

Who is TeamCare?

TeamCare is one of the largest multiemployer labor Health Funds in the country that meets the healthcare needs for over 1,100 employers and municipal groups and our 575,000 covered members. National clients include top companies like UPS, American Red Cross, Foremost Farms, Leinenkugel, Miller, Dannon, and Aramark, along with over 150 public sector groups.

What separates TeamCare from other carriers?

First, TeamCare provides a three-year rate guarantee allowing our public sector employers the ability to budget one of their highest economic costs over a 36-month period. Second, because of their size, public groups are forced to contract separately for health, dental, vision, short-term disability, and life insurance benefits. That leads to the expensive and unnecessary burden of paying higher administrative and commission fees. These costs are substantially reduced when TeamCare handles all your healthcare needs.

Simplifying Healthcare for Municipalities

Faced with ever-increasing healthcare costs and lower tax revenues, municipalities are challenged each year to balance a budget. TeamCare can provide coverage for just the bargaining unit, or for the entire public sector group. In addition, TeamCare rates are community-rated which means rates are based on entire Fund population. This is a major incentive providing smaller employers the benefits of reducing their risk through a pool that consists of close to 600,000 members.

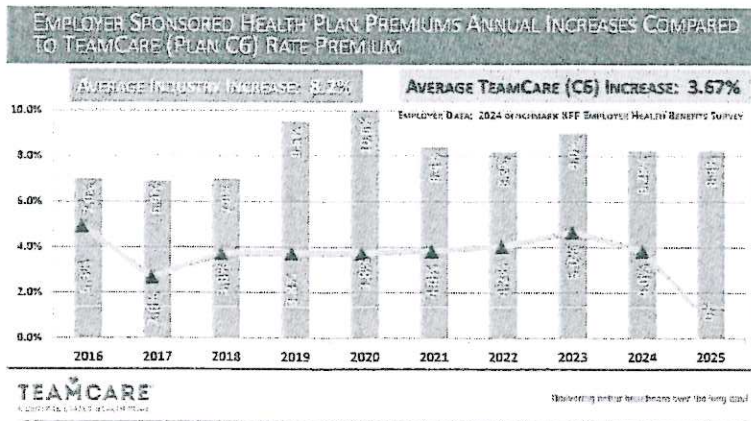
Why TeamCare? Two words . . . Cost and Benefits!

For many municipalities, getting your annual renewal letter usually leads to a discussion on how to reduce costs or reduce benefits. With many municipalities seeing increases of 8-10% annually, usually the only option is to reduce benefits. **Not with TeamCare.**

the past decade, the health insurance industry has seen annual rate increases of 8.2%, while TeamCare's annual rate increase has been 3.67%, including a 0% increase in 2025. This is what we do and what we have done for over 75 years – and we're good at it as attested by our near 100% renewal rate with our employers. TeamCare has not reduced benefits in over 20 years.

PUBLIC SECTOR GROUPS IN TEAMCARE

BAZETTA TOWNSHIP (OH)	VANDERBURGH COUNTY (IN)
CITY OF ALTOONA (IL)	GIBSON COUNTY (IN)
CITY OF BLACK RIVER FALLS (WI)	JACKSON COUNTY (IA)
CITY OF BLUE GRASS (IA)	JOHN A. LOGAN COLLEGE (IL)
CITY OF BOONVILLE (IN)	LAKE COUNTY HIGHWAY DEPT (IN)
CITY OF BUFFALO (IA)	LAWRENCE COUNTY ENGINEER (OH)
CITY OF CHILLICOTHE (IL)	LAWRENCE COUNTY (OH)
CITY OF COLFAX (IA)	MADISON COUNTY HWY DEPT (IL)
CITY OF CORNELL (WI)	MARSHALL COUNTY (IL)
CITY OF DURANT (IA)	MENARD COUNTY HIGHWAY (IL)
CITY OF EAST CHICAGO (IN)	PIKE COUNTY (IN)
CITY OF EAST DUBUQUE (IL)	REAVIS HIGH SCHOOL (IL)
CITY OF EVANSVILLE (IN)	SCHOOL DISTRICT OF THORP (WI)
CITY OF GARY (IN)	ST FRANCOIS COUNTY (MO)
CITY OF GOSHEN (IN)	TAZEWELL COUNTY (IL)
CITY OF HAMMOND (IN)	VILLAGE OF BIRON (WI)
CITY OF KANKAKEE (IL)	VILLAGE OF BONDIJEL (WI)
CITY OF LOUISA (KY)	VILLAGE OF BOYD (WI)
CITY OF MANITOWOC (WI)	VILLAGE OF CADOTT (WI)
CITY OF MERRILL (IA)	VILLAGE OF DENMARK (WI)
CITY OF MILFORD (IA)	VILLAGE OF FAIRCHILD (WI)
CITY OF OAKLAND CITY (IN)	VILLAGE OF FOOTVILLE (WI)
CITY OF OKOBOJI (IA)	VILLAGE OF HAMMOND (IN)
CITY OF OWEN (WI)	VILLAGE OF KRONENWETTER (WI)
CITY OF PEORIA (IL)	VILLAGE OF LUCK (WI)
CITY OF PESHTIGO (WI)	VILLAGE OF MARATHON CITY (WI)
CITY OF PRINCETON (IN)	VILLAGE OF MERRILLAN (WI)
CITY OF SCHOFIELD (WI)	VILLAGE OF MILLTOWN (WI)
CITY OF SHULLSBURG (WI)	VILLAGE OF ORFORDVILLE (WI)
CITY OF STEVENS POINT (WI)	VILLAGE OF OSCEOLA (WI)
CITY OF URBANA (IA)	VILLAGE OF RAYMOND (WI)
CITY OF WHITING (IN)	VILLAGE OF SALEM LAKES (WI)
CITY OF WICHITA (KS)	VILLAGE OF SPENCER (WI)
CLARKE COUNTY (IA)	VILLAGE OF SUAMICO (WI)
REYNOLDS COUNTY (MO)	VILLAGE OF TWIN LAKES (WI)
DOUGLAS COUNTY (NE)	VILLAGE OF WATERFORD (WI)
	VILLAGE OF WHEELER (WI)



