

**Southwestern Teamsters Security Fund
SCHEDULE OF BENEFITS - ACTIVE**

This chart shows what the Plan pays. All benefits are subject to the deductible except where noted otherwise.
See Rules and Regulations in this booklet for more information.

Benefit Description	Explanation and Limitations	PPO Providers (In-Network)	Non-PPO Providers (Out of Network)
Accident – Supplemental	<ul style="list-style-type: none"> ▪ 100% of the first \$500 of Allowable Expenses incurred within 90 days of the accident. • After the 1st \$500.00 benefits payable @ 80% or 60% - subject to deductible 	80%	60%
Acupuncture	<ul style="list-style-type: none"> ▪ Payable when performed by a Physician 	80%	60%
Allergy	<ul style="list-style-type: none"> • Testing, desensitization and allergy antigen services 	80%	60%
Ambulance	<ul style="list-style-type: none"> ▪ Surface/Air 	80%	60%
Ambulatory Surgery Facility	<ul style="list-style-type: none"> • In a hospital-based or free-standing outpatient surgery center. 	80%	60%
Anesthesia		80%	60%
Annual Coinsurance Limit	<ul style="list-style-type: none"> ▪ Effective 1/1/08 the Plan pays 80% of the first \$25,000 in covered charges for PPO providers and 100% for the remainder of the calendar year for PPO providers only. Annual coinsurance limit does not apply to non-PPO providers. 		
Annual Maximum	<ul style="list-style-type: none"> • \$400,000 		
Assistant Surgeons	<ul style="list-style-type: none"> ▪ Payable to a maximum of 20% of the allowed fee payable to the surgeon 	80%	60%
Blood transfusions and blood products		80%	60%
Chemotherapy		80%	60%
Chiropractic Care	(SEE SPINAL MANIPULATION)		
Death Benefits (Life)	<ul style="list-style-type: none"> ▪ \$3,000 (paid to your beneficiary) Employee Only 		
Death Benefits (AD&D)	<ul style="list-style-type: none"> ▪ Up to \$3,000 Employee Only 		
Deductible • Per calendar year	<ul style="list-style-type: none"> ▪ \$200 per person ▪ \$600 per family 		
Diagnostic Outpatient	<ul style="list-style-type: none"> • X-ray and Laboratory 	80%	60%
Dialysis		80%	60%
Durable Medical Equipment (DME) (No Pre-Certification Required)	<ul style="list-style-type: none"> ▪ DME is payable for rental up to the purchase price of the item, repair, adjustment or servicing of the item or medically necessary replacement due to a change in the covered person's physical condition or if the item cannot be satisfactorily repaired. ▪ RX Required 	80%	60%
Emergency Room (ER)	<ul style="list-style-type: none"> ▪ ER Copay of \$150 applies ▪ Copay waived if treatment of fracture, surgery or inpatient admission follows. 	80%	60%

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Experimental Treatment	Vax-D, IDD and any other experimental treatment is not covered.	0%	0%
Extended Care/Skilled Nursing Facility (Pre-Certification Required)	<ul style="list-style-type: none"> ▪ Custodial care not covered ▪ Maximum of 60 days per calendar year 	80%	60%
Hearing Benefit	<ul style="list-style-type: none"> • No Benefit 	N/A	N/A
Home Health/Home Infusion Therapy Services (No Pre-Certification Required)	<ul style="list-style-type: none"> ▪ Home health/home infusion therapy services payable to a maximum of 120 visits/person per calendar year. 	80%	60%
Hospice Care (No Pre-Certification Required)		80%	60%
Hospital (Inpatient) (Pre-Certification Required)	<ul style="list-style-type: none"> ▪ Hospital room and board expenses will be paid at the average semi-private room rate; except room and board expenses in special care units will be paid at the rate for such units. 	80%	60%
Hospital – Other Charges		80%	60%
Infertility	<ul style="list-style-type: none"> ▪ Not Covered 		
Laboratory Services		80%	60%
Lifetime Maximum	<ul style="list-style-type: none"> ▪ \$1,000,000 		
Maternity	<ul style="list-style-type: none"> ▪ Employees or dependent wives, only • Maternity charges are paid @ global rate at time of delivery 	80%	60%
Outpatient Expenses		80%	60%
Outpatient Surgical Facility		80%	60%
Orthotic Devices	<ul style="list-style-type: none"> ▪ Orthopedic shoes and related items such as wedges, cookies and foot orthotics are payable if custom made and are payable once in a 12-month period for adults and once in a 6-month period for children under 19 yrs, when replacement due to growth. 	80%	60%
Physician And Health Care Practitioner Office Services	<ul style="list-style-type: none"> ▪ Charges for other services provided at the physician's office paid at 80% or 60% 	100% less \$25 PCP Co-Pay \$35 Specialist Co-Pay	60%

