

**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**

## SCHEDULE OF BENEFITS PLAN 501 B

### Group # UF-108

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 1<sup>st</sup> \$300.00 per accident if treated within 30 days of accident and charge is incurred within 6 months of the accident</li> <li>After the 1<sup>st</sup> \$300.00 benefits Subject to deductible and co-insurance</li> </ul>	80%	55%
<b>Acupuncture</b>	<ul style="list-style-type: none"> <li>Payable when administered by a Physician</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Ambulance</b>	<ul style="list-style-type: none"> <li>Air – Per Trip</li> <li>Surface – Maximum of \$600.00 per trip</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Anesthesia</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	55%
<b>Annual Calendar Yr Maximum</b>	<ul style="list-style-type: none"> <li><b>\$1,250,000</b> (effective 1/1/2012)</li> </ul>		
<b>Annual Out of Pocket Maximum</b>	<ul style="list-style-type: none"> <li>Individual annual OOP maximum</li> <li>Each maximum is separate and amounts do not apply to each other</li> </ul>	\$4,500	\$9,000
<b>Assistant Surgeons</b>	<ul style="list-style-type: none"> <li>Maximum of 20% of surgeon's benefit</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Blood transfusions and blood products</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	55%
<b>COB -Carve Out Method</b>	<ul style="list-style-type: none"> <li>Applies to Medical claims only</li> <li>Subject to deductible</li> </ul>	N/A	N/A
<b>Convalescent Care Facility</b> <ul style="list-style-type: none"> <li>Not for custodial care</li> <li>Pre-certification required</li> </ul>	<ul style="list-style-type: none"> <li>Max 60 days per calendar year</li> <li>Must be preceded by hospitalization in a covered facility.</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Chemotherapy</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	55%
<b>Chiropractic Care</b> <ul style="list-style-type: none"> <li>Manipulations and x-rays only</li> </ul>	<ul style="list-style-type: none"> <li>Maximum allowance: \$40 per visit</li> <li>Max 25 visits per year/Subject to deductible</li> </ul>	50%	50%
<b>Death Benefits</b>	<ul style="list-style-type: none"> <li>Employee \$5,000.00</li> <li>Dependent – \$1,000.00</li> </ul>	N/A	N/A
<b>Deductible</b> <ul style="list-style-type: none"> <li>Per calendar year</li> </ul>	<b>EFFECTIVE 02-01-12</b> <b>PPO and Non-PPO deductibles are separate and do not apply to each other.</b>	\$250 Indv \$1,000 Fam	\$500 Indv \$1,000 Fam
<b>Diagnostic Outpatient</b> <ul style="list-style-type: none"> <li>X-ray and Laboratory</li> </ul>	<ul style="list-style-type: none"> <li>100% of the 1<sup>st</sup> \$200.00</li> <li>After the 1<sup>st</sup> \$200.00 benefits payable @ 80% or 55% - Subject to deductible.</li> </ul>	80%	55%

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<b>Diabetic Supplies</b>	<ul style="list-style-type: none"> <li>Diabetic Supply Program through Nations Health– mail order, No co-pay, no deductible; paid at 100% - call 1-800-354-1653</li> </ul>	80%	55%
<b>Dialysis</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	55%
<b>Dietary/Nutritional/Herbal</b>	<ul style="list-style-type: none"> <li>Supplements and medications available without a prescription, except as authorized under any “Step-Therapy” program implemented by the Trustees within the Prescription Drug Network are considered non covered.</li> <li>No over-the-counter drugs are reimbursed.</li> </ul>	N/A	N/A
<b>Durable Medical Equipment (DME)</b>	<ul style="list-style-type: none"> <li>Charges for rental of wheelchair, special Hospital Bed, iron lung, crutches, and other reasonable mechanical therapeutic and durable medical equipment, but not to exceed the purchase of such equipment.</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Emergency Room (ER)</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	80%
<b>Experimental Treatment</b>	<ul style="list-style-type: none"> <li>Vax-D, IDD and any other experimental treatment is not covered.</li> </ul>	N/A	N/A
<b>Hearing Benefit</b>	<ul style="list-style-type: none"> <li>No Benefits Available</li> </ul>	N/A	N/A
<b>Home Health Care</b>	<ul style="list-style-type: none"> <li>Maximum of 60 visits per year</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Hospice Care</b>	<ul style="list-style-type: none"> <li>Treatment for terminal illnesses for individuals whose life expectancy is six months or less</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Hospital (Inpatient) (Pre-certification)</b>	<ul style="list-style-type: none"> <li>Room and Board</li> <li>Intensive Care Unit</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Hospital – Other Charges</b>	<ul style="list-style-type: none"> <li>• Subject to deductible</li> </ul>	80%	55%
<b>Infertility</b>	<ul style="list-style-type: none"> <li>Lifetime maximum \$10,000 for covered expenses</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Laboratory Services</b>	<ul style="list-style-type: none"> <li>Subject to deductible after 1<sup>st</sup> \$200</li> </ul>	80%	55%
<b>Lasik (RK)</b>	<ul style="list-style-type: none"> <li>No benefit</li> </ul>	N/A	N/A

