

**EFFECTIVE IMMEDIATELY, CLAIMS WILL  
NO LONGER BE ACCEPTED VIA FAX.**

**PLEASE SUBMIT YOUR CLAIMS  
ELECTRONICALLY OR REGULAR MAIL**

**TO:**

**Southwest Service Administrators, Inc.**

**2400 W. Dunlap Ave., Suite 250**

**Phoenix, AZ 85021**

**PROFESSIONAL PROVIDERS WITHIN THE  
STATE OF ARIZONA ARE ENCOURAGED  
TO SUBMIT CLAIMS ELECTRONICALLY  
TO BCBSAZ USING PAYER ID NUMBER**

**53589**

**Southwestern Teamsters Security Fund**  
**SCHEDULE OF BENEFITS - ACTIVE**  
**Group # CL400**

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)
<b>Accident – Supplemental</b>	<ul style="list-style-type: none"> <li>▪ 100% of the first \$500 of Allowable Expenses incurred within 90 days of the accident.</li> <li>• After the 1<sup>st</sup> \$500.00 benefits payable @ 80% or 60% - subject to deductible</li> </ul>	80%	60%
<b>Acupuncture</b>	<ul style="list-style-type: none"> <li>▪ Payable when performed by a Physician</li> </ul>	80%	60%
<b>Allergy</b>	<ul style="list-style-type: none"> <li>• Testing, desensitization and allergy antigen services</li> </ul>	80%	60%
<b>Ambulance</b>	<ul style="list-style-type: none"> <li>▪ Surface/Air</li> </ul>	80%	60%
<b>Ambulatory Surgery Facility</b>	<ul style="list-style-type: none"> <li>• In a hospital-based or free-standing outpatient surgery center.</li> </ul>	80%	60%
<b>Anesthesia</b>		80%	60%
<b>Annual Calendar Yr Maximum</b>	<ul style="list-style-type: none"> <li>• \$1,250,000 on all “Essential Benefits (Effective 12-01-11)</li> </ul>		
<b>Annual Out of Pocket - Co-Insurance Maximums</b>	<ul style="list-style-type: none"> <li>▪ Effective 1/1/08 the Plan pays 80% of the first <b>\$25,000</b> 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.</li> </ul>		
<b>Assistant Surgeons</b>	<ul style="list-style-type: none"> <li>▪ Payable to a maximum of 20% of the allowed fee payable to the surgeon</li> </ul>	80%	60%
<b>Blood transfusions and blood products</b>		80%	60%
<b>Chemotherapy</b>		80%	60%
<b>Chiropractic Care</b>	(SEE SPINAL MANIPULATION)		
<b>Death Benefits (Life)</b>	<ul style="list-style-type: none"> <li>▪ \$3,000 (paid to your beneficiary) Employee Only</li> </ul>		
<b>Death Benefits (AD&amp;D)</b>	<ul style="list-style-type: none"> <li>▪ Up to \$3,000 Employee Only</li> </ul>		
<b>Deductible</b>	<ul style="list-style-type: none"> <li>▪ \$200 per person</li> <li>• Per calendar year</li> <li>▪ \$600 per family</li> </ul>		
<b>Diagnostic Outpatient</b>	<ul style="list-style-type: none"> <li>• X-ray and Laboratory</li> </ul>	80%	60%
<b>Dialysis</b>		80%	60%
<b>Durable Medical Equipment (DME) (No Pre-Certification Required)</b>	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ RX Required</li> </ul>	80%	60%

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<b>Emergency Room (ER)</b>	<ul style="list-style-type: none"> <li>▪ ER Copay of \$150 applies</li> <li>▪ Copay waived if treatment of fracture, surgery or inpatient admission follows.</li> </ul>	80%	60%
<b>Experimental Treatment</b>	Vax-D, IDD and any other experimental treatment is not covered.	0%	0%
<b>Extended Care/Skilled Nursing Facility (Pre-Certification Required)</b>	<ul style="list-style-type: none"> <li>▪ Custodial care not covered</li> <li>▪ Maximum of 60 days per calendar year</li> </ul>	80%	60%
<b>Hearing Benefit</b>	<ul style="list-style-type: none"> <li>• No Benefit</li> </ul>	N/A	N/A
<b>Home Health/Home Infusion Therapy Services (No Pre-Certification Required)</b>	<ul style="list-style-type: none"> <li>▪ Home health/home infusion therapy services payable to a maximum of 120 visits/person per calendar year.</li> </ul>	80%	60%
<b>Hospice Care (No Pre-Certification Required)</b>		80%	60%
<b>Hospital (Inpatient) (Pre-Certification Required)</b>	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>	80%	60%
<b>Hospital – Other Charges</b>		80%	60%
<b>Infertility</b>	<ul style="list-style-type: none"> <li>▪ Not Covered</li> </ul>		
<b>Laboratory Services</b>		80%	60%
<b>Lifetime Maximum</b>	<ul style="list-style-type: none"> <li>▪ \$1,000,000 <b>(Prior to 12-01-10)</b> <ul style="list-style-type: none"> <li>• <b>Effective 12-01-10 Lifetime Maximum no longer applies</b></li> </ul> </li> </ul>		
<b>Maternity</b>	<ul style="list-style-type: none"> <li>▪ Employees or dependent wives, only</li> <li>• Maternity charges are paid @ global rate at time of delivery</li> </ul>	80%	60%
<b>Outpatient Expenses</b>		80%	60%
<b>Outpatient Surgical Facility</b>		80%	60%
<b>Orthotic Devices</b>	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>	80%	60%