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Physical Exam	<ul style="list-style-type: none"> ▪ \$300 maximum every 2 years ▪ Employees and dependents over age 19 	80%	60%
Physical, Occupational & Osteopathic Manipulative Therapy	<ul style="list-style-type: none"> ▪ See Rehabilitation Services 	80%	60%
<p>Prescription Drugs (Outpatient)</p> <ul style="list-style-type: none"> • Drugs may be purchased at a Retail Pharmacy or through the Mail Order (Home Delivery Service) for maintenance medication. • The Plan covers medically necessary FDA approved drugs which may be lawfully dispensed by a Physician or Health Care Practitioner. • Payable drugs include but are not limited to prescription contraceptives, diabetic supplies, and prenatal vitamins. 	<ul style="list-style-type: none"> ▪ The Trust has contracted with an independent Prescription Benefit manager (PBM) to administer the Prescription Drug Program. The PBM provides a network of retail pharmacies that offer a discount on prescriptions, a mail order service for home delivery of prescriptions and processing of outpatient prescription drug claims. ▪ Some drugs have a quantity limit or may require prior authorization by contacting the Prescription Drug Program. ▪ See Article III Part D in the Benefit Booklet for drugs that are not payable by the Plan. ▪ Expenses for outpatient prescription drugs do not apply toward the Plan's Coinsurance Maximum. ▪ Certain over the counter medications will be covered by the Fund. Prilosec OTC and Claritin OTC will be covered at the generic copay. Both will require a valid prescription from your doctor. <p align="center"><u>Effective June 1, 2010</u></p> <p align="center">New specialty pharmacy benefit available through Prescription Solution Specialty Pharmacy. 1-800-797-9791 Prescription Solution Specialty Pharmacy (30 day Supply) High Cost Oral & Injectable medications \$75.00 co-pay</p>	<p>In-Network Retail Pharmacy: (up to a 30-day supply) <i>Generic:</i> 100% after a \$10 co-pay <i>Brand with no generic available:</i> 100% after a \$30 co-pay <i>Brand with generic available:</i> 100% after a \$75 co-pay</p> <p>Mail-Order (3-Month Supply) <i>Generic:</i> \$20 co-pay <i>Brand with no generic available:</i> \$60 co-pay <i>Brand with generic available:</i> \$150 co-pay</p>	<p>Non-contracted Retail Pharmacy within the service area: 60% of billed charges</p> <p>Non-contracted Retail Pharmacy outside the service area: 80% of billed charges.</p>
Pre-Certification/ Authorization	Also required, SNF admits, Inpatient Rehabilitation, Long term acute care facility & Transplants – Call Medical Management, (602) 249-3582 option 6	80%	60%
Pre-Existing	<ul style="list-style-type: none"> ▪ Limited to \$5,000 payment maximum 	80%	60%

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Preventive (Wellness) Services	<ul style="list-style-type: none"> ▪ Routine Childhood Immunizations to age 19 – Office visit not covered • Annual Gynecological Exam and Pap Smear Mammograms • Women Ages 30 – 39: One single baseline mammogram during that ten year period. • Women Ages 40+: One mammogram every year. ▪ Adult Preventive Immunizations only when required for treatment of injury or exposure. • Also See Physical Exam 	80%	60%
Prosthetic Appliances	<ul style="list-style-type: none"> ▪ Prosthetic appliance means items replacing a missing body part, such as an artificial limb. ▪ One pair of contact lenses is payable after the surgical removal of the lens of the eye such as after cataract extraction surgery. 	80%	60%
Lasik (RK)	<ul style="list-style-type: none"> ▪ Not Covered 		
Radiology and Nuclear Medicine Services		80%	60%
Rehabilitation Services • (Outpatient Physical, Occupational and Speech Therapy) (No Pre-Certification Required)	<ul style="list-style-type: none"> ▪ Outpatient Rehabilitation includes any combination of Physical, Occupational and/or Speech therapy, Respiratory therapy or Cardiac Rehabilitation and is payable to a maximum of \$5,000 per person per calendar year. ▪ Speech therapy is covered for the purpose of restoring partial or complete loss of speech. See Benefit Booklet for definition. ▪ Maintenance rehabilitation is not payable. 	80%	60%
Rehabilitation Services • (Inpatient Rehabilitation Admission) (Pre-Certification Required)	<ul style="list-style-type: none"> ▪ Inpatient Rehabilitation is payable for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting to a maximum of 60 days per calendar year. 	80%	60%
Smoking Cessation	<ul style="list-style-type: none"> ▪ Not Covered 		
Spinal Manipulation	<ul style="list-style-type: none"> ▪ Maximum \$1,500/person per calendar year. • Spinal manipulation and related services by a Physician or Chiropractor <ul style="list-style-type: none"> • Radiology services and medically necessary supplies are not included in this limit. 	80%	60%
Stop Loss	<ul style="list-style-type: none"> ▪ See Annual Coinsurance Limit 		
Surgeons		80%	60%

