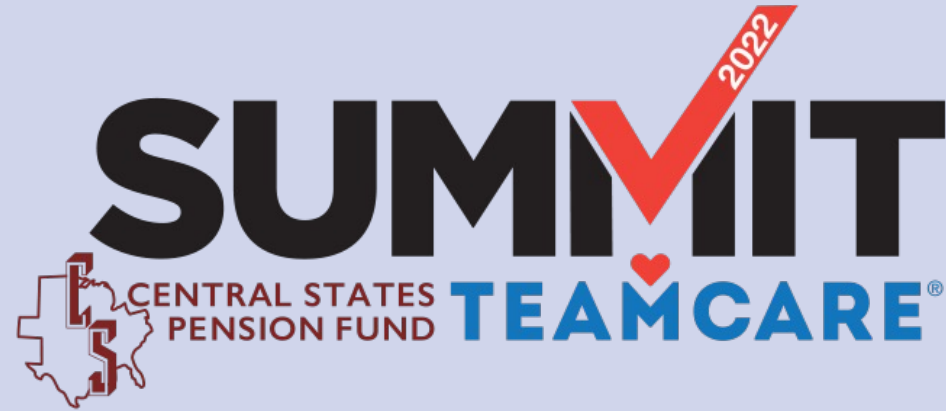


TEAMCARE® Benefits Deep Dive

Presenters: Juan J Beatón, Manager, H&W Group
Laura Kallio, Manager, CustomerCare Group

October 13, 2022



- SHORT-TERM DISABILITY
- EXTENSION OF BENEFITS
- LIFE INSURANCE
- FAMILY PROTECTION BENEFIT

SHORT-TERM DISABILITY (STD)



SHORT-TERM DISABILITY

Requirements

- The benefit only applies to the Participant
- Must be disabled from a non-work-related injury/illness or pregnancy while under regular care from a doctor*
- Actively employed with coverage by the plan at the beginning of the disability
- Employer Pay Obligation (EPO) typically 4 weeks of payments

*STD benefits are not payable for cosmetic or dental procedures.

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.	Call 800-533-0550 or email tfleave@tforcefreight.com so that your leave can be opened.	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 your disability check comes directly from the state and not from TeamCare.

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.

All Members Who Work in California or Rhode Island:

Submit a claim through the state's short-term disability program:

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



SHORT-TERM DISABILITY - APPLICATION PROCESS

The STD form has three sections that must be completed by the following:

- Member
- Doctor
- Employer

UPS employees must also contact The Hartford

Remember, STD benefits for New York, New Jersey, Rhode Island and California are handled differently.

NOTE: In addition to completing and returning this form to TeamCare:
 • **UPS employees must** call The Hartford at 866-825-0186 or visit abilityadvantage.thehartford.com to initiate your leave.
 • **TForce Freight employees must** call Lifeworks at 800-533-0550 or email tffleave@tforcefreight.com to initiate your leave.

SHORT-TERM DISABILITY CLAIM FORM - INITIAL REPORT OF DISABILITY

FORM MUST BE COMPLETED IN FULL BEFORE PAYMENT IS CONSIDERED

Remit To: TeamCare, PO Box 5107 Des Plaines IL 60017-5107 or Fax Form To: 847-518-9757

SECTION 1 – PARTICIPANT'S INFORMATION PLEASE PRINT

Participant's Identification Number: 8 0 6		Participant's Full Name:		Date of Birth:
Participant's Complete Address:			Employer:	
If accident related, please answer the following questions:	Date of Accident:	Where did the accident occur? check one <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other		
	How did the accident occur? _____			
Is your disability in any way work related? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please explain: _____				
***If you have been denied by Workers' Compensation, attach a copy of the denial.				
Authorization: I hereby authorize any doctor, hospital, or insurance company to furnish and disclose all known facts.				
Signature of Participant		Participant's Phone Number		Date