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<b>Physician And Health Care Practitioner Office Services</b>	<ul style="list-style-type: none"> <li>▪ Charges for other services provided at the physician's office paid at 80% or 60%</li> <li>▪ <b>Physicians must secure specialty medications through Prescription Solutions 1-800-797-9791</b> <ul style="list-style-type: none"> <li>• A list of specialty medications can be found on the website by clicking on "Drug Lists" then "Prescription Solutions SP Drug List"</li> </ul> </li> </ul>	<p style="text-align: center;">100% less \$25 PCP Co-Pay \$35 Specialist Co-Pay</p>	<p style="text-align: center;">60%</p>
<b>Physical Exam</b>	<ul style="list-style-type: none"> <li>▪ \$300 maximum every 2 yrs (Prior to 12-01-10)</li> <li>▪ Employees and dependents over age 19</li> </ul> <p style="text-align: center;"><b>*****EFFECTIVE 12-01-10*****</b></p> <ul style="list-style-type: none"> <li>▪ <b>1 Exam every 2 yrs subject to deductible</b></li> <li>▪ Employees and dependents over age 19</li> </ul>	<p style="text-align: center;">80%</p>	<p style="text-align: center;">60%</p>
<b>Physical, Occupational &amp; Osteopathic Manipulative Therapy</b>	<ul style="list-style-type: none"> <li>▪ See Rehabilitation Services</li> </ul>	<p style="text-align: center;">80%</p>	<p style="text-align: center;">60%</p>

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<p><b>Prescription Drugs (Outpatient)</b></p> <ul style="list-style-type: none"> <li>• Drugs may be purchased at a Retail Pharmacy or through the Mail Order (Home Delivery Service) for maintenance medication.</li> <li>• The Plan covers medically necessary FDA approved drugs which may be lawfully dispensed by a Physician or Health Care Practitioner.</li> <li>• Payable drugs include but are not limited to prescription contraceptives, diabetic supplies, and prenatal vitamins.</li> </ul>	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Some drugs have a quantity limit or may require prior authorization by contacting the Prescription Drug Program.</li> <li>▪ See Article III Part D in the Benefit Booklet for drugs that are not payable by the Plan.</li> <li>▪ Expenses for outpatient prescription drugs do not apply toward the Plan's Coinsurance Maximum.</li> <li>▪ 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.</li> </ul> <p style="text-align: center;"><b>**SPECIALTY PHARMACY**</b></p> <p style="text-align: center;"><b>All specialty medications Oral, Injectable or Infused must be secured through Prescription Solutions.</b></p> <p style="text-align: center;"><b>1-800-797-9791</b></p> <p style="text-align: center;">High Cost Oral, Injectable or Infused medications \$75.00 co-pay (30 day Supply)</p> <p style="text-align: center;"><b>A list of specialty medications can be found on the website by clicking on "Drug Lists" then "Prescription Solutions SP Drug List"</b></p>	<p><b>In-Network Retail Pharmacy: (up to a 30-day supply)</b></p> <p><i>Generic:</i> 100% after a \$10 co-pay</p> <p><i>Brand with no generic available:</i> 100% after a \$30 co-pay</p> <p><i>Brand with generic available:</i> 100% after a \$75 co-pay</p> <p><b>Mail-Order (3-Month Supply)</b></p> <p><i>Generic:</i> \$20 co-pay</p> <p><i>Brand with no generic available:</i> \$60 co-pay</p> <p><i>Brand with generic available:</i> \$150 co-pay</p>	<p>Non-contracted Retail Pharmacy <b>within the service area:</b> 60% of billed charges</p> <p>Non-contracted Retail Pharmacy <b>outside the service area:</b> 80% of billed charges.</p>
<p><b>Pre-Certification/ Authorization</b></p>	<p>Also required, SNF admits, Inpatient Rehabilitation, Long term acute care facility &amp; Transplants – Call Medical Management, (602) 249-3582 option 6</p> <ul style="list-style-type: none"> <li>• <b>Specialty Pharmacy – Call Prescription Solution @ 1-800-797-9791 for all high cost Oral, Injectable or Infused medications</b></li> </ul>	<p style="text-align: center;">80%</p>	<p style="text-align: center;">60%</p>
<p><b>Pre-Existing</b></p>	<ul style="list-style-type: none"> <li>• Limited to \$5,000 (Prior to 12-01-10)</li> </ul> <p style="text-align: center;">*****Effective 12-01-10*****</p> <ul style="list-style-type: none"> <li>• <b>Limited to \$5,000 (Age 19 &amp; Over)</b></li> </ul>	<p style="text-align: center;">80%</p>	<p style="text-align: center;">60%</p>