TEAMCARE®

A CENTRAL STATES HEALTH PLAN

TeamCare offers various traditional health benefit plan options with low deductibles and out-of-pocket limits. Two of our most popular "all-inclusive" plans (medical, prescription, dental, vision, short-term disability, life insurance, and TeamCare Family Protection benefits) are Plan C6, and Plan M9. A summary of these benefits and rates are below. To see a full *Plan Benefit Profile, Summary of Benefits and Coverages, or Summary Plan Description*, please visit MyTeamCare.org.

	ALL-INCLUSIVE FULL PLAN C6	ALL-INCLUSIVE PLAN M9
FULL PLAN RATE <small>MED. DEN. VIS. STD. & LIFE INSURANCE</small>	WEEKLY COST OR MONTHLY COST	
12-month set rate starting between 7/1/2025 – 6/30/2026	\$506.40 weekly or \$2,194.40 monthly	\$451.30 weekly or \$1,955.60 monthly
12-month max rate* renewing between 7/1/2026 – 6/30/2027 <small>*Set rate will be determined in 2026</small>	\$526.70 weekly or \$2,282.40 monthly	\$469.40 weekly or \$2,034.10 monthly
12-month max rate* renewing between 7/1/2027 – 6/30/2028 <small>*Set rate will be determined in 2027</small>	\$547.80 weekly or \$2,373.80 monthly	\$488.20 weekly or \$2,115.50 monthly
KEY MEDICAL BENEFITS		
NETWORK	BlueCross BlueShield National PPO Network	
ANNUAL DEDUCTIBLE	Individual: \$200 / Family: \$400	Individual: \$250 / Family: \$500
ANNUAL OUT-OF-POCKET MAX	Individual: \$1,000 / Family: \$2,000	Individual: \$1,000 / Family: \$2,000
MEDICAL COINSURANCE	0% / 20%	10%
HOSPITAL AND SURGICAL	0%	10%
OFFICE VISIT COPAY <small>PRIMARY CARE OR SPECIALIST</small>	\$20	\$20
PREVENTIVE CARE <small>NOT SUBJECT TO DEDUCTIBLE</small>	No cost to member. Covered in full by TeamCare.	
TELEMEDICINE <small>NOT SUBJECT TO DEDUCTIBLE</small>	No cost to member. Covered in full by TeamCare through Teladoc network.	
CVS MINUTE CLINIC <small>NOT SUBJECT TO DEDUCTIBLE</small>	No copay to member. Covered in full by TeamCare.	
OUTPATIENT LAB <small>NOT SUBJECT TO DEDUCTIBLE</small>	No cost to member. Covered in full by TeamCare through Quest LabCard network.	
OUTPATIENT IMAGING <small>CT, MRI, AND PET SCANS NOT SUBJECT TO DEDUCTIBLE</small>	No cost to member. Covered in full by TeamCare through US Imaging network.	
CHIROPRACTIC BENEFIT	80%, 24-visits per year	70%, 24-visits per year
INPATIENT BEHAVIORAL HEALTH	0%	10%
OUTPATIENT BEHAVIORAL HEALTH	\$20	\$20
PRESCRIPTION BENEFITS <small>CAREMARK NETWORK NOT SUBJECT TO DEDUCTIBLE</small>	Short-Term fill: 20% Maintenance fill: 25% Generic Requirement based on medical necessity.	
DENTAL BENEFITS <small>HUMAN NETWORK (VOLUNTARY)</small>	No Dental deductible. Annual Plan Max per person: \$2,500. Lifetime Child Ortho Max: \$2,500.	
VISION BENEFITS <small>EYEMED NATIONAL NETWORK (VOLUNTARY)</small>	Benefit is payable every 12 months. \$10 copay. All lenses covered in full. Frames covered to \$150 allowance. Contacts covered to \$120 allowance.	
SHORT-TERM DISABILITY BENEFITS	\$300 per week for weeks 1-10, then \$350 per week for weeks 11-26. Includes continued coverage without employer premium while on Short-Term Disability.	
LIFE INSURANCE BENEFITS <small>(DOUBLE FOR ACCIDENTAL DEATH)</small>	\$40,000	\$25,000
FAMILY PROTECTION BENEFITS	After an employee's death, the Family Protection Benefit continues coverage for family members for five-years at no-cost . This coverage is provided by TeamCare at no cost to employer.	

This is meant as a summary. If there is a discrepancy between this comparison and the Plan Document, the Plan Document will govern.

