TEAMCARE
A NATIONAL TEAMSTER HEALTH PLAN

UPS TEAMCARE PLAN BENEFIT PROFILE

PLAN BENEFIT LIMIT	PLAN DEDUCTIBLE (ANNUAL)	OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
None	None per Individual; None per Family	$1,000 per Individual; $2,000 per Family

TEAMCARE PPO OFFICE VISIT	OUT-OF-NETWORK PENALTY
$10 co-payment for in-network office visit	For non-emergency medical care, your cost is 10% greater than an in-network provider plus all charges above Reasonable and Customary, and the loss of TeamCare Family Protection Benefit.

MEDICAL PLAN BENEFITS		*For further information, including a full Summary Plan Description (SPD), visit the Fund's website at MyTeamCare.org.*
TeamCare Wellness – Adult A TeamCare Physician must be used.	♦	A $10 TeamCare office visit co-payment covers an Annual Physical Exam (Plan Deductible does not apply). After Plan Deductible, the Women's Health Benefits (pap test and mammogram) are covered at 100%. After Plan Deductible, all routine screening tests and procedures are covered at 80%; then 100% after Out-of-Pocket Expense Limit is met. Routine immunizations are not covered.
TeamCare Wellness – Child and Adult Child A TeamCare Physician must be used.	♦	A $10 TeamCare office visit co-payment covers wellness exams and routine immunizations at 100% (Plan Deductible does not apply).
Hospital Expense Benefit	♦	After Plan Deductible, 100% of semi-private room rate with no maximum day limit.
Surgical and Obstetrical Benefit	♦	After Plan Deductible, 100% of covered charges.
Ambulance Service Benefit	♦	After Plan Deductible, 100% subject to medical necessity review.
Outpatient Accidental Bodily Injury Benefit	♦	After Plan Deductible, on the first day of treatment, 100%.
TeamCare Lab Benefit For more information call 1-800-646-7788 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 Out-of-Pocket Expense Limit is met.
TeamCare Imaging Benefit For more information call 1-877-674-0674 or visit **usimagingnetwork.com**	♦	The TeamCare Imaging Benefit is a voluntary program that covers only 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 Out-of-Pocket Expense Limit is met.
Outpatient Cancer Treatment Benefit	♦	After Plan Deductible, 100% of covered charges 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 $10 TeamCare office visit co-payment is due.
Organ Transplant Benefit and Organ Donor Benefit	♦	Prior to an Organ Transplant, a predetermination of benefits must be submitted through the TeamCare network for review. The Organ Donor Benefit covers charges for medical treatment the donor receives for the donation of an organ.
Hearing Aid Benefit	♦	After Plan Deductible, a maximum of $1,000 per ear ($2,000 total) every 36 months. The Out-of-Pocket Expense Limit does not apply.
Chiropractic Benefit	♦	After Plan Deductible, 80% of covered charges to a maximum $1,000 per person per calendar year. The Out-of-Pocket Expense Limit does not apply.
Psychiatric, Alcoholism and Drug Abuse Treatment – 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 Out-of-Pocket Expense Limit does not apply.
Psychiatric, Alcoholism and Drug Abuse Treatment – Outpatient	♦	After Plan Deductible, 80% of covered charges to a maximum 30 visits per person per calendar year. The Out-of-Pocket Expense Limit does not apply.
Major Medical Benefit	♦	After Plan Deductible, 80% of covered charges; then 100% after Out-of-Pocket Expense Limit is met.

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, Central States, Southeast and Southwest Areas Health and Welfare Fund, 9377 West Higgins Road, Rosemont, IL 60018-4938 or call Toll-Free 1-800-323-5000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444- 3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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TEAMCARE Rx PRESCRIPTION DRUG BENEFIT

For more information call 1-888-483-2650 or visit **caremark.com**

RETAIL PHARMACY STORE: Under Retail Pharmacy program, the Participant pays $5 co-payment for short-term prescription fills and non-maintenance medications. By the third fill of the same prescription, long-term maintenance medications must be filled through the CVS Caremark Maintenance Choice / Mail Service Pharmacy or be subject to a 50% co-payment if filled through the Retail Pharmacy Program.

MAINTENANCE CHOICE / MAIL SERVICE PHARMACY: Under the CVS Caremark Mail Service Pharmacy or Maintenance Choice, the Participant pays $0 co-payment. Under Maintenance Choice, Participant can receive a 90-day supply of medication at a local CVS pharmacy store.

If a generic equivalent is available, the Participant must take the generic or be responsible for the cost difference and the maximum prescription co-payment does not apply.

The Out-of-Pocket Expense Limit does not apply.

DENTAL BENEFITS

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

Annual Dental Deductible	None
Annual Dental Maximum	None
Preventive Services	100%
Diagnostic and Restorative	100%
Crown and Bridgework	80%
Dentures (Full and Partial)	100%
Orthodontic (Child/Adult Child)	50%
	No Lifetime Maximum

The Fund offers a voluntary network through Humana Dental (Group: TC60018) that provides negotiated discounts and protection from balance billing.

To find a provider, call 1-800-592-3112 or visit: **humanadentalnetwork.com**.

VISION BENEFITS

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

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

The Vision Benefits are payable once every 12 months.

The Fund offers TeamCare Vision - a voluntary vision network offered through EyeMed Vision Care (Advantage Plan):

- $10 Participant co-payment for routine eye exam, and
- $0 Participant co-payment for lenses (or contacts to a maximum $80 retail value), and
- $0 Participant co-payment for frames (to a maximum of $100 retail value).

For a directory of EyeMed providers in the Advantage Plan network, call 1-866-393-3401 or visit **eyemedvisioncare.com**.

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

Eye Exam	$25.00 **
Frames	$30.00
Lenses	$30.00
Bi-Focal Lenses	$40.00
Tri-Focal Lenses	$50.00
Lenticular Lenses	$60.00
Contacts	$60.00

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

SHORT-TERM DISABILITY BENEFITS

Also referred to as **Loss of Time** (Participant 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 max of $100,000 (minimum of $40,000) Part-Time Plan U3: 1040 hours x hourly wage to max of $100,000 (minimum of $40,000)
Accidental Death	Full-Time Plan U1: 2080 hours x hourly wage to max of $100,000 (minimum of $40,000) Part-Time Plan U3: 1040 hours x hourly wage to max of $100,000 (minimum of $40,000
Spouse Death ***	$5,000
Child/Adult Child Death ***	$2,500

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

ASKMAYO CLINIC

Participants 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 – 1-800-700-MAYO (6296).

TEAMCARE FAMILY PROTECTION BENEFIT

In the event of a Participant's death, the TeamCare Family Protection Benefit provides a maximum of five years of free coverage for the Covered Spouse and Dependents provided that during the two year period prior to death, TeamCare providers were used exclusively for all non-emergency care. Please refer to the SPD for further information.

MyTeamCare.org or 1-800-323-5000

We're here to help. For further benefit information on your benefits, visit the Fund's website at **MyTeamCare.org**. You can review detailed claims information, re-print your Explanation of Benefits, review benefit accumulators, download forms, and link to all of your TeamCare benefits and networks. You can also call the Fund at 1-800-323-5000 and speak to a Benefits Specialist. We are available to help from Monday through Friday 8:00 a.m. to 6:00 p.m. (CST).

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.

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