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<b>Preventive (Wellness) Services</b>	<ul style="list-style-type: none"> <li>▪ Routine Childhood Immunizations to age 19 – Office visit not covered</li> <li>• Annual Gynecological Exam and Pap Smear Mammograms</li> <li>• Women Ages 30 – 39: One single baseline mammogram during that ten year period.</li> <li>• Women Ages 40+: One mammogram every year.</li> <li>▪ Adult Preventive Immunizations <b>only</b> when required for treatment of injury or exposure.</li> <li>• Also See Physical Exam</li> </ul>	80%	60%
<b>Prosthetic Appliances</b>	<ul style="list-style-type: none"> <li>▪ Prosthetic appliance means items replacing a missing body part, such as an artificial limb.</li> <li>▪ One pair of contact lenses is payable after the surgical removal of the lens of the eye such as after cataract extraction surgery.</li> </ul>	80%	60%
<b>Lasik (RK)</b>	<ul style="list-style-type: none"> <li>▪ Not Covered</li> </ul>		
<b>Radiology and Nuclear Medicine Services</b>		80%	60%
<b>Rehabilitation Services</b> • (Outpatient Physical, Occupational and Speech Therapy)  <b>(No Pre-Certification Required)</b>	<ul style="list-style-type: none"> <li>▪ <b>Outpatient Rehabilitation</b> includes any combination of Physical, Occupational and/or Speech therapy, Respiratory therapy or Cardiac Rehabilitation and is payable to a max of \$5,000 per person per calendar yr. (Prior to 11-30-10)</li> </ul> <p style="text-align: center;"><b>*****EFFECTIVE 12-01-2010*****</b></p> <ul style="list-style-type: none"> <li>▪ <b>Outpatient Rehabilitation</b> includes any combination of Physical, Occupational and/or Speech therapy, Respiratory therapy or Cardiac Rehabilitation and is payable to a max of <b>50 visits</b> per person per calendar yr.</li> <li>▪ <b>Speech therapy</b> is covered for the purpose of restoring partial or complete loss of speech. See Benefit Booklet for definition.</li> <li>▪ <b>Maintenance rehabilitation</b> is not payable.</li> </ul>	80%	60%
<b>Rehabilitation Services</b> • (Inpatient Rehabilitation Admission) <b>(Pre-Certification Required)</b>	<ul style="list-style-type: none"> <li>▪ <b>Inpatient Rehabilitation</b> 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.</li> </ul>	80%	60%
<b>Smoking Cessation</b>	<ul style="list-style-type: none"> <li>▪ Not Covered</li> </ul>		

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<b>Spinal Manipulation &amp; Related Services</b>	<p style="text-align: center;"><b>****EFFECTIVE 12-01-10****</b></p> <ul style="list-style-type: none"> <li>• 20 visits maximum per calendar year</li> <li>• Subject to the deductible</li> </ul>	80%	60%
<b>Stop Loss</b>	▪ See Annual Coinsurance Limit		
<b>Surgeons</b>		80%	60%
<b>TMJ dysfunction/syndrome</b>	▪ Maximum \$1,500/person per lifetime (combined dental, surgical & medical benefits).	80%	60%
<b>All Other Covered Charges</b>		80%	60%