PLAN BENEFIT LIMIT (ANNUAL)	PLAN DEDUCTIBLE (ANNUAL)	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
None	\$200 per Individual \$400 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 Allowed Amount and the loss of TeamCare Family Protection Benefit.	
MEDICAL PLAN BENEFITS	<i>For further information, including a full Summary Plan Description (SPD), visit our website at MyTeamCare.org.</i>	
TeamCare Wellness A TeamCare Physician must be used.	◆ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.	
Teladoc Telemedicine Benefit Teladoc.com/TeamCare 800-TELADOC (835-2362)	◆ Teladoc provides 24/7 access to doctors by phone or video for a variety of services, including general medical conditions, mental health, diabetes management and dermatology at no cost (\$0 copay). Plan Deductible does not apply.	
CVS MinuteClinic CVS.com/MinuteClinic 866-389-ASAP (2727)	◆ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost (\$0 copay). Plan Deductible does not apply.	
Hospital Expense Benefit	◆ After Plan Deductible, 100% of covered charges.	
Surgical and Maternity Benefit	◆ After Plan Deductible, 100% of covered charges.	
Ambulance Service Benefit	◆ After Plan Deductible, 100% of covered charges subject to medical necessity review.	
Outpatient Accidental Bodily Injury Benefit	◆ After Plan Deductible, 100% on the first day of treatment for accidental injury; 80% for all other services.	
Lab Benefit questselect.com 800-646-7788	◆ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% provided the Physician submits the requisition through QuestSelect. If a Physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site. Plan Deductible does not apply. 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.	
Advanced 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 (excludes x-rays) at 100% provided that the scans are scheduled directly through USIN. Plan deductible does not apply. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (includes 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, 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 \$20 TeamCare office visit copayment is due.	
Hearing Aid Benefit	◆ After Plan Deductible, 100% of covered charges to a maximum of \$3,000 per ear (\$6,000 total) every 36 months. The Medical Out-of-Pocket Expense Limit does not apply.	
Chiropractic Benefit	◆ After Plan Deductible, 80% of covered charges to a maximum 24 visits per person per calendar year. The Medical Out-of-Pocket Expense Limit does not apply.	
Behavioral Health Benefits – Inpatient	◆ Facility: After Plan Deductible, 100% of covered charges. Physician: After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Behavioral Health Benefits – Outpatient	◆ \$20 copayment for in-network office visit. Plan Deductible does not apply. Otherwise, after Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Major Medical Benefit	◆ After Plan Deductible, 80% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	

PRESCRIPTION BENEFIT

For more information or to find a participating pharmacy, call 888-483-2650 or visit caremark.com

Certain states have laws that may affect your Prescription Benefit. Visit MyTeamCare.org/statelaws for more information.

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.

Before the third fill of the same prescription at a Retail Pharmacy, long-term maintenance medications must be filled through the Maintenance Choice Network or the CVS/Caremark Mail Service Pharmacy or be subject to a 50% copayment. 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. Plan Deductible 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 TeamCareDental.

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 TeamCareVision 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.

TeamCareVision 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 eyemed.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

Plan Deductible does not apply.

* 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.

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.

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, TeamCare – A Central States Health Plan, PO Box 5126, Rosemont IL 60017-5126 or call 800-TEAMCARE. You may also contact the Employee Benefits Security Administration, U.S. Department 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.

PLAN BENEFIT LIMIT (ANNUAL)	PLAN DEDUCTIBLE (ANNUAL)	MEDICAL OUT-OF-POCKET EXPENSE LIMIT (ANNUAL)
None	\$250 per Individual \$500 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 Allowed Amount and the loss of TeamCare Family Protection Benefit.	
MEDICAL PLAN BENEFITS	<i>For further information, including a full Summary Plan Description (SPD), visit our website at MyTeamCare.org.</i>	
TeamCare Wellness A TeamCare Physician must be used.	◆ Wellness benefits are payable at 100% of covered charges. PPO office visit copayment does not apply.	
Teladoc Health Benefit Teladoc.com/TeamCare 800-TELADOC (835-2362)	◆ Teladoc provides 24/7 Care by phone or video for a variety of services, including general medical conditions, mental health, diabetes management and dermatology at no cost (\$0 copay). Plan Deductible does not apply.	
CVS MinuteClinic CVS.com/MinuteClinic 866-389-ASAP (2727)	◆ MinuteClinic is a walk-in facility within certain CVS and Target stores that provides treatment for general medical conditions, minor injuries and illnesses, health screenings and routine vaccinations at no cost (\$0 copay). Plan Deductible does not apply.	
Hospital Expense Benefit	◆ After Plan Deductible, 90% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Surgical and Maternity Benefit	◆ After Plan Deductible, 90% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Ambulance Service Benefit	◆ After Plan Deductible, 90% of covered charges subject to medical necessity review; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Emergency Room Services	◆ After Plan Deductible, 90%; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Outpatient Lab Benefit questselect.com 800-646-7788	◆ The TeamCare Lab Benefit is a voluntary program that covers lab testing at 100% provided the Physician submits the requisition through QuestSelect. If a Physician does not submit specimens through QuestSelect, simply visit a QuestSelect collection site. Plan Deductible does not apply. If you do not use the TeamCare Lab Benefit, after Plan Deductible the outpatient lab benefit is 90%; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Outpatient Advanced 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 (excludes x-rays) at 100% provided that the scans are scheduled directly through USIN. Plan deductible does not apply. If you do not use the TeamCare Imaging Benefit, after Plan Deductible the outpatient imaging benefit (includes x-rays) is paid under Major Medical at 90%; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Outpatient Cancer Treatment Benefit	◆ After Plan Deductible, 90% 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	◆ Your Plan does not have a Hearing Aid Benefit.	
Chiropractic Benefit	◆ After Plan Deductible, 70% of covered charges to a maximum 24 visits per person per calendar year. The Medical Out-of-Pocket Expense Limit does not apply.	
Behavioral Health Benefits – Inpatient	◆ Facility: After Plan Deductible, 90% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met. Physician: After Plan Deductible, 90% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Behavioral Health Benefits – Outpatient	◆ \$20 copayment for in-network office visit. Plan Deductible does not apply. Otherwise, after Plan Deductible, 90% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	
Major Medical Benefit	◆ After Plan Deductible, 90% of covered charges; then 100% after Medical Out-of-Pocket Expense Limit is met.	

