TEAMCARE®
A CENTRAL STATES HEALTH PLAN

PLAN C6 BENEFIT PROFILE

Coverage Period: Beginning on or after 01/01/2019

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	$2,500 *
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)	$2,500 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)

Benefit provides $300 per week for the first 10 weeks and $350 per week for the next 16 weeks (maximum of 26 weeks); and includes continued coverage while on Short-Term Disability.

LIFE INSURANCE BENEFITS

Member Death	$40,000
Accidental Death	$40,000
Spouse Death *	$4,000
Child/Adult Child Death *	$2,000
Total Permanent Disability (Waiver of Premium)	$16,000

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

TEAMCARE FAMILY PROTECTION BENEFIT

In the event of a Member's death, the TeamCare Family Protection Benefit provides a maximum of five years of free TeamCare PPO 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 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.

his 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 randfathered 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 onsumer 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 lans 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 rotections 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 epartment, TeamCare – A Central States Health Plan, 9377 West Higgins Road, Rosemont IL 60018-4938 or call 800-TEAMCARE. You may also contact the Employee Benefits Security Administration, U.S. epartment 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.