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<b>Mammogram Benefit</b> <ul style="list-style-type: none"> <li>• No deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Women Ages 30 – 39: One single baseline mammogram during that ten year period, payable up to \$300.00.</li> <li>• Women age 40 &amp; over: One mammogram every calendar year payable up to \$300.00.</li> </ul> <p style="text-align: center;"><b>**CHARGES THAT EXCEED \$300.00 SUBJECT TO CO-INSURANCE/NO DEDUCTIBLE**</b></p>	80%	55%
<b>Maternity</b> For employee or legal spouse only	<ul style="list-style-type: none"> <li>• Maternity charges are paid @ global rate at time of delivery</li> <li>• Lab charges, ultrasound or non-fetal stress test not included in global charges</li> <li>• Healthy Maternity Program: Initial OB Care – Call the Fund Office to enroll</li> </ul>	80%	55%
<b>Nutritional/ Dietary</b>	<ul style="list-style-type: none"> <li>• Supplements and medications available without a prescription, except as authorized under any “Step-Therapy” program implemented by the Trustees within the Prescription Drug Network are considered non covered.</li> </ul>	N/A	N/A
<b>Outpatient Expenses</b>	<ul style="list-style-type: none"> <li>• Subject to deductible</li> </ul>	80%	55%
<b>Outpatient Surgical Facility</b>	<ul style="list-style-type: none"> <li>• No pre-authorization required for in-network facilities</li> <li>• In a hospital-based or Free standing surgery center/ Subject to deductible</li> </ul>	80%	55%
<b>Orthopedic Equipment Orthotics &amp; Braces (Must have RX)</b>	<ul style="list-style-type: none"> <li>• Charges for prescribed orthopedic shoes and other supportive appliance</li> <li>• Includes replacement once every 12 months</li> <li>• Includes replacement once every 6 months for 19 years or under</li> <li>• Subject to deductible</li> </ul>	80%	55%
<b>Physician And Health Care Practitioner Office Visit Services</b>	<ul style="list-style-type: none"> <li>• One co-pay per office visit</li> <li>• Charges for other services provided at the physician’s office Subject to deductible and co-insurance.</li> </ul>	100% less the \$20 co-pay	55% Deductible Applies
<b>Physical Exam</b> No deductible	<ul style="list-style-type: none"> <li>• Paid at 100% up to \$250 <b>charges that exceed \$250 Subject to co-insurance/No deductible</b></li> <li>• Includes routine evaluations, lab charges, x-rays</li> </ul>	80%	55%

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<b>Physical, Occupational, Vision &amp; Osteopathic Manipulative Therapy</b>	<ul style="list-style-type: none"> <li>• Payable when rendered by a Registered Physical Therapist or a Registered Occupational Therapist</li> <li>• Prescription for frequency and duration required by a Physician (M.D. or D.O.)</li> <li>• 16 visits per calendar year combined</li> <li>• Does not include maintenance or Industrial care</li> <li>• Subject to deductible</li> </ul>	80%	55%
<b>Prescription Drugs (Outpatient)</b>  <u>Ascend Specialty Rx Medications for Oncology or Transplant Treatment obtained at the pharmacy</u>	<b>Informed RX 1-800-880-1188</b> <b>Ascend Specialty Rx 1-800-850-9122</b> <ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand Name (no generic equivalent)</li> <li>• Brand name (with generic equivalent)</li> <li>• Certain drugs will be covered by the plan only after less costly alternatives have been explored. In furtherance of such a program, the plan may be provide coverage of non prescription medications that would otherwise not be covered by the plan</li> <li>• Effective 02-01-12 prior auth &amp; quantity limits apply. Go to <a href="http://www.southwestservicetpa.com">www.southwestservicetpa.com</a> for details.</li> </ul>	<b>In-Network Retail Pharmacy</b> <ul style="list-style-type: none"> <li>• \$12 co-pay</li> <li>• \$35 co-pay</li> <li>• \$12 + difference between Generic/Brand Cost</li> </ul>	55%
<b>Pre-Certification/Authorization</b>	<ul style="list-style-type: none"> <li>• Also required for SNF admits &amp; Transplants – Call Medical Management, (602) 249-3582 option 6</li> </ul>		
<b>Pre-Existing</b>	<ul style="list-style-type: none"> <li>• \$1,000.00 maximum (Age 19 &amp; Over Only)</li> </ul>	80%	55%
<b>Preventive (Wellness) Services</b>	<ul style="list-style-type: none"> <li>• Go to <a href="http://www.southwestservicetpa.com">www.southwestservicetpa.com</a> for a complete list.</li> </ul>	100%	55%
<b>Prosthetic Appliances</b>	<ul style="list-style-type: none"> <li>• Items replacing a missing body part, such as an artificial limb</li> <li>• Prescription of medical necessity required</li> <li>• Subject to deductible</li> </ul>	80%	55%

