

**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**

**ARIZONA SHEET METAL TRUST FUNDS**

**SCHEDULE OF BENEFITS**

**PLAN: ACTIVE Group # ASM001**

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>• Paid same as illness</li> </ul>	80%	70%
<b>Acupuncture</b>	<b>See Chiropractic Care</b>		
<b>Ambulance</b>	<ul style="list-style-type: none"> <li>▪ Surface/Air</li> </ul>	80%	70%
<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%	70%
<b>Anesthesia</b>		80%	70%
<b>Annual Maximum</b>	<ul style="list-style-type: none"> <li>• <b>\$1,250,000</b></li> <li>• <b>Effective October 1, 2011</b></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%	70%
<b>Blood transfusions and blood products</b>		80%	70%
<b>Chemotherapy</b>		80%	70%
<b>Chiropractic Services/Acupuncture</b> <ul style="list-style-type: none"> <li>• Musculoskeletal Manipulation Services (by a Physician or Chiropractor) including related ancillary services (e.g., office visit, physical therapy, Diagnostic &amp; tests).</li> </ul>	<p align="center">****EFFECTIVE 10-01-10****</p> <ul style="list-style-type: none"> <li>• Musculoskeletal Manipulation and related services (by a Physician or Chiropractor) are payable to a maximum of 16 visits per calendar year. This limit does not include radiology services performed by the Health Care.</li> <li>• Subject to deductible</li> </ul>	80%	70%
<b>Deductible</b> <ul style="list-style-type: none"> <li>• Per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>▪ \$200 per person</li> <li>▪ \$600 per family</li> </ul>	N/A	N/A
<b>Diagnostic Outpatient</b> <ul style="list-style-type: none"> <li>• X-ray and Laboratory</li> </ul>		80%	70%
<b>Dialysis</b>		80%	70%
<b>Durable Medical Equipment (DME)</b> (No Pre-Certification Required)	<ul style="list-style-type: none"> <li>• Rental of equipment will not exceed the purchase price</li> <li>• Prescription required</li> </ul>	80%	70%
<b>Emergency Room (ER)</b>	<ul style="list-style-type: none"> <li>• \$250 copay applies to non-emergency visits</li> <li>• Copay waived if admitted as inpatient or surgery</li> </ul>	80%	70%

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<b>Experimental Treatment</b>	Vax-D, IDD and any other experimental treatment is not covered.	0%	0%									
<b>Hearing Benefit</b>	• Not covered	N/A	N/A									
<b>Home Health Care (No Pre-Certification Required)</b>	• In lieu of confinement • Prescription required	80%	70%									
<b>Hospice Care (No Pre-Certification Required)</b>	• Terminally ill persons assessed to have a life expectancy of six months or less • Bereavement Counseling – 6 visits within 12 months of patient’s death.	100%	100%									
<b>Hospital (Inpatient) (Pre- Certification Required)</b>	• Non PPO Inpatient Hospital charges are subject to an additional \$300 copay in addition to the calendar year deductible and coinsurance percentage • <b>Failure to Pre-cert elective hospital admission will result in \$150.00 penalty</b>	80%	70%									
<b>Hospital – Other Charges</b>		80%	70%									
<b>Infertility</b>	• Not covered	N/A	N/A									
<b>Laboratory Services</b>		80%	70%									
<b>Life and AD&amp;D Benefits</b>	<table border="0"> <tr> <td></td> <td align="center"><b>Life</b></td> <td align="center"><b>AD&amp;D</b></td> </tr> <tr> <td>• Employee</td> <td align="center">\$10,000</td> <td align="center">\$10,000</td> </tr> <tr> <td>• Dependents</td> <td align="center">\$ 1,000 (Life only)</td> <td></td> </tr> </table>		<b>Life</b>	<b>AD&amp;D</b>	• Employee	\$10,000	\$10,000	• Dependents	\$ 1,000 (Life only)			
	<b>Life</b>	<b>AD&amp;D</b>										
• Employee	\$10,000	\$10,000										
• Dependents	\$ 1,000 (Life only)											
<b>Lifetime Maximum</b>	<ul style="list-style-type: none"> <li>• \$1,000,000 (Prior to 10-01-10)</li> <li>• See Annual Calendar Yr Max</li> </ul> <p align="center">**Effective 10-01-10 lifetime max no longer applies**</p>											
<b>Maternity</b>	• Employee and dependent spouse only	80%	70%									
<b>Obesity</b>	<ul style="list-style-type: none"> <li>• Limited to \$20,000 per lifetime, including complications resulting from treatment</li> <li>• Only treatment of clinically severe (morbid) obesity is covered.</li> </ul> <ul style="list-style-type: none"> <li>• <b>Pre-Cert through Medical Management Required</b></li> </ul>	80%	70%									
<b>Outpatient Surgical Facility</b>		80%	70%									

