor's billing office to discuss. Never pay more than what is listed—you can send the billing office a copy of your explanation of benefits as proof of what they can bill you for.

How do I ensure I get my Short-Term Disability Benefit?

Here are a few tips:

- Please make sure that all three sections on the form are entirely completed before submitting.
    - This includes filling it in with actual dates, not TBD, unknown, or "upon next visit," which can delay the process.
- If you live in California, Rhode Island, New York, or New Jersey, or if you work for UPS or TForce, you will have different requirements for filing. Please see the Short-Term Disability section for details.
- Once Short-Term Disability is approved, you will receive weekly benefit checks attached to an EOB. Under the payment information on the EOB, there will be an update as to when automatic payments will end. A Continuation Form should be submitted if you will need Short-Term Disability benefits beyond that date.
- Please see the Short-Term Disability section of this handbook for more instructions.



Do I have to use a mail order pharmacy?

If you are prescribed a long-term maintenance medication, you should use Maintenance Choice or CVS/Caremark Mail Service Pharmacy by the third fill, or the prescription will be subject to a 50% co-insurance payment and the plan limit on the maximum co-payment per prescription will not apply.

Do I have to use generic medications?

If you purchase a brand-name drug when a generic equivalent is available, you will pay your generic co-insurance plus the difference in cost between the brand-name and the generic drug. The limit on the maximum co-payment per prescription does not apply for brand-name drugs when a generic equivalent is available. Please refer to your Plan Benefit Profile for specific coverage.

What is not covered under my TeamCare Prescription Benefit?

TeamCare does not cover medication or supplies ordered from outside the United States, over the counter medications, vitamins, or dietary supplements. For a complete listing of non-covered items under your Prescription Benefit, please refer to your Summary Plan Description.

Are Department of Transportation (DOT) physicals or executive exams covered under my Wellness Benefit?

No, TeamCare does not cover any work-related physicals

Does TeamCare cover vaccines?

Yes, TeamCare covers most vaccines including the Rotavirus vaccine for children under age 26, and Gardasil for children between ages 9 and 25. There is no deductible for the Well Child Exam or immunizations for children. TeamCare does not, however, cover required immunizations for international travel. Contact TeamCare for a full list of covered vaccinations.

Additional FAQs can be found in the **Health Fund: TeamCare** and **Pension** sections.

Helpful Links

Below are some frequently used forms and applications. For additional forms and documents, please visit **MyTeamCare.org** or **MyCentralStatesPension.org**.

Short-Term Disability Form and Instructions:
MyTeamCare.org/Help/Short-Term-Disability

Life Insurance Beneficiary Form:
MyTeamCare.org/-/media/Files/Forms-and-Documents/Members/Life-Insurance/li-beneficiary-designation.pdf

Pension Benefits Application:
MyCentralStatesPension.org/Benefit-Applications/How-to-Apply-for-Retirement-Benefits

LOGO - FPO