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Benefit Description	Explanation and Limitations	PPO Providers (In-Network)	Non-PPO Providers (Out of Network)
<b>Radiology and Nuclear Medicine Services</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	55%
<b>Smoking Cessation</b>	<ul style="list-style-type: none"> <li>No benefit</li> </ul>	N/A	N/A
<b>Speech Therapy</b>	<ul style="list-style-type: none"> <li>Payable when rendered by a Licensed Speech Pathologist</li> <li>Covered for patients who have had an injury or surgery affecting speech for 90 days following the event.</li> <li>Speech therapy benefits are available for dependent children under age 17 for diagnoses listed in the Plan Booklet (pre-certification required).</li> <li>Up to 32 visits per calendar year</li> <li>Prescription for frequency and duration required by a Physician</li> <li>Subject to deductible.</li> </ul>	80%	55%
<b>Surgeons</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	55%
<b>TMJ (temporomandibular joint dysfunction)</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	55%
<b>Well Baby Care</b> (Co-Pay applies to Office Visit)	<ul style="list-style-type: none"> <li>Immunization through age 18 and other treatment</li> <li>Subject to deductible</li> </ul>	80%	55%
<b>Working Spouse Reduction</b>	<ul style="list-style-type: none"> <li>Benefit rate payable for spouse's charges when other insurance is offered through their employer but is declined</li> </ul>	40%	40%
<b>All Other Covered Charges</b>	<ul style="list-style-type: none"> <li>Subject to deductible</li> </ul>	80%	55%

#### In Network



#### Secondary Wrap Network



**SCHEDULE OF BEHAVIORAL HEALTH BENEFITS**

**Plan 501B**

**Group # UF-108**

**\*\*\*\*BENEFIT CHANGES EFFECTIVE FOR 2012\*\*\*\***

**\*\*\* YOU MUST CALL HMC-APS HEALTHCARE 1-800-464-7101 FOR TREATMENT \*\*\***

Benefits	Coinsurance Payable by the Plan	
	Precertified Providers (In-Network)	Non-Precertified Providers (Out of Network)
<b>Deductible</b>	<ul style="list-style-type: none"> <li>• \$250.00 Per Person</li> <li>• \$1000.00 Per Family</li> </ul>	<ul style="list-style-type: none"> <li>• \$500.00 per Person</li> <li>• \$1000.00 per Family</li> </ul>
<b>Psychiatric</b>	<ul style="list-style-type: none"> <li>• <b>Deductible applies</b></li> <li>• Hospital – 80% of EMAP approved treatment</li> <li>• Professional Fees- 80% of EMAP approved treatment</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Deductible applies</b></li> <li>• Hospital – 55% of EMAP approved treatment</li> <li>• Professional Fees- 55% of EMAP approved treatment</li> </ul>
<b>Alcohol/ Drug</b>	<ul style="list-style-type: none"> <li>• <b>Deductible Applies</b></li> <li>• Hospital – 80% of EMAP approved treatment for first treatment</li> <li>• Professional Fees – 80% of EMAP approved treatment for first treatment</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Deductible Applies</b></li> <li>• Hospital – 55% of EMAP approved treatment for first treatment</li> <li>• Professional Fees – 55% of EMAP approved treatment for first treatment</li> </ul>
<b>Outpatient Treatment</b>	<ul style="list-style-type: none"> <li>• First 8 visits no co-pay, no deductible</li> <li>• After 8 visits co-pay applies: \$20 co-pay for Master level, Psychologist &amp; MD's</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Deductible applies</b></li> <li>• 55% of EMAP negotiated rates</li> </ul>