SECTION 2 – PHYSICIAN'S STATEMENT PLEASE PRINT

Patient's Name:	Date Disability Began:	Diagnosis
DO NOT SUBMIT FORM BEFORE THIS DATE		
All dates of treatment for this disability:		Surgery date and procedure performed:
Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the treatment plan? For a pregnancy, please give the estimated delivery date: _____	Is condition due to patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date: _____	Briefly explain: _____	
ACTUAL OR ESTIMATED RETURN TO WORK DATE REQUIRED		
Actual return to work date: _____ OR Estimated return to work date: _____		
Physician's Signature:	Print Physician's Name:	Physician's Phone Number:
		Date Form Completed:

SECTION 3 – EMPLOYER'S STATEMENT PLEASE PRINT

What was the employee's last day paid or compensated (i.e., vacation)? Last day worked: _____	What date did the employee actually return to work? (Do not use a future date) _____
Was the employee on layoff? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of layoff: _____ Date recalled: _____	Has a claim been filed for Workers' Compensation related to this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer's Signature:	Print Employer's Name and Position:
Employer's Phone Number:	
Date Form Completed:	

REMINDERS:

- ❖ All three sections must be completed in their entirety, may be submitted separately
 - ❖ Member
 - ❖ Doctor
 - ❖ Employer

- ❖ Ensure that all the dates are actual dates and not TBD, unknown or upon next visit

Local Union
Claim No.

SHORT-TERM DISABILITY CLAIM FORM – REPORT OF CONTINUED DISABILITY

FORM MUST BE COMPLETED IN FULL BEFORE PAYMENT IS CONSIDERED

Remit To: TeamCare, PO Box 5107 Des Plaines IL 60017-5107 or Fax Form To: 847-518-9757

PARTICIPANT

Participant's Identification Number:

8	0	6																	
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Employer: _____

Full Name: _____ Participant's Address: _____

By signing below, I am certifying that I have not returned to work or retired:

Signature of Participant _____ Participant's Phone Number _____ Date _____

PHYSICIAN

Patient's Name: _____

Have any complications or other conditions arisen since the last medical update? Yes No

If yes, please explain: _____

Please list all dates of treatment related to this disability:

Office Visits: _____ Surgery/Hospital Date(s): _____

ACTUAL OR ESTIMATED RETURN TO WORK DATE REQUIRED

Actual Return to Work Date: _____ OR Estimated Return to Work Date: _____

Physician's Signature: _____ Print Physician's Name: _____

Physician's Phone Number: _____ Date Form Completed: _____

EMPLOYER

THIS SECTION REQUIRED ONLY IF PARTICIPANT HAS RETURNED TO WORK

What date did the employee actually return to work (do not use a future date)? _____ Please verify the last day paid or compensated (i.e., vacation)? _____

Employer Signature: _____ Printed Name: _____

Employer Phone Number: _____ Date Form Completed: _____

When is a continuation form needed?

It depends on the diagnosis, the original length of the disability and the physician's recommendation. Check the remarks section of the EOB.

The employer section is only required if the member has returned to work since the inception of the original disability.

OTHER STD TIPS/INFORMATION

- The end date for the STD benefit can be found in the remarks section of the EOB.
- A continuation form is needed in order to obtain additional benefits beyond the end date.
- Processing time is normally 7 days from receipt.
- STD benefits are paid via checks.
- STD is only payable on work comp after 5 years of the event or upon receipt of an agreement to reimburse.
- If the employer has a sick leave pay obligation, it must be reported in order for STD benefits to commence.

STD -- EOB COMMENTS

From	Year	To	Benefit Description	Gross Benefit	FICA / Adjustments	Net Amount	YTD Amount	Remarks
09/19	2022	10/09	ACCIDENT SICKNESS BENEFIT FICA WITHHOLDING ADJUSTMENTS	\$213.97	\$16.36 \$0.00		\$789.00	JA BD
Totals				\$213.97	\$16.36	\$197.61	\$789.00	

Explanation:

Cause: **ILLNESS**
 Last Day Worked: **08/04/22**
 Initial Physician Visit: **08/04/22**

Remarks

Payments end 10/28: Then have Dr provide Estimated return to work date	
JA You have been placed on automatic benefits. Please see explanation below.	
BD Per Plan Section 12.02 (b) (1): Short-Term Disability benefits for illness begin on the 8th day from your disability date.	

