Summary of Benefits and Coverage

as Required by the Patient Protection and Affordable Care Act

UPS TeamCare Plan

For assistance, visit our specific UPS web pages at www.MyTeamCare.org. In addition, we al so have Benefits Specialists available Monday through Friday at our special UPS number, 1-800-323-9257 bet ween 8:00 a.m. and 6:00 p.m. (CST). This number will be available for your use and convenience during the next few months

CENTRAL STATES HEALTH AND WELFARE FUND – UPS TeamCare Plan

TEAMCARE
A NATIONAL TEAMSTER HEALTH PLAN

Coverage Period: Beginning on or after 01/01/2014
Coverage for: You and Your Elected Dependents | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MyTeamCare.org or by calling **1-800-323-5000**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	No deductible until 2018 of contract; then $100 Per Individual, $200 per Family. Does not apply to in-network office visits and in-network Prescription benefits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for most covered services you use. The annual deductible is based on a calendar year from 1/1 through 12/31. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**No**	
Is there an out–of–pocket limit on my expenses?	$1,000 Per Individual, $2,000 Per Family	The **out-of-pocket limit** is the most you could pay during the calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Not included in the out-of-pocket limit are: Deductibles; In network co-payments; Out of network penalty; Co-insurance from Chiropractic, Psychiatric, Drug Abuse and Alcoholism Treatment, Prescription Drugs, Dental and Vision benefits; Premiums, and Health care charges this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	In 2014, the overall annual limit is eliminated.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	**Yes.** For a list of **preferred providers** in the TeamCare network call 1-800-323-5000 or visit www.MyTeamCare.org.	If you use an **in-network** doctor or other health care provider, this plan will pay some or all of the costs of covered services. For a list of **preferred providers** in the TeamCare network**,** visit www.MyTeamCare.org or call 1-800-323-5000.
Do I need a referral to see a specialist?	**No**	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes**	Some of the services this plan doesn't cover are listed on page 6. See your Plan Document for additional information on **excluded services.**

Questions: Call **1-800-323-5000** or visit us at **www.MyTeamCare.org.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.MyTeamCare.org** or call 1-800-323-5000 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 23, 2013 (corrected)

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use TeamCare in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury illness	$10 copayment per visit	After deductible, 30% plus any charges determined to be above Reasonable and Customary.	Additional costs may be owed for medical services payable beyond the office visit (e.g. x-rays, injections, lab tests, etc.)
	Specialist visit	$10 copayment per visit		
	Other practitioner office visit	$10 copayment per visit		
	Preventive care/screening/immunization	$10 copayment per visit	Not Covered	Immunizations for adults are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	20%, After Deductible or 0% for lab work if through Quest LabCard benefit. For a Quest LabCard provider, call Lab Card Client Services at 800-646-7788 or visit www.labcard.com	10% greater than your cost for an in-network provider. You are also responsible for charges above Reasonable and Customary.	------------ None ----------------
	Imaging (CT/PET scans, MRIs)	20%, After Deductible; or 0% if through US Imaging. For a US Imaging provider, visit www.usimagingnetwork.com .	10% greater than your cost for an in-network provider. You are also responsible for charges above Reasonable and Customary.	------------ None ----------------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MyTeamCare.org or www.caremark.com	Generic drugs	$5 Retail $0 Mail Order If you purchase a brand name prescription when a generic is available, you are responsible for the cost difference and the per prescription maximum does not apply.	25% of Reasonable and Customary charges and Mail Order is not available. The 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% co-pay 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 www.MyTeamCare.org. If you continue using one of these drugs after this date, you will be required to pay the full cost. Wal-Mart is not a participating pharmacy.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	$5 Retail $0 Mail Order	25% of Reasonable and Customary charges and Mail Order is not available. The 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%.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0%, After Deductible	10% greater than your cost for an in-network provider. You are also responsible for charges above Reasonable and Customary.	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).
	Physician/surgeon fees	0%, After Deductible		
If you need immediate medical attention	Emergency room services	20%, After Deductible, 0% after Out-of-Pocket Expense Limit is met.	Emergency care is paid the same as if in-network. However, you are responsible for charges above Reasonable and Customary.	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	0%, After Deductible		
	Urgent care	20%, After Deductible, 0% after Out-of-Pocket Expense Limit is met.	10% greater than your cost for an in-network provider. You are also responsible for charges above Reasonable and Customary.	
If you have a hospital stay	Facility fee (e.g., hospital room)	0%, After Deductible		------------ None -----------------
	Physician/surgeon fee	Physician fee is 20% after Deductible, 0% after the Major Medical Out-of-Pocket Expense Limit is met. Surgeon fee is 0%, After Deductible .		
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20%, After Deductible	10% greater than your cost for an in-network provider. You are also responsible for charges above Reasonable and Customary.	To a Maximum of 30 Days Per Calendar Year.
	Mental/Behavioral health inpatient services	20%, After Deductible		To a Maximum of 21 Days Per Calendar Year and to a Maximum of 42 Days Lifetime.
	Substance use disorder outpatient services	20%, After Deductible		To a Maximum of 30 Days Per Calendar Year.
	Substance use disorder inpatient services	20%, After Deductible		To a Maximum of 21 Days Per Calendar Year and to a Maximum of 42 Days Lifetime.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$10 copayment for initial visit	10% greater than your cost for an in-network provider. You are also responsible for charges above Reasonable and Customary.	Additional costs may be owed for medical services payable beyond the surgery (e.g. x-rays, lab tests).
	Delivery and all inpatient services	0%, After Deductible		
If you need help recovering or have other special health needs	Home health care	20%, After Deductible, 0% after Out-of-Pocket Expense Limit is met.	10% greater than your cost for an in-network provider. You are also responsible for charges above Reasonable and Customary.	Charges for services that are not considered Standard Medical Care, Treatment, Services or Supplies are not covered. In addition, Maintenance Care is not covered.
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam	$10 co-payment under the TeamCare Vision program.	After Deductible, your cost for an Eye Exam for a child is 20% of covered charges plus charges above Reasonable and Customary. The Fund will pay a maximum of $30 for frames and $30 for standard lenses. Any charges above these maximums paid by the Fund will be the responsibility of the Participant.	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 $80 maximum. For TeamCare Vision providers, contact EyeMed at 1-866-393-3401 or www.eyemedvisioncare.com .
	Glasses	$0 co-payment for Lenses, and $0 co-payment for Frames. Standard lenses and frames up to a $100 are included in the co-payment. The Participant is responsible for any difference in cost.		
	Dental check-up	0%	The Fund will pay 100% of Reasonable and Customary charges. 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 1-800-592-3112 or www.humanadentalnetwork.com