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Certain states have laws that may affect your Prescription Benefit. Visit MyTeamCare.org/statelaws for more information.

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.

Before the third fill of the same prescription at a Retail Pharmacy, long-term maintenance medications must be filled through the Maintenance Choice Network or the CVS/Caremark Mail Service Pharmacy or be subject to a 50% copayment. 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. Plan Deductible does not apply. The Medical Out-of-Pocket Expense Limit does not apply.

TeamCare does not cover medications that are not on the formulary list of covered drugs. The formulary lists can be found on MyTeamCare.org.

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 *TeamCareDental*.

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	85%
Crown and Bridge Work	70%
Dentures (Full and Partial)	70%
Orthodontic (Child/Adult Child)	50%
Orthodontic Maximum (Child/Adult Child)	\$2,500 Lifetime Maximum

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

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

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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 eyemed.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

Plan Deductible does not apply.

* 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 90%.

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	\$25,000
Accidental Death	\$25,000
Spouse Death *	\$3,000
Child/Adult Child Death *	\$1,500
Total Permanent Disability (Waiver of Premium)	\$16,000

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

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.

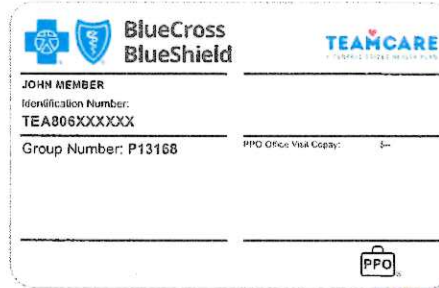
MyTeamCare.org or 800-TEAMCARE

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Right Place, Right Card



TeamCare PPO Medical ID Card

Present this card when you visit any medical provider, mental health provider, or chiropractor. To check if your doctor, facility, or hospital participates in the network, call the phone number on the back of your card or visit the *Find A Provider* link at **MyTeamCare.org**. You can also log in to download an e-card version.



TeamCare Benefits ID Card

Present this card to take advantage of your other great health benefits such as:

- Telehealth: Teladoc Health
- Prescription: CVS Caremark
- Dental: Humana Dental
- Vision: EyeMed Vision Care
- Advanced Imaging: USIN
- Lab Testing: QuestSelect
(Not available in the Eau Claire & the Menomonie Area)

...and more



MyTeamCare.org



No-Cost Benefit
No Deductible, No Copay—No Cost to You



Schedule Your Advanced Imaging Scans Through USIN

The TeamCare Imaging Benefit is a NO-COST voluntary program that covers MRI, CT, and PET scans at 100% when scheduled directly through US Imaging (USIN). USIN is an advanced imaging network that contracts with free-standing facilities and offers a VIP concierge service to schedule appointments through their network.

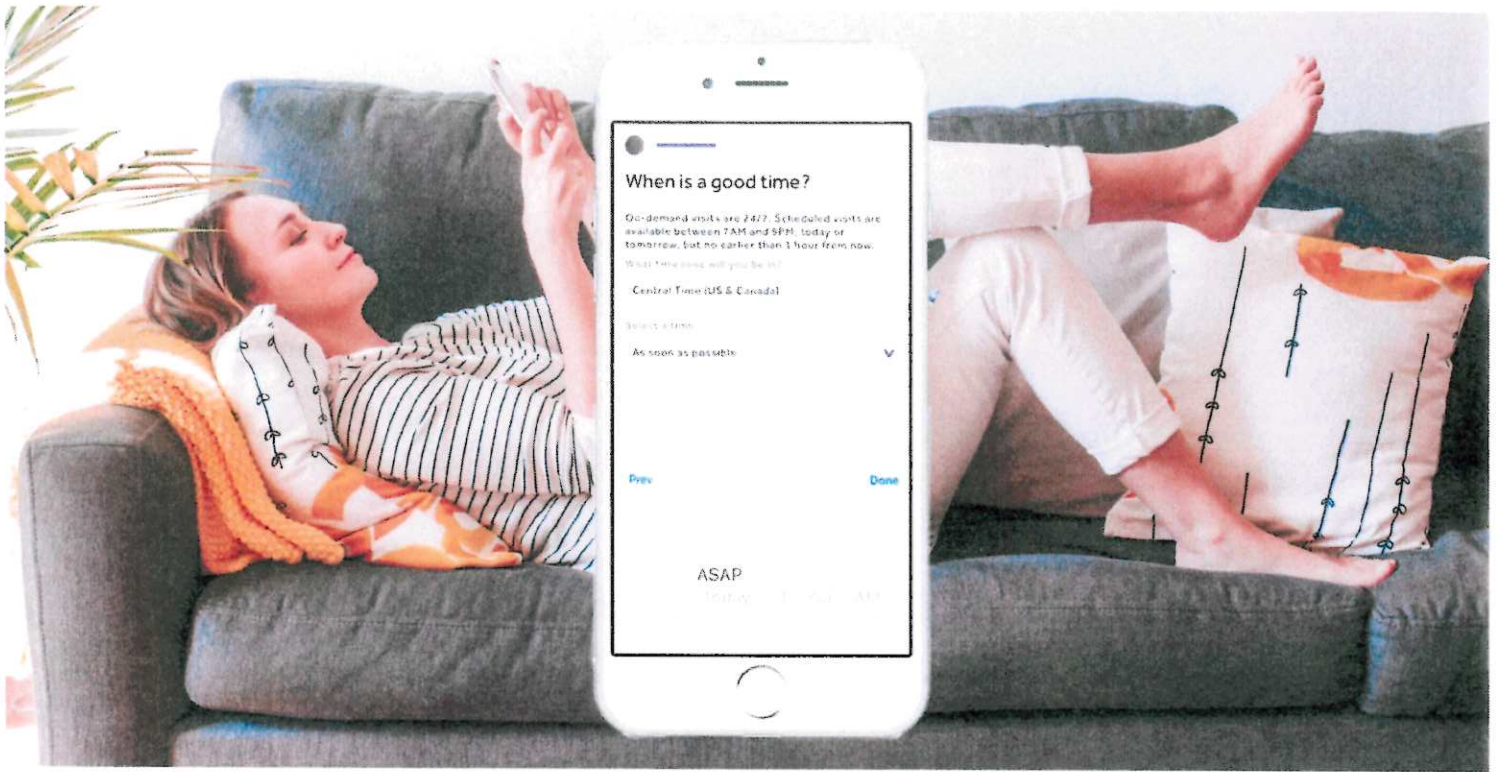
How Get Your Scan Covered at 100% Through USIN:

- Call USIN at **877-674-0674** (also on the back of your TeamCare Benefits ID Card), 8:30 am-7:00 pm ET, Monday through Friday.
- USIN will find the closest location and schedule your appointment.
 - If you live more than 40 miles away from a USIN facility, you can then get a one-time exception for a local participating TeamCare/BCBS facility or hospital. Just call USIN each time an MRI, CT scan, or PET scan is needed to have it covered at no-cost to you.

If you use any other in-network imaging facility, these services will be processed under your Major Medical benefits and will be subject to your deductible and out of pocket.

No-Cost Benefit
No Deductible, No Copay—No Cost to You

When you need a doctor,
call one **anytime, anywhere**



Teladoc® It's convenient and easy.
HEALTH

Skip the trip to the waiting room.
With Teladoc, you can talk with a doctor by phone or app from wherever you are.



24/7 Care (General Medicine)
For non-emergency conditions like the flu, allergies, infections, and much more. Our doctors can also prescribe medicine, if needed.



Dermatology
Eczema
Acne
Skin rash
And more



Mental Health
Stress & anxiety
Depression
Grief counseling
And more

Feel better when you need to with Teladoc

Call **800-TELADOC**
(835-2362)

TEAMCARE®
800-TEAMCARE • MyTeamCare.org





FAMILY PROTECTION BENEFIT

*One of TeamCare's best benefits
—a benefit we hope you never have to use.*

When your spouse and children need health coverage the most, TeamCare is there—with the **Family Protection Benefit**.

In the event of a member's death, the **Family Protection Benefit** provides your covered family members with the same TeamCare plan of benefits for **free**—no cost to the family. This Benefit provides **free** coverage to your covered family members for up to five years; or until the spouse remarries, the children turn age 26, or the family has other insurance coverage—whichever happens first.

Qualifying for this benefit is easy.

Provided the family uses in-network providers for all non-emergency medical care during the two years prior to the member's death, the family qualifies for the Family Protection Benefit.

It's that simple.

To find an in-network medical provider, visit **MyTeamCare.org**.