**In Network**



**Secondary Wrap Network**



## SCHEDULE OF BEHAVIORAL HEALTH BENEFITS

### Group # CL400

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)
<b>Deductible</b>	None	None
<b>Employee Assistance Program (EAP)</b> (1-6 Visits)	No Charge	Not Available
<b>Inpatient Care (Mental/Nervous)</b> • 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.
<b>Inpatient Calendar Year Limit</b>	30 days	3 days
<b>Outpatient Care (Mental/Nervous)</b> 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.
<b>Outpatient Calendar Year Limit</b>	45 days	3 visits
<b>Total Substance Abuse (Alcoholism/Drug Abuse) Lifetime Limit</b> ▪ 2 In-patient substance abuse treatments per lifetime, including detoxification.		
Inpatient:	60 days	6 days
Outpatient:	180 visits	12 visits
<b>Utilization Review</b>	Pre-authorization required for all in-network benefits. <b>Failure to obtain pre-authorization will result in payment at the out-of-network benefit levels.</b> <b>Emergency:</b> 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.

<b>Calendar Year Deductible</b>	\$35 per individual (3 per family)
<b>Calendar Year Maximum</b>	\$1,400 (Applies to Age 19 & over only)
<b>Preventative Care</b> <ul style="list-style-type: none"> <li>• Exams (2 per calendar year)</li> <li>• Fluoride Treatment (1 per year to age 19)</li> <li>• Prophylaxis (1 per 6 month period)</li> <li>• Bitewing X-Rays (1 per 6 month period)</li> <li>• Additional Single Film X-Rays Require A Tooth Number</li> <li>• Full Mouth X-Rays (1 per 3 year period)</li> <li>• Space Maintainers (for children under 14 only)</li> <li>• Sealants (for children under 14 only and only on molars)</li> </ul>	100% of allowed charges
<b>Restorative Care</b> <ul style="list-style-type: none"> <li>• Fillings</li> <li>• Extractions</li> <li>• Oral Surgery</li> <li>• Anesthesia</li> <li>• Periodontal Services</li> <li>• Endodontics</li> </ul>	80% of allowed charges
<b>Major Care</b> <ul style="list-style-type: none"> <li>• Crowns</li> <li>• Bridges</li> <li>• Dentures</li> </ul>	50% of allowed charges Replacements limited to every 5 years
<b>Not Covered</b>	<ul style="list-style-type: none"> <li>• Tooth Implants and related services</li> <li>• Cosmetic procedures</li> <li>• Replacement for lost, misplaced or stolen bridge or dentures</li> </ul>
<b>Notes</b>	<ul style="list-style-type: none"> <li>• Claims may be subject to an independent dental review.</li> <li>• Supporting x-rays and/or notes may be required or requested.</li> </ul>
<b>Orthodontia</b> <ul style="list-style-type: none"> <li>• Dependent children only</li> </ul>	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
<b>EYE EXAM</b>	Covered in full every 12 months	100% -No copay applies	Plan pays up to \$40 once every 12 months
<b>FRAMES</b>	Covered every 24 months	100% -No copay applies <ul style="list-style-type: none"> <li>• Frame of your choice covered up to \$95.00</li> </ul>	Plan pays up to \$35 once every 24 months
<b>LENSES</b>	Covered in full every 12 months	100% -No Copay applies <ul style="list-style-type: none"> <li>• Single vision, lined bifocal, lined trifocal and lenticular lenses</li> <li>• Polycarbonate lenses for dependent children</li> </ul>	Plan pays up to: <ul style="list-style-type: none"> <li>• Single Vision: Up to \$30</li> <li>• Lined Bifocal: Up to \$60</li> <li>• Lined Trifocal: Up to \$80</li> <li>• Lenticular: Up to \$80</li> </ul>
<b>Contact Lenses</b>	Covered every 12 months	<ul style="list-style-type: none"> <li>• When you choose contacts instead of glasses, your \$65.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation)</li> <li>• <b>Visually Necessary Contacts are covered in full when specific benefit criteria is satisfied and when prescribed by a doctor.</b></li> </ul> <p>When contact lenses are obtained, the covered person shall not be eligible for lenses again for 12 months and frames for 24 months</p>	<ul style="list-style-type: none"> <li>• Elective Contacts up to \$65.00 once every 12 months in lieu of all other lens and frame benefits.</li> <li>• Visually Necessary Contacts – Professional fees and materials up to \$250.00 once every 12 months.</li> </ul>

**When choosing Out of Network Providers you are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. Call VSP @ 800-877-7195**

**SCHEDULE OF WEEKLY DISABILITY EXPENSE BENEFITS Class 4**

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

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