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- **Long Term Care.**
- **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.
- **Private Duty Nursing**
- **Weight loss programs**
- **Acupuncture**
- Injury or illness that is work-related or covered by Worker's Compensation or an Occupational Disease Law.
- **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.
  - Rhinoplasty (plastic surgery on the nose), unless surgery is the result of an accident or chronic nasal obstruction.
  - Otoplasty (plastic surgery on ears), sometimes referred to as "lopears" or "cauliflower ears."
  - 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.
  - Rhytidectomy (face lift), Dyschromia (tattoo removal), Genioplasty (chin augmentation).
- **Bariatric Surgery**: Surgery for obesity, including gastric bypass, gastric stapling, intestinal bypass, lipectomy, suction lipectonomy, abdominoplasty, panniculectomy or any other surgical procedure for which the primary purpose is to remove fat tissue, even if surgery results in some medical benefit.
- Charges for medical services that are not considered Standard Medical Care, Treatment, Services or Supplies.
- Reversal of sterilization procedures.
- Charges for stand-by surgeons.
- Personal comfort items, state taxes or surcharges.
- Eye examinations for the correction of vision and fitting of glasses or contact lenses, except contact lenses or glasses for treatment of glaucoma, keratoconus or resulting from cataract surgery (see "Vision Benefit" in the Summary Plan Description).
- Hospital confinements longer than accepted standards of medical practice.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
• **Chiropractic Care** • **Routine Foot Care** • **Non-emergency care** when traveling outside U.S. • **Emergency care** when traveling outside the U.S.	• **Hearing Aid** • **Routine Eye Care (Adult)** • **Dental Care (Adult)**

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-323-5000. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Central States Research and Correspondence Department, 9377 W. Higgins Rd., Rosemont, IL 60018, or call 1-800-323-5000. In addition, you can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-800-323-5000.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Español: Para obtener asistencia en Español, llame al 800-323-5000.

Tagalog Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-323-5000.

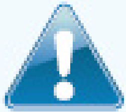
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-323-5000.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, holne' 800-323-5000.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,330
- **Patient pays** $210

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$190
Total	**$210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,800
- **Patient pays** $1,600

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$100
Coinsurance	$1000
Limits or exclusions	$500
Total	**$1,600**

NOTE: The above examples are based on using in network PPO providers including the use of Quest Diagnostics for laboratory tests.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 23, 2013 (corrected)