SHORT-TERM DISABILITY - PAYMENT PERIOD

Benefits Begin

- Non-work-related injury – 1st Day

- Illness or pregnancy
 - UPS and all others – 8th day
 - TForce Freight – 4th business day

SHORT-TERM DISABILITY – PAYMENT PERIOD

Benefit date based on medical treatment

Participant first received medical attention by a physician within one (1) day before or three (3) days after the date of disablement specified by the physician as resulting from the illness or pregnancy.

If the Covered Participant did not receive medical attention within these time frames, benefits shall accrue from the eighth (8th) day after the date medical attention is received from a physician.

SHORT-TERM DISABILITY – PAYMENT PERIOD

Benefits Cease

The earlier of:

- The date you are no longer disabled
- Lack of medical treatment
- After the maximum weeks of payment elapse, either 20 or 26 weeks
- Your retirement date (Retiree plans do not include STD benefits)

SHORT-TERM DISABILITY BENEFIT - AMOUNT

STD benefit amount is dependent on the participant's Plan

- Fixed amounts range between \$100 and \$400 per week
- UPS and TForce Plans utilize a percentage of the weekly base pay formula (up to \$500)
 - Fourth Quarter wages are not utilized in the calculation

Where to find the benefit amount of the Plan:

- Plan Benefit Profile (PBP)
- Summary Plan Description (SPD)
- Plan Document

The above documents can be obtained at MyTeamCare.org



PLAN BENEFIT LIMIT (ANNUAL)	None	PLAN DEDUCTIBLE (ANNUAL)	\$100 per Individual \$200 per Family	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)	\$1,000 per Individual \$2,000 per Family
TEAMCARE PPO OFFICE VISIT	\$10 copayment for in-network office visit (Plan Deductible does not apply)				
MEDICAL PLAN BENEFITS	For further information, including a full Summary Plan Description (SPD), visit our website at MyTeamCare.org .				
TeamCare Wellness A TeamCare Physician must be used.	♦ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.				
Teladoc Telemedicine Benefit Teladoc.com/TeamCare 800-TELADOC (835-2362)	♦ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, dermatology and behavioral health at no cost (\$0 copay). Plan Deductible does not apply.				
CVS MinuteClinic CVS.com/MinuteClinic 866-389-ASAP (2727)	♦ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost (\$0 copay). Plan Deductible does not apply.				

PRESCRIPTION BENEFIT	RETAIL PHARMACY STORE: \$5 copayment for short-term prescription fills and non-maintenance medications.	MAINTENANCE CHOICE / MAIL SERVICE PHARMACY: \$0 copayment for a 90-day supply of medication. Under Maintenance Choice, Member can receive a 90-day supply of medication at a local CVS pharmacy store.
	After the second fill of the same prescription, long-term maintenance medications must be filled through Maintenance Choice or CVS/Caremark Mail Service Pharmacy or be subject to a 50% co-payment if filled through the Retail Pharmacy Program. On both Retail and Mail Order, if a generic equivalent is available, the Member must take the generic or be responsible for the cost difference plus any copayment. Plan Deductible does not apply. The Medical Out-of-Pocket Expense Limit does not apply.	
	TeamCare does not cover drugs or medicines on a formulary exclusion list compiled by CVS/Caremark. The formulary exclusion list is available at MyTeamCare.org or by contacting CVS/Caremark.	
DENTAL BENEFITS	Annual Dental Maximum: None Annual Dental Deductible: None Preventive Services: 100% Diagnostic and Restorative: 100% Crown and Bridge Work: 80% Dentures (Full and Partial): 100% Orthodontic (Child/Adult Child): 50% Orthodontic Maximum (Child/Adult Child): No Lifetime Maximum	TeamCare offers a voluntary network through Humana Dental that provides negotiated discounts and protection from balance billing. To find a provider, call 800-592-3112 or visit: humanadentalnetwork.com .