Contact Your **TEAMCARE**® Partners



BlueCross BlueShield
bcbsil.com



Teladoc Health
TeladocHealth.com/TeamCare
800-TELADOC



Caremark
caremark.com
888-483-2650



USIN (Imaging Benefit)
877-674-0674



Humana Dental
humanadentalnetwork.com
800-592-3112

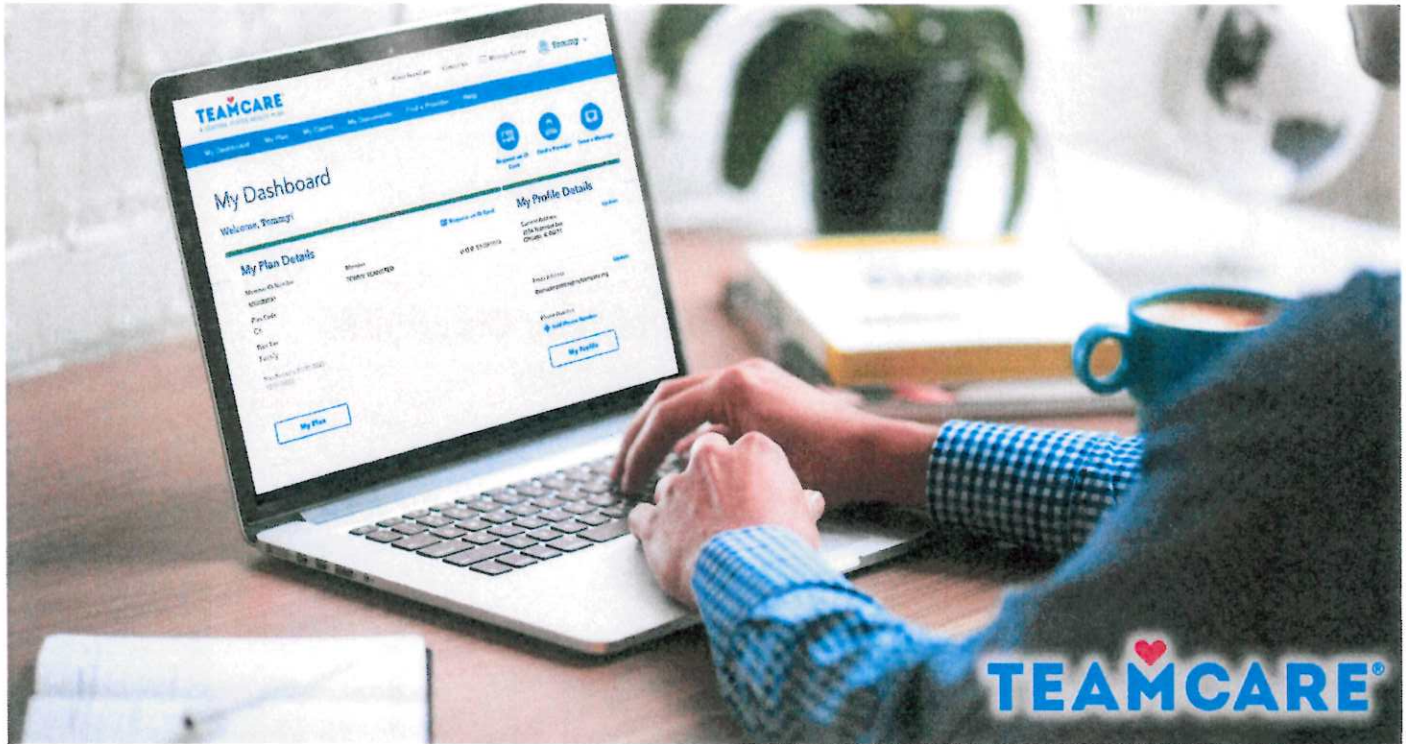


EyeMed Vision Care
eyemed.com
866-723-0514

TEAMCARE®

TeamCare • Message Center at MyTeamCare.org • 800-TEAMCARE

Get The Info You Need—Visit MyTeamCare.org



The homepage is where you can Find A Provider, download Forms & Documents, and find contact information for all of TeamCare's partners, but logging in gives you even more self-serve options.

Here's What You Can Find:

- **ID Cards:** Download an electronic version of your Medical ID Card and Benefits ID Card or request new cards to be mailed.
- **Health Claims:** See the claim's status or search by family member, claim type, provider, status, or date.
- **Your Annual Benefits:** See a breakdown of the total amount your healthcare services have cost so far this year—and how much you saved!
- **Individual Overview:** See how close you are to meeting your medical deductible, out-of-pocket expense limit, and how much you've used in the past years you've been with TeamCare.
- **Message Center:** Send a secure message to our CustomerCare Center.
- **Your Profile:** Go paperless, update your contact information, or request an alternate payee, like an adult child living outside your home or a former spouse who shares custody.
- **Documents:** Download your Plan Benefit Profile, Summary Plan Descriptions, Plan Document, Summary of Benefits and Coverage, and tax documents.
- **Benefits Specific to Your Plan:** See the last dates you had services and when you are eligible for them again for Dental, Vision, Chiropractic, and Hearing Aid Benefits.

Recent Claims

Plan	Benefit	Event Date	Claim Date	Amount	Out of Pocket	View Claim
Medical Expense	Medical Expense	12/20/19	12/20/19	\$500	\$0.00	View Claim
Medical Expense	Medical Expense	12/20/19	12/20/19	\$100	\$9.99	View Claim
Medical Expense	Medical Expense	12/20/19	12/20/19	\$100	\$9.99	View Claim
Medical Expense	Medical Expense	12/20/19	12/20/19	\$100	\$9.99	View Claim
Medical Expense	Medical Expense	12/20/19	12/20/19	\$100	\$9.99	View Claim

Annual Benefits

Benefit	Amount
Dental	\$377.82
Vision	\$93.39
Chiropractic	\$284.43
Hearing Aid	\$0.00



Your Dental Benefits

Specially Prepared for the Employees of City Of Nekoosa

The summary below does not cover all plan details. Further information can be found in the summary plan description or dental benefit handbook. That document provides a thorough explanation of your dental plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

Benefit Plan Design	Delta Dental PPO [®] <small>When you see a Delta Dental PPO provider</small>	Delta Dental Premier <small>When you see a Delta Dental Premier or any other provider*</small>
Individual Annual Maximum	\$2,000	\$2,000
Deductible		
Individual	\$25	\$25
Family	\$75	\$75
Dependent Eligibility		
Dependents are eligible to the date on which they attain age 26; except as noted for orthodontics		
Diagnostic & Preventive Services		
Exams	100%	100%
Cleanings	100%	100%
Fluoride treatments [^]	100%	100%
X-rays	100%	100%
Sealants [^]	100%	100%
Space maintainers	100%	100%
Deductible applies	No	No
Basic & Major Services		
Emergency treatment to relieve pain	80%	80%
Fillings	80%	80%
Endodontics – nonsurgical	50%	50%
Endodontics – surgical	50%	50%
Periodontics – nonsurgical	50%	50%
Periodontics – surgical	50%	50%
Extractions – nonsurgical	80%	80%
Extractions – surgical and other oral surgery	50%	50%
Crowns, inlays, onlays	50%	50%
Bridges and dentures	50%	50%
Repairs and adjustments to bridges and dentures	50%	50%
Implants	50%	50%
Deductible applies	Yes	Yes
Orthodontic Services		
Coverage copayment	50%	50%
Individual lifetime maximum	\$2,000	\$2,000
Dependents eligible to age	19	19
Full-time students eligible to age	19	19
Adult ortho	No	No
Deductible applies	Yes	Yes
Special Plan Provisions (see following pages for more information)		
Evidence-Based Integrated Care Plan	Yes	Yes
CheckUp Plus	Yes	Yes

Regardless of the provider you see, you will be responsible for your plan's deductible, coinsurance, and fees for services that are not covered benefits under your plan.

*If you visit an out-of-network provider, you will be responsible for the difference between the provider's charges and the amount your Delta Dental plan pays.

[^]Age limitations may apply.



Specially prepared for the employees of City Of Nekoosa

Special Plan Provisions

Your group dental plan from Delta Dental of Wisconsin includes one or more special features designed to encourage good oral health and promote overall health. Details of these provision(s) are addressed in the policy amendments provided with your dental plan handbook. Below is a brief summary.

Evidence-Based Integrated Care Plan: Expanded benefits for persons with medical conditions that have oral health implications

- Delta Dental of Wisconsin's Evidence-Based Integrated Care Plan (EBICP) option is included in your plan. It provides additional benefits for persons with medical conditions that have oral-health implications. Conditions include:
 - Diabetes
 - Pregnancy
 - High risk cardiac conditions
 - Kidney disease
 - Weakened immune system
 - Cancer therapy
 - Periodontal disease
- EBICP's unique enrollment mechanism requires no medical claims be filed.
- EBICP requires self-enrollment by the patient or his/her provider at www.deltadentalwi.com, or by calling 800-236-3712.

CheckUp Plus™

- CheckUp Plus™ lets you obtain diagnostic and preventive services - including examinations, X-rays, regular cleanings and other related treatments - without the costs of those services applying to your individual annual maximum.
- The full value of your annual maximum is applied to the benefits you receive for basic and major restorative services.
- CheckUp Plus™ promotes regular visits to the provider for exams and cleanings, which can improve your oral health and overall health.

Confirming Your Coverage

If you are not sure of the effective date of your coverage, please call Delta Dental at 800-236-3712 before you have any dental work done.

Also, before scheduling appointments for extensive dental care, you may ask your provider to send the treatment plan to Delta Dental. The plan will be reviewed by Delta Dental and you and your provider will receive a **Predetermination of Benefits** form. You and your provider may then discuss the treatment and your out-of-pocket costs. Delta Dental encourages you to be informed about your dental care.

Delta Dental's Website

www.deltadentalwi.com has a lot to offer. You can use it to obtain coverage information under your plan, check the status of a claim, find a network provider, evaluate your oral health and learn ways to improve and protect it.

Visit www.deltadentalwi.com for eligibility, claims or provider information.

We are also available every weekday from 7:30 a.m. to 5 p.m. (Central Time) to answer your questions. Call us at 800-236-3712. We look forward to talking with you!

YOUR VISION BENEFITS

Prepared for the employees of City of Nekoosa

The summary below does not cover all plan details. Further information can be found in the vision benefit handbook, which provides a thorough explanation of your vision plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

DeltaVision® Full Plan

Network	Insight
Frame/Contact Allowance	\$200/\$200
Copay (exams/standard plastic lenses)	\$20/\$20
Frequency (exams/lenses or contact/frames) Based on calendar year	12 months/12 months/24 months
Dependent Age Limit	To age 26

Benefit Details	Network Benefit	Out-of-Network Reimbursement
Comprehensive Glasses Exam	Member pays \$20, plan pays balance	\$35
Retinal Imaging	Member pays up to \$39	None
Standard Contact Lens* Fit and Follow-Up	Paid in full	\$40
Premium Contact Lens** Fit and Follow-Up	10% discount off retail, plus \$55 allowance	\$40
Frames (any available frame at provider location)	\$200 allowance, then 20% off balance	\$100
Laser Vision Correction (Lasik or PRK)	15% off retail price or 5% off promotional price	None

Includes Diabetic Eye Care Benefits that provide an additional office visit and diagnostic testing for those who have diabetes.

Standard Plastic Lenses

Single Vision	Member pays \$20, plan pays balance	\$25
Bifocal	Member pays \$20, plan pays balance	\$40
Trifocal	Member pays \$20, plan pays balance	\$55
Standard Progressive	Member pays \$85	\$40
Premium Progressive	See next page for benefit details	

Lens Options

UV Coating	Member pays \$15	None
Tint (solid and gradient)	Member pays \$15	None
Standard Scratch Resistance	Member pays \$15	None
Standard Polycarbonate	Member pays \$40	None
Standard Anti-Reflective Coating	Member pays \$45	None
Premium Anti-Reflective Coating	See next page for benefit details	
Other Add-Ons and Services	20% off retail	None

*Lenses that are spherical power only, soft lens materials, including planned replacement and conventional lenses. Lenses are to be used in a daily wear (removed prior to sleep) mode only.

**Includes all lens powers and designs other than spherical powers (i.e. toric, multifocal, etc.), modes of wear that are extended or overnight schedules, and rigid or gas-permeable materials.