**SCHEDULE OF INDEMNITY DENTAL PLAN BENEFITS**

**Plan 501B**

**Group # UF-108**



Note: Dental services may be obtained from any licensed dental care provider

<b>Deductible</b>	None
<b>Annual Dental Plan Maximum</b>	\$750.00 (Age 19 & Over Only)
<b>Surgical Treatment</b> <ul style="list-style-type: none"> <li>• <b>Excision of bony impacted teeth</b></li> <li>• <b>Root canals with apicoectomy</b></li> <li>• <b>Osseous surgery with graft or gingivectomy</b></li> </ul>	50% of Allowable expenses
<b>Diagnostic &amp; Preventative</b> <ul style="list-style-type: none"> <li>• <b>Exams</b> (2 per calendar year)</li> <li>• <b>Fluoride Treatment</b> 2 per calendar year)</li> <li>• <b>Prophylaxis</b> (2 per calendar year)</li> <li>• <b>Bitewing X-Rays</b> (2 per calendar year)</li> <li>• <b>Additional Single Film X-Rays Require A Tooth Number</b></li> <li>• <b>Sealants</b></li> <li>• <b>Space Maintainers</b></li> </ul>	80% of Allowable expenses
<b>Restorative &amp; Surgical Treatment</b> <ul style="list-style-type: none"> <li>• <b>Fillings</b></li> <li>• <b>Extractions</b></li> <li>• <b>Oral Surgery</b></li> <li>• <b>Anesthesia</b></li> <li>• <b>Periodontal Services</b></li> <li>• <b>Endodontics</b></li> </ul>	50% of Allowable expenses
<b>Prosthetic Treatment</b> <ul style="list-style-type: none"> <li>• <b>Crowns</b></li> <li>• <b>Bridges</b></li> <li>• <b>Dentures</b> (Replacements limited to every 5 years)</li> </ul>	50% of Allowable expenses
<b>Orthodontic</b>	No Benefits
<b>Not Covered</b>	<ul style="list-style-type: none"> <li>• <b>Tooth Implants and related services</b></li> <li>• <b>Cosmetic procedures</b></li> <li>• <b>Replacement for lost, misplaced or stolen bridge or dentures</b></li> </ul>
<b>Notes</b>	<ul style="list-style-type: none"> <li>• <b>Claims may be Subject to an independent dental review.</b></li> <li>• <b>Supporting x-rays and/or notes may be required or requested.</b></li> </ul>

**SCHEDULE OF VISION PLAN BENEFITS PLAN 501 B**

Payable vision services must be obtained from the in-network Vision Care Providers. Contact the Vision Plan (as noted on the Quick Reference Chart) for the list of in-network vision providers.

<b>Vision Services</b> <b>Call VSP 1-800-877-7195</b> <b>In- Network</b>	<b>Non- Network</b>	
<b>Vision Exam</b> <ul style="list-style-type: none"> <li>• Covered in Full</li> <li>• Every 12 months</li> </ul>	\$35.00	Benefit allowances same as In-network. Bills must be submitted to VSP for reimbursement. Services rendered in Mexico paid by SSA
<b>Lenses:</b> <ul style="list-style-type: none"> <li>•Covered in full</li> <li>•Single vision, lined bifocal and lined trifocal lenses</li> </ul>	Single \$42 Bi-Focal \$65 Tri-Focal \$82 Lenticular \$82	
<b>Contact Lenses</b> <ul style="list-style-type: none"> <li>• If Medically Necessary</li> <li>•Every 12 months</li> <li>• Your \$117.00 allowance applies to cost and the fitting and evaluation exam.</li> </ul>	\$190	
<b>Contact Lenses</b> <ul style="list-style-type: none"> <li>• Cosmetic</li> </ul>	\$82	
<b>Frame Allowance</b> <ul style="list-style-type: none"> <li>• Every 12 months</li> <li>•Covered up to \$115.00 Plus 20% off any out of pocket cost.</li> </ul>	\$40	

**SCHEDULE OF DISABILITY INCOME BENEFITS PLAN 501 B**

See Rules and Regulations in this booklet for more information (Article 6)

<b>Accident</b>	• Payable from the 1 <sup>st</sup> day
<b>Illness</b>	• Payable from the 8 <sup>th</sup> day
<b>Maximum Benefit period</b>	• 13 weeks after the one-week waiting period. Contact 1-800-474-