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<b>Orthopedic Equipment Orthotics &amp; Braces</b>	<ul style="list-style-type: none"> <li>• Prescription required</li> <li>• Payable every 5 years (once every six months for children)</li> <li>• Shoes/boots not covered</li> </ul>	80%	70%
<b>Physician And Health Care Practitioner Office Services</b>		80%	70%
<b>Physical Exam</b> • Annual exam	<ul style="list-style-type: none"> <li>• Employee and spouse up to a maximum of \$200 per calendar year</li> <li>• Deductible waived</li> </ul>	100%	100%
<b>Physical Therapy, Respiratory Therapy, Cardiac Rehab, Speech Therapy, and Occupational Therapy</b>	<ul style="list-style-type: none"> <li>• Up to a maximum of \$750 per calendar year, <b>unless precertified and provided by a PPO provider (PRIOR TO 10-01-10)</b></li> </ul> <p align="center"><b>***EFFECTIVE 10-01-10***</b></p> <p align="center"><b>16 visits per calendar year</b></p> <ul style="list-style-type: none"> <li>• Prescription required</li> </ul>	80%	70%
<b>Pre-Certification/Authorization</b>	Also required for SNF admits, Inpatient Rehabilitation, Long Term Acute Care & Transplants – Call Medical Management, (602) 249-3582 option 6		
<b>Pre-Existing</b>		N/A	N/A

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<b>Prescription Drugs (Outpatient)</b>	<ul style="list-style-type: none"> <li>• All claims to Envision RX Options for processing 1-800-361-4542</li> <li>• Participating pharmacy co-pays (greater co-pay applies):               <ul style="list-style-type: none"> <li>Generic - 20% or \$10</li> <li>Formulary Brand – 20% or \$20</li> <li>Non-formulary Brand – 20% or \$20</li> </ul> </li> <li>• Mail Order thru Orchard Pharmaceutical Services 1-866-909-5170               <ul style="list-style-type: none"> <li>Generic co-pay - \$15</li> <li>Formulary Brand copay - \$40</li> <li>Non-formulary Brand copay - \$40</li> </ul> </li> </ul>	See Explanation And Limitations	70%
<b>Preventive (Wellness) Services</b>	<ul style="list-style-type: none"> <li>• Employee and spouse up to a maximum of \$200 per calendar year includes Annual Routine Pap Smear</li> <li>• Deductible waived</li> </ul>	80%	70%
<b>Prosthetic Appliances</b>	<ul style="list-style-type: none"> <li>• Prescription required</li> </ul>	80%	70%
<b>Radiology and Nuclear Medicine Services</b>	<ul style="list-style-type: none"> <li>• <b>Mammograms</b></li> <li>• Women Ages 35 – 39: One single baseline mammogram during that ten year period.</li> <li>• Women Ages 40-49: One mammogram every two years.</li> <li>• Women Ages 50+: One mammogram every year.</li> </ul>	80%	70%
<b>Skilled Nursing Facility (Pre-Certification Required)</b>	<ul style="list-style-type: none"> <li>• Not to exceed 60 days during any 12 consecutive month period</li> <li>• Services under the supervision of Doctors for a medical reason and not for custodial care</li> </ul>	80%	70%
<b>Smoking Cessation</b>	<ul style="list-style-type: none"> <li>• Not a benefit</li> </ul>	N/A	N/A
<b>Speech Therapy (No Pre-Certification Required)</b>	<ul style="list-style-type: none"> <li>• Prescription required</li> </ul>	80%	70%
<b>Surgeons</b>		80%	70%
<b>Surgical Facility</b>		80%	70%
<b>TMJ (temporo-mandibular joint dysfunction)</b>	<ul style="list-style-type: none"> <li>• Not Covered</li> </ul>	N/A	N/A