Benefit Details (continued)

	Network Benefit	Out-of-Network Reimbursement
Contact Lenses – In lieu of glasses (Contact lens allowance covers materials only)		
Conventional	\$200 allowance, then 15% off balance	\$160
Disposable	\$200 allowance	\$160
Medically Necessary***	Paid in full	\$200
Premium Progressive Lens		
Tier 1	\$105 copay	\$60
Tier 2	\$115 copay	\$60
Tier 3	\$130 copay	\$60
Tier 4	\$85 copay, 80% of charge less \$120 allowance	\$60
Premium Anti-Reflective Coating		
Tier 1	\$57	None
Tier 2	\$68	None
Tier 3	80% of charge	None

Additional In-Network Discounts

- 20% discount on items not covered by the plan at network providers. This discount may not be combined with any other discounts or promotional offers. This discount does not apply to an EyeMed® provider's professional services (i.e. exams) or contact lenses. Retail prices may vary by location.
- 40% discount on complete eyeglass purchases after your plan benefits have been fully used (includes prescription sunglasses).
- 15% discount on conventional contact lenses after your plan benefits have been fully used.
- Members can purchase eyeglasses online and apply their in-network eyeglass benefits at www.glasses.com, lenscrafters.com, targetoptical.com, or rayban.com.
- Members can purchase contact lenses online and apply their in-network contact lenses benefits at www.contactsdirect.com.
- Discounts do not apply for benefits provided by other group benefit plans.

How to Maximize Your DeltaVision Plan

- Use providers participating in your vision plan network; your benefit dollars will go farther at participating providers. For an up-to-date listing of EyeMed providers in your area, visit our website at <https://www.deltadentalwi.com/vision> or call EyeMed's Customer Care Center at 844-848-7090.
- For laser vision correction, LASIK*Plus* is the network provider offering members additional benefits. Additional information can be obtained by calling 1-800-988-4221 or visiting eyemedlasik.com.
- Use your full benefit allowance. Frames and lenses (plastic or contact) each have an annual benefit allowance. **The benefit allowance must be used on a single day purchase; there is no remaining balance if entire allowance is not used after initial purchase.**
- Frequency of benefits: your benefit frequency is based on calendar year. For example, you'll be covered for another pair of glasses as of January 1 of the next calendar year.
- Participating providers may offer promotional pricing on vision materials. You can partake in either the DeltaVision Network Benefit or the promotional price available, but not both. Your provider can help you to determine which is best for you. If you select the promotional pricing you can submit your expenses for Out-of-Network Reimbursement.
- Prescription sunglasses can be purchased with your benefit allowance for frames and plastic lenses.
- A 20% discount may be available on selected brands of non-prescription sunglasses from participating providers — ask your vision provider.
- Premium progressive lenses are more costly than standard progressive lenses. Please discuss your costs for progressive lenses with your vision provider.

***Medically necessary contacts require authorization from a vision doctor when some conditions are present. Please contact the plan for more information.



DeltaVision®

Plan Limitations/Exclusions

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan.
- Services provided as a result of any worker's compensation law.
- Plano nonprescription lenses and nonprescription sunglasses (except for 20% discount).
- Aniseikonic lenses.
- Services or materials provided by any other group benefit providing vision care.
- Two pairs of glasses in lieu of bifocals.
- Lost or broken materials are not covered.

DeltaVision is underwritten by Wyssta Insurance Company.

Quote ID: 12285

Benefits	Renewal Option 1	Product Options	Renewal Option 3
	\$1700 HDHP Umbrella Premier HMO	Renewal Option 2 \$2000 HDHP Umbrella Premier HMO	\$2000 w/Coins HDHP Umbrella Premier HMO
	Premier/HMO HDHP Umbrella	Premier/HMO HDHP Umbrella	Premier/HMO HDHP Umbrella
Deductible (Single/Family)	\$1,700/\$3,400	\$2,000/\$4,000	\$2,000/\$4,000
Coinsurance	100%	100%	80%
Maximum Out-of-Pocket (Single/Family)	\$3,300/\$6,600	\$3,500/\$7,000	\$3,500/\$7,000
Emergency Room Copayment	Ded/Coins	Ded/Coins	Ded/Coins
Urgent Care Copayment	Ded/Coins/\$0	Ded/Coins/\$0	Ded/Coins/\$0
Office Visit Copayment	Ded/Coins/\$0	Ded/Coins/\$0	Ded/Coins/\$0
Specialist Office Visit Copayment	Ded/Coins/\$0	Ded/Coins/\$0	Ded/Coins/\$0
Preventive Benefit	Paid at 100%*	Paid at 100%*	Paid at 100%*
Laboratory/Radiology Benefit	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance
Pharmacy Benefit	Integrated drug coverage then \$10/\$30/\$60/25% Preventive covered at 100%	Integrated drug coverage then \$10/\$30/\$60/25% Preventive covered at 100%	Integrated drug coverage then \$10/\$30/\$60/25% Preventive covered at 100%
Mail Order	x 2 Copay(s)	x 2 Copay(s)	x 2 Copay(s)
	Contracts Rates	Contracts Rates	Contracts Rates
EE Only	0 \$868.13	0 \$851.59	0 \$799.19
ES	8 \$2,170.32	8 \$2,128.98	8 \$1,997.98
EE +1 child	0 \$2,170.32	0 \$2,128.98	0 \$1,997.98
EE +2 or more children	2 \$2,604.39	2 \$2,554.77	2 \$2,397.57
Family	10 \$2,604.39	10 \$2,554.77	10 \$2,397.57
Medicare Single	0 \$607.69	0 \$596.11	0 \$559.43
Medicare Couple	0 \$1,215.38	0 \$1,192.23	0 \$1,118.87
Medicare Split	0 \$1,475.82	0 \$1,447.70	0 \$1,358.62
Total	20 \$48,615.24	20 \$47,689.08	20 \$44,754.68

*Paid at 100% subject to frequency schedule that meets or exceeds the guidelines of the U.S. Preventive Services Task Force (USPSTF).

Deductibles are based on calendar year. Rates have been calculated for the period 1/1/2026 through 12/31/2026.

Chosen plan for 2026

Benefits and rates as shown. Circle choices.

Acceptance Signature Kalle Ferik Date 11/04/2025