Hospital Expense Benefit
Surgical and Maternity Benefit
Ambulance Service Benefit
Outpatient Accidental Bodily Injury
Lab Benefit 800-646-7788 labcard.com
Imaging Benefit To schedule a service call 877-674-0674
Outpatient Cancer Treatment Benefit
Hearing Aid Benefit
Chiropractic Benefit
Behavioral Health Benefits – Inpatient

SHORT-TERM DISABILITY BENEFITS (Member Only)

Benefit provides 60% of average weekly base pay up to \$500 per week for a maximum of 26 weeks; and includes continued coverage while on Short-Term Disability.

LIFE INSURANCE BENEFITS

Member Death	Full-Time Plan U1: 2080 hours x hourly wage to maximum of \$100,000 (min of \$40,000)	Part-Time Plan U3: 1040 hours x hourly wage to maximum of \$100,000 (min of \$40,000)
Accidental Death	Full-Time Plan U1: 2080 hours x hourly wage to maximum of \$100,000 (min of \$40,000)	Part-Time Plan U3: 1040 hours x hourly wage to maximum of \$100,000 (min of \$40,000)
Spouse Death *	\$5,000	
Child/Adult Child Death *	\$2,500	
Total Permanent Disability (Waiver of Premium)	\$16,000	

* Dependent Life Insurance Benefits are only payable on Covered Dependents.

Behavioral Health Benefits – Outpatient	♦ \$10 copayment for in-network office visit (Plan Deductible does not apply). Otherwise, after Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Major Medical Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.

TeamCare Summary Plan Description for further information.
MyTeamCare.org or 800-TEAMCARE For further benefit information, visit our website at MyTeamCare.org or call CustomerCare at 800-TEAMCARE (832-6227).

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



SHORT-TERM DISABILITY BENEFIT – NEW CLAIMS

Return to work after initial claim and new STD claim

New non- related illness or injury

❖ Must return to work for at least one day

Same illness or injury

❖ Must return for the 30 consecutive calendar days of actual work (TForce Freight requires return for 14 days).

❖ Vacation, sick leave and personal days do not count

BENEFIT EXTENSIONS



BENEFIT EXTENSIONS

- Available to Participants if they remain disabled after exhausting STD benefits
 - No other coverage available from any source
 - Only for disabling diagnosis
 - Coverage for participant only
 - Eligibility dependent on active plan

- Two Types
 - Basic Benefit Extension (Up to 13 weeks)
 - Major Medical Extension (Up to an additional 24 months)
 - Ends with coverage by Medicare or any other coverage source

BENEFIT EXTENSIONS TIPS/INFORMATION

- The 13-week basic extension provides a benefit level as the plan immediately preceding the extension but **only** provides coverage for the disabling diagnosis.
- The 24-month major medical extension provides coverage at the major medical benefit rate as the plan immediately preceding the extension but **only** provides coverage for the disabling diagnosis. Additionally, there isn't an OOP max under the major med extension.
- Members must apply for the extensions, they are not automatically granted.

APPLICATION FOR EXTENSION OF COVERAGE

FORM MUST BE COMPLETED IN FULL BEFORE PAYMENT IS CONSIDERED

Remit To: TeamCare, PO Box 5107 Des Plaines IL 60017-5107 or Fax Form To: 847-518-9757

PARTICIPANT'S INFORMATION PLEASE PRINT

Participant's Identification Number: 8 0 6	Participant's Full Name:
Participant's Complete Address:	
Applicant's Name: (if other than Participant)	Applicant's Date of Birth:

THE EXTENSION OF COVERAGE IS ONLY AVAILABLE IF CERTAIN CRITERIA IS MET. IF APPROVED, BENEFITS ARE ONLY FOR THE PERSON WHO IS TOTALLY DISABLED AND COVERS ONLY THE SPECIFIC MEDICAL CONDITION THAT HAS TOTALLY DISABLED HIM OR HER. ANOTHER OPTION THAT MAY BE AVAILABLE FOR CONTINUED COVERAGE IS COBRA SELF-PAYMENTS. A COBRA NOTICE HAS BEEN OR WILL BE SENT REGARDING ELIGIBILITY TO MAKE COBRA SELF-PAYMENTS.