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<b>Wellness (Preventative) Child Services</b>	<ul style="list-style-type: none"> <li>• <b>Well Child during the first 15 months of the child's life.</b> <ul style="list-style-type: none"> <li>• 1<sup>st</sup> \$600.00 of well child is payable at 100% not subject to deductible; The balance paid at normal co-insurance after the deductible is met</li> </ul> </li> <li>• Includes doctor visits and immunizations</li> </ul>	<p align="center">100%</p> <p>No deductible up to \$600.00 of allowable charges. Balance sub to deductible and payable at 80%</p>	<p align="center">100%</p> <p>No deductible up to \$600.00 of allowable charges. Balance sub to deductible and payable at 70%</p>
<b>All Other Covered Charges</b>		80%	70%

**In Network**



**Secondary Wrap Network**



**SCHEDULE OF BEHAVIORAL HEALTH BENEFITS**

**PLAN: ACTIVE Group # 001**

**See Rules and Regulations in this booklet for more information.**

**Services must be pre-certified with  
Mines & Associates  
(800)873-7138**

Benefits	Coinsurance Payable by the Plan	
	Mental Nervous	Substance Abuse
<b>Inpatient</b> Including day treatment, partial day care and Intensive outpatient care.	<u><b>EFFECTIVE 10-01-10</b></u> • Subject to deductible • 80% in-network, 70% out-of-network	<u><b>EFFECTIVE 10-01-10</b></u> • <b>Detoxification only</b> Subject to deductible & co-insurance
<b>Outpatient</b>	<u><b>EFFECTIVE 10-01-10</b></u> • First 8 EAP visits 100% <u><b>Then</b></u> • Subject to deductible • 80% in-network, 70% out-of-network	
<b>Intensive Outpatient</b>	N/A	
<b>Psychiatric Day Treatment</b>	<u><b>EFFECTIVE 10-01-10</b></u> • Deductible applies • 80% in network, 70% out-of-network • Upon approval by Mines & Associates, in lieu of inpatient.	

## SCHEDULE OF DENTAL PLAN BENEFITS

### PLAN: ACTIVE

Services are provided thru Delta Dental Plan of Arizona 1-800-352-6132 or 602-938-3131

<b>Deductible</b>	Per Person: \$25 Family: \$75
<b>Coinsurance Percentage</b>	Routine Services: 100% Basic Services: 80% Major Services: 60%
<b>Annual Dental Plan Maximum</b>	\$2,000 <u>for age 19 &amp; over only</u> (effective 10-01-10)
<b>Surgical Treatment (Bony Impacted only)</b>	Covered under the Basic Services
<b>Surgical Treatment</b>	Covered under the Basic Services
<b>Diagnostic &amp; Preventative</b>	Covered under Routine Services
<b>Restorative &amp; Surgical Treatment</b>	Covered under the Basic Services
<b>Prosthetic Treatment</b>	Covered under Major Services
<b>Orthodontic</b>	Not Covered

## SCHEDULE OF VISION PLAN BENEFITS

### PLAN: ACTIVE

Vision Care benefits are provided through United Healthcare Vision (formerly Spectera) at 1-800-638-3895 or [www.myuhcspecialtybenefits.com](http://www.myuhcspecialtybenefits.com) for the list of participating vision providers.

<b>Vision Services</b>	<b>Panel Doctors</b>	<b>Non-Panel Reimbursement Benefit Schedule</b>
<b>Vision Exam</b>	\$10 copay	\$36
<b>Bifocal Lenses</b>	Included in exam copay	\$30
<b>Trifocal Lenses</b>	Included in exam copay	\$46
<b>Lenticular Lenses</b>	Included in exam copay	\$100
<b>Tint</b>	Included in exam copay	\$5
<b>Contact Lenses Cosmetic</b>	\$60	\$60
<b>Contact Lenses Non-Cosmetic</b>	\$300	\$300
<b>Frames</b>	No limit for standard frames	\$31

**SCHEDULE OF DISABILITY INCOME BENEFITS**  
**PLAN: ACTIVE**

<b>Weekly Benefit Amount</b>	\$100
<b>Maximum Benefit period</b>	13 weeks
<b>Accident</b>	Benefits begin on the first day
<b>Illness</b>	Benefits begin on the eighth day