TEAMCARE®
A CENTRAL STATES HEALTH PLAN

UPS RETIREE PLANS

Plan RU (Full-Time UPS) and Plan RV (Part-Time UPS) Benefit Profile
Coverage Period: Beginning on or after 03/01/2018

PLAN BENEFIT LIMIT (ANNUAL)	PLAN DEDUCTIBLE (ANNUAL)	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
$200,000 per Individual	$100 per Individual $200 per Family	$1,000 per Individual $2,000 per Family

TEAMCARE PPO OFFICE VISIT	OUT-OF-NETWORK PENALTY
$20 copayment for in-network office visit (Plan Deductible does not apply)	For non-emergency medical care, your cost is 10% greater than an in-network provider plus all charges above Reasonable and Customary allowances.

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.
Hospital Expense Benefit	♦ After Plan Deductible, 80% of semi-private room rate with no maximum day limit; then 100% after Medical Out-of-Pocket Expense Limit is met.
Surgical and Obstetrical Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
Ambulance Service Benefit	♦ After Plan Deductible, 80% of covered charges subject to medical necessity review; then 100% after Medical Out-of-Pocket Expense Limit is met.
Outpatient Accidental Bodily Injury Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.
TeamCare Lab Benefit For more information call 800-646-7788 or visit **labcard.com**	♦ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% (Plan Deductible does not apply) provided the physician submits the requisition through Quest Lab Card. If a physician does not submit specimens through Quest Lab Card, simply visit a Quest Diagnostics collection site. If you do not use the TeamCare Lab Benefit, after Plan Deductible the outpatient lab benefit is 80%; then 100% after Medical Out-of-Pocket Expense Limit is met.
TeamCare Imaging Benefit To schedule a service call 877-674-0674	♦ The TeamCare Imaging Benefit is a voluntary program that covers MRI, CT, and PET scans at 100% (Plan Deductible does not apply) provided that the scans are scheduled directly through US Imaging. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (including x-rays) is paid under Major Medical at 80%; then 100% after Medical Out-of-Pocket Expense Limit is met.
Outpatient Cancer Treatment Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met for outpatient nuclear therapy, radiation therapy, chemotherapy, x-ray and lab procedures for the treatment of cancer. If treatment is provided in a doctor's office, a $20 TeamCare office visit copayment is due.
Hearing Aid Benefit	♦ After Plan Deductible, 100% of covered charges to a maximum of $1,000 per ear ($2,000 total) every 36 months. The Medical Out-of-Pocket Expense Limit does not apply.
Chiropractic Benefit	♦ After Plan Deductible, 70% of covered charges to a maximum $800 per person per calendar year. The Out-of-Pocket Expense Limit does not apply.
Behavioral Health Benefits – Inpatient	♦ After Plan Deductible, 80% of covered charges to a maximum 21 days per person per calendar year; maximum 42 days per person Lifetime. The Medical Out-of-Pocket Expense Limit does not apply.
Behavioral Health Benefits – Outpatient	♦ After Plan Deductible, 80% of covered charges to a maximum 30 visits per person per calendar year. The Medical Out-of-Pocket Expense Limit does not apply.
Major Medical Benefit	♦ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.

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TEAMCARE Rx PRESCRIPTION DRUG BENEFIT

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

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

MAINTENANCE CHOICE / MAIL SERVICE PHARMACY:
20% copayment to a maximum copayment of $200 per prescription for a 90-day supply of medication. Under Maintenance Choice, Member can receive a 90-day supply of medication at a local CVS pharmacy store.

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

TeamCare does not cover drugs or medicines on a formulary exclusion list compiled by CVS/Caremark. The formulary exclusion list is available at MyTeamCare.org or by contacting CVS/Caremark.

DENTAL BENEFITS

You may use any dental provider for services without an out-of-network penalty. However, TeamCare does offer a voluntary dental network through TeamCare*Dental*.

The Dental Plan Benefit maximums are per person per calendar year.

Annual Dental Maximum	$1,500*
Annual Dental Deductible	None
Preventive Services	100%
Diagnostic and Restorative	100%
Crown and Bridge Work	80%
Dentures (Full and Partial)	100%
Orthodontic (Child/Adult Child)	100%
Orthodontic Maximum (Child/Adult Child)	$1,500 Lifetime Maximum

** Annual Dental Maximum does not apply to children under age 19.*

TeamCare offers a voluntary network through Humana Dental that provides negotiated discounts and protection from balance billing – stretching the Annual Dental Maximum further.

To find a provider, call 800-592-3112 or visit: **humanadentalnetwork.com**.

VISION BENEFITS

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

Vision Plan Benefits do not have an out-of-network penalty but there is a maximum reimbursement per service as indicated.

The Vision Plan Benefits are payable once every 12 months.

TeamCare*Vision* is a voluntary vision network offered through EyeMed Vision Care:

Routine Eye Exam	$10 copayment
Frames	$0 copayment up to $150 allowance
Lenses (per pair)	$0 copayment
Contacts (in lieu of glasses)	$0 copayment up to $120 allowance

For a directory of EyeMed providers in the **Select** network, call 866-723-0514 or visit **eyemedvisioncare.com**.

For non-EyeMed providers, the maximum reimbursement for Vision Plan Benefits is:

Routine Eye Exam	$50.00 *
Frames	$75.00
Lenses (per pair)	$50.00
Bi-Focal Lenses (per pair)	$50.00
Tri-Focal Lenses (per pair)	$50.00
Lenticular Lenses (per pair)	$60.00
Contacts (in lieu of glasses)	$80.00

* *Routine Eye Exam charges from non-EyeMed providers for Covered Dependents under age 19 will be subject to Reasonable and Customary allowances and paid at 80%.*

SHORT-TERM DISABILITY BENEFITS (Member Only)

Your Plan does not have Short-Term Disability Benefits.

LIFE INSURANCE BENEFITS

Your Plan does not have Life Insurance Benefits.

ASKMAYO CLINIC

Members have access to the AskMayo Clinic nurse line which provides reliable health information 24 hours a day. Experienced registered nurses, who draw on the resources of Mayo Clinic, are available to answer your health-related questions. Health information is only a phone call away – 800-700-MAYO (6296).

TEAMCARE FAMILY PROTECTION BENEFIT

Your Plan does not have the Family Protection Benefit.

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.