****** PLEASE BE SURE TO HAVE PAGE 2 COMPLETED BY YOUR PHYSICIAN ******

SECTIONS 1, 2, 3 and 4 TO BE COMPLETED IN FULL BY THE PARTICIPANT

- Is your spouse employed? Yes No If yes, please complete the following:
Employer's Name: _____ Name of Insurance Carrier: _____
- IF YOUR SPOUSE HAS NO INSURANCE COVERAGE THROUGH HIS OR HER EMPLOYER OR IF THE APPLICANT IS NOT COVERED UNDER THE ABOVE NAMED INSURANCE, A LETTER IS REQUIRED FROM THE EMPLOYER VERIFYING NO INSURANCE COVERAGE AND THE REASON FOR NO COVERAGE.**
I have attached a letter from my spouse's employer verifying the applicant is not covered under insurance through my spouse:
 Yes No
- Is the applicant covered under Medicare or any other medical insurance plan? Yes No
If yes, please complete the following:
Name of insurance carrier: _____ Date coverage began: _____
- Has the applicant applied for a Social Security Disability Award? Yes No
If yes, please check the status of the award: APPROVED STILL UNDER REVIEW DENIED UNDER APPEAL
PLEASE SEND A COPY OF ALL DOCUMENTS THAT APPLY TO YOUR SOCIAL SECURITY APPLICATION, INCLUDING A MEDICARE CARD.

I CERTIFY THAT ALL OF THESE STATEMENTS ARE TRUE AND CORRECT: _____
Participant's Signature

APPLICATION FOR EXTENSION OF COVERAGE

FORM MUST BE COMPLETED IN FULL BEFORE PAYMENT IS CONSIDERED

Remit To: TeamCare, PO Box 5107 Des Plaines IL 60017-5107 or Fax Form To: 847-518-9757

PARTICIPANT'S INFORMATION PLEASE PRINT

Participant's Identification Number: 8 0 6	Participant's Full Name:
Participant's Complete Address:	

PLEASE HAVE YOUR PHYSICIAN COMPLETE THIS FORM IN FULL

IN ORDER TO PROCESS OUR PARTICIPANT'S REQUEST FOR AN EXTENSION OF BENEFITS, WE NEED A CURRENT STATEMENT FROM HIS OR HER PHYSICIAN REGARDING THE EXTENT AND DEGREE OF THE DISABLING CONDITION.

Patient's Name:	Patient's Date of Birth:
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- Disabling Diagnosis: _____ ICD.9 CODE: _____
- Is the patient disabled from work? Yes No
- Is the patient disabled from normal daily activities? Yes No
- What is the extent/degree of the disability? _____
Prognosis? _____
- What is the anticipated duration of the disability and the treatment plan? Please attach the treatment plan if necessary.

Physician's Signature: _____ Printed Name: _____
Physician's Phone Number: _____ Date Form Completed: _____



LIFE INSURANCE BENEFIT

- The participant/dependent 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 a Participant dies because of an accident, their beneficiary may receive the Accidental Death Benefit in addition to the Life Insurance Benefit.
 - The 31-day grace period does not apply to this benefit.
 - The cause of death, will determine if an accidental death benefit applies.

LIFE INSURANCE BENEFIT

- Life Insurance benefit amount is dependent on the Participant's Plan
 - Fixed amounts range between \$4,000 and \$50,000 for a participant death
 - Fixed amounts range between \$750 and \$5,000 for a dependent death
 - UPS and TForce Plans utilize a weekly base pay formula (min \$40k / max \$100k)

- Here is how to find the benefit amount of the Plan:
 - Plan Benefit Profile (PBP)
 - Summary Plan Description (SPD)
 - Plan Document

The above documents can be obtained at MyTeamCare.org

TEAMCARE® - A CENTRAL STATES HEALTH PLAN
NOTICE OF CLAIM

PARTICIPANT'S LOCAL NO.: _____ DATE: _____

In order to apply for **DEATH** and **ACCIDENTAL DEATH BENEFITS**, please complete this form and follow the instructions set forth below:

(Please type or print)

1	Participant's Name: (Last) (First) (MI)	Date of Birth:	Participant ID Number:
	Participant's Address (No. Street, City, State, Zip Code): *	Participant's Phone:	Occupation:

2	Name and Address of Employer:	Date Last Worked:
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3	Was Participant on Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, send us a copy of your Medicare Card
---	---

4	If the Participant's death certificate indicates divorced, please give date:
---	--

5	Type of Claim (Check One)	<input type="checkbox"/> Participant Death <input type="checkbox"/> Participant Accidental Death <input type="checkbox"/> Dependent Spouse Death <input type="checkbox"/> Dependent Child Death	<input type="checkbox"/> Participant Total & Permanent Disability (Under age 50 on date of disability) <input type="checkbox"/> Participant Total & Permanent Disability (Ages 50 thru 59 on date of disability)
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6	Name and Address of Applicant for Benefits:	Telephone No.:
		Relationship to Participant:

(If more than one applicant, use back of form)

7	Please attach the indicated documents to this Notice of Claim ALL DEATH CLAIMS MUST HAVE CERTIFIED DEATH CERTIFICATE <small>*Form is available from TeamCare by calling 800-TEAMCARE or visiting our website at MyTeamCare.org</small>	FOR PARTICIPANT DEATH Participant had Waiver of Premium: _____ Claim No.: _____ Participant was on TPD: _____ Claim No.: _____
		FOR ACCIDENTAL DEATH • Include police, autopsy and toxicology reports when available
		FOR DEPENDENT SPOUSE OR CHILD DEATH <ul style="list-style-type: none"> • Copy of Birth Certificate for Child Death • Copy of Marriage Certificate for Spouse Death Name: _____ Relationship to Participant: _____
		FOR PARTICIPANT TOTAL & PERMANENT DISABILITY / WAIVER OF PREMIUM <ul style="list-style-type: none"> • Claimant's/Employer's Statement Sections 1 and 2* • Doctor's Statement Section 3* • Copy of Social Security Award • Copy of Birth Certificate or Driver's License • Completed and Signed Health and Welfare Designation of Beneficiary Form* Date of Disability: _____

8	Mail this completed Notice of Claim with the requested Documents to: TEAMCARE - A CENTRAL STATES HEALTH PLAN LIFE INSURANCE DEPARTMENT PO BOX 5116 DES PLAINES, IL 60017-5116	_____ Signature of Applicant(s)
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LIFE INSURANCE

- Must apply for benefit
 - All claimants must submit an application
- Same application for all types

The life insurance form can be obtained at MyTeamCare.org



FAMILY PROTECTION BENEFIT



FAMILY PROTECTION BENEFIT - QUALIFICATIONS

- Upon the death of the Participant, the dependents eligible at the time of death may qualify for **free** TeamCare coverage for up to 5 years.
- The family protection eligibility review is automatically performed with the life insurance review.
- In order to qualify:
 - In the 24 months prior to the date of death, non-emergency care must be received by a provider in the TeamCare network.
 - The dependent must be an eligible dependent on the date of death
 - Must not have other health coverage

FAMILY PROTECTION BENEFIT

- Coverage may be provided for a maximum of 5 years.
- The Family Protection benefit plan will have the same benefits as the active plan immediately preceding the Family Protection plan.
- Some limitations/exclusions:
 - ❖ Required to use providers in the TeamCare network for non-emergency care
 - ❖ No life insurance benefit
 - ❖ No short-term disability benefit

FAMILY PROTECTION BENEFIT

Benefits cease upon the earliest of one of the following:

- Upon receiving coverage for the maximum five-year period
- Obtaining health coverage under another plan
- Loss of dependent child status (e.g. turning 26)
- Spouse remarries
 - If the spouse remarries, the children remain eligible for family protection.

APPEALS

Submitting The Appeal:

ONLINE



Logging in at
MyTeamCare.org and
select the Message Center
found on your Dashboard

FAX



847-518-9794

MAIL



TeamCare
A Central States Health Plan
PO Box 5126
Des Plaines, IL 60017-5126

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

MORE SUMMIT TO DO AT THE SUMMIT

Other Sessions you may want to attend:

What's New with TeamCare in 2023

Retiree Health Plan Eligibility

MyTeamCare.org

If you have specific member questions to discuss visit our help desk in River breakout room. Fund staff are available to assist throughout the day.

THANK YOU!!

