TEAMCARE®
A CENTRAL STATES HEALTH PLAN

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Central States Health & Welfare Fund – Plan C4
Coverage Period: 01/01/2024 - 12/31/2024
Coverage for: You and Your Covered Dependents | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to MyTeamCare.org or call 800-TEAMCARE (832-6227). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 800-TEAMCARE to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 per Individual, $400 per Family. Does not apply to in-network office visits and in-network prescription benefits.	Generally you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care; lab services through QuestSelect; advanced imaging services through USIN; and services requiring a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,000 per Individual, $2,000 per Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Deductibles; in-network copayments; out-of-network penalty; chiropractic coinsurance; hearing aids; prescription drugs; dental & vision benefits; premiums; health care services this plan doesn't cover; and expenses not payable by the plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See MyTeamCare.org or call 800-TEAMCARE for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment per visit	30% coinsurance	Additional costs may be owed for medical services payable beyond the office visit (e.g. x-rays, injections, lab tests, etc.).
	Specialist visit	$20 copayment per visit		
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for bloodwork if through QuestSelect, otherwise 20% coinsurance.	30% coinsurance	For a QuestSelect provider, call QuestSelect Client Services at 800-646-7788 or visit questselect.com.
	Imaging (CT/PET scans, MRIs)	No charge if scheduled through USIN, otherwise 20% coinsurance.		For a USIN provider, you must schedule an appointment by calling 877-674-0674.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at MyTeamCare.org or caremark.com Certain states have laws that may affect your Prescription Benefit. Visit MyTeamCare.org/statelaws for more information.	Generic drugs	25% coinsurance Retail 20% coinsurance Mail Order Member's maximum expense is $200 copayment per prescription. However, if you purchase a brand name prescription when a generic is available, you are responsible for the cost difference plus any copayment and the $200 copayment per prescription maximum does not apply.	25% coinsurance of reasonable and customary charges and Mail Order is not available. The $200 copayment per prescription maximum does not apply.	By the third fill, maintenance medications must be filled through the Caremark Mail Order Program / Maintenance Choice or be subject to a 50% copayment if filled through the Retail Card program. There are some non-preferred brand drugs that are excluded from coverage as determined by Caremark. For a list of these excluded drugs, visit our website at MyTeamCare.org. If you continue using one of these drugs after this date, you will be required to pay the full cost. Walmart and Amazon are not participating pharmacies.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	25% coinsurance Retail 20% coinsurance Mail Order $200 copayment	25% coinsurance of reasonable and customary charges and Mail Order is not available. The $200 copayment per prescription maximum does not apply.	If you use injectable medications, the plan provides a $1,000 per member per calendar year out-of-pocket maximum. Once the $1,000 out-of-pocket maximum is met, all in-network injectable medications will be paid by the Plan at 100%.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	Emergency care is paid the same as if in network. You may also be responsible for charges above allowed amounts.	If admitted, the emergency room services will be payable under the Hospital benefit. Additional costs may be owed for services payable beyond the urgent care visit (e.g. x-rays, lab).
	Emergency medical transportation	20% coinsurance		
	Urgent care	20% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% coinsurance	---------- None ----------
	Physician/surgeon fee	Physician fee: 20% coinsurance Surgeon fee: 10% coinsurance	Physician fee: 30% coinsurance Surgeon fee: 20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	$20 copayment for physician visit (deductible does not apply). Otherwise, 20% coinsurance.	30% coinsurance	---------- None ----------
	Inpatient Services	Facility Fee: No charge Physician Fee: 20% coinsurance	Facility Fee: 10% coinsurance Physician Fee: 30% coinsurance	---------- None ----------
If you are pregnant	Office Visits	$20 copayment for initial visit	30% coinsurance	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests). Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care Rehabilitation services Habilitation services Skilled nursing care Durable medical equipment Hospice services	20% coinsurance	30% coinsurance	Charges for services that are not considered Standard Medical Care, Treatment, Services or Supplies are not covered. In addition, Maintenance Care is not covered.
If your child needs dental or eye care	Children's eye exam	$10 copayment under the TeamCare Vision program.	Routine eye exam is 20% of reasonable and customary allowance.	If your plan provides Vision coverage, it is provided to covered children through age 25 and only once every 12 months. Also, in lieu of glasses, contact lenses are covered to $120 maximum. For TeamCare Vision providers, contact EyeMed at 866-723-0514 or eyemed.com.
	Children's glasses	$0 copayment for Lenses, and $0 copayment for Frames. Standard lenses and frames up to $150 are included in the copayment. The member is responsible for any difference in cost.	TeamCare will pay a maximum of $75 for frames and $50 for standard lenses. Any charges above these maximums paid by TeamCare will be the responsibility of the member.	
	Children's dental check-up	No charge	TeamCare will pay 100% of reasonable and customary allowance. You would be responsible for charges above reasonable and customary.	If your plan provides Dental coverage, a Dental check-up is provided to covered children through age 25 only once every six months. For TeamCare Dental providers call 800-592-3112 or visit humanadentalnetwork.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Charges for medical services that are not considered Standard Medical Care, Treatment, Services or Supplies.
- Charges for stand-by surgeons.
- Cosmetic Surgery (except to the extent it's required due to an accidental bodily injury)

  Surgical procedures that are considered Cosmetic unless they're a result of an accidental injury include but are not limited to:
  - Augmentation mammoplasty (breast enlargement surgery), unless it is part of reconstruction following breast surgery due to cancer.
  - Blepharoplasty (repair of drooping eyelids), unless the droop restricts the field of vision as verified by an ophthalmologist.
  - Keratectomy or keratotomy–for diagnosis of myopia (nearsightedness) when the myopia is correctable by lenses.
  - Otoplasty (plastic surgery on ears), sometimes referred to as "lop ears" or "cauliflower ears."
  - Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction.
  - Rhytidectomy (face lift), Dyschromia (tattoo removal), Genioplasty (chin augmentation).
- Hearing Aids
- Infertility Treatment: charges for services and drugs related to the treatment of infertility, including charges in connection with in-vitro fertilization, artificial insemination and reversal of prior sterilization
- Injury or illness that is work-related or covered by Worker's Compensation or an Occupational Disease Law
- Hospital confinements longer than accepted standards of medical practice.
- Long-Term Care
- Personal comfort items, state taxes or surcharges.
- Private Duty Nursing
- Reversal of sterilization procedures.
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Dental Care (Adult)
- Non-emergency care when traveling outside U.S.
- Routine Eye Care (Adult)
- Routine Foot Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 800-TEAMCARE (832-6227), you may also contact your state insurance department; the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Research and Correspondence Department, TeamCare – A Central States Health Plan, PO Box 5126, Des Plaines IL 60017-5126 or call 800-TEAMCARE (832-6227). In addition, you can contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Español: Para obtener asistencia en Español, llame al 800-832-6227

Tagalog Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-832-6227

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 800-832-6227

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-832-6227

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$20
Coinsurance	$560
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$840**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$120
Coinsurance	$860
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$40
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$260**

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Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: MyTeamcare.org.

The plan would be responsible for the other costs of these EXAMPLE covered services.