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TMJ dysfunction/syndrome	▪ Maximum \$1,500/person per lifetime (combined dental, surgical & medical benefits).	80%	60%
All Other Covered Charges		80%	60%

In Network



Secondary Wrap Network



SCHEDULE OF BEHAVIORAL HEALTH BENEFITS

See Rules and Regulations in the Plan Booklet for more information.

call Mines & Associates 1-800-873-7138

Benefits	Coinsurance Payable by the Plan	
	Precertified Providers (In-Network)	Non-Precertified Providers (Out of Network)
Deductible	None	None
Employee Assistance Program (EAP) (1-6 Visits)	No Charge	Not Available
Inpatient Care (Mental/Nervous) • Hospital expenses, room & board, drug, x-ray and lab, physician charges, detoxification, residential and partial hospital (paid at 2 partial days to 1 inpatient day).	100% coverage to the calendar year limit.	50% coverage per day for facility and professional fees combined to the calendar year limit.
Inpatient Calendar Year Limit	30 days	3 days
Outpatient Care (Mental/Nervous) Visits 1-6: Visits 7-45:	100% no copay for EAP visits 1-6 100% after a \$5 copay per visit	60% coverage to the calendar year limit.
Outpatient Calendar Year Limit	45 days	3 visits
Total Substance Abuse (Alcoholism/Drug Abuse) Lifetime Limit ▪ 2 In-patient substance abuse treatments per lifetime, including detoxification.		
Inpatient:	60 days	6 days
Outpatient:	180 visits	12 visits
Utilization Review	Pre-authorization required for all in-network benefits. Failure to obtain pre-authorization will result in payment at the out-of-network benefit levels. Emergency: For emergency admission, notification must be received by the next scheduled workday.	No pre-authorization required. No penalties apply

SCHEDULE OF INDEMNITY DENTAL PLAN BENEFITS

Dental services may be obtained from any licensed dental care provider.

Calendar Year Deductible	\$35 per individual (3 per family)
Calendar Year Maximum	\$1,400
Preventative Care <ul style="list-style-type: none"> • Exams (2 per calendar year) • Fluoride Treatment (1 per year to age 19) • Prophylaxis (1 per 6 month period) • Bitewing X-Rays (1 per 6 month period) • Full Mouth X-Rays (1 per 3 year period) • Space Maintainers (for children under 14 only) • Sealants (for children under 14 only and only on molars) 	100% of allowed charges
Restorative Care <ul style="list-style-type: none"> • Fillings • Extractions • Oral Surgery • Anesthesia • Periodontal Services • Endodontics 	80% of allowed charges
Major Care <ul style="list-style-type: none"> • Crowns • Bridges • Dentures 	50% of allowed charges Replacements limited to every 5 years
Not Covered	<ul style="list-style-type: none"> • Tooth Implants and related services • Cosmetic procedures • Replacement for lost, misplaced or stolen bridge or dentures
Notes	<ul style="list-style-type: none"> • Claims may be subject to an independent dental review. • Supporting x-rays and/or notes may be required or requested.
Orthodontia <ul style="list-style-type: none"> • Dependent children only 	50% of allowed charges Lifetime maximum \$1,000

SCHEDULE OF VISION PLAN BENEFITS

Payable vision services must be obtained from the in-network Vision Care Providers. Contact the Vision Service Plan 1-800-877-7195 for the list of in-network vision providers.

Vision Services		In-Network Providers	Out of Network Providers
EYE EXAM	One exam in any 12 consecutive month period	100% after a \$10 copay	Plan pays up to \$40
FRAMES	One frame in any 24 consecutive month period	100% after a \$25 copay. One copay applies if both lenses and frames purchased together at the same time.	Plan pays up to \$35
LENSES	One pair of lenses in any 12 consecutive month period	100% after a \$25 copay	Plan pays up to: Single: \$30 Bifocal: \$60 Trifocal: \$80 Lenticular: \$180
Contact Lenses	One pair of contact lenses in any 12 consecutive month period, in lieu of all other lens and frame benefits.	<ul style="list-style-type: none"> • Visually Necessary: 100% • All others: Plan pays up to \$40 	<ul style="list-style-type: none"> • Visually Necessary Lenses: Plan Pays up to \$380 • All others: Plan pays up to \$65

SCHEDULE OF WEEKLY DISABILITY EXPENSE BENEFITS Class 4

See Benefit Provisions in the Plan Booklet for more information (Article III,Part C)

Weekly Benefit	\$150/week
Duration of Disability Benefit	Up to 26 weeks
When Payment Begins	<ul style="list-style-type: none">• Payment begins with the 1st day of disability due to an accident• Payment begins on the 4th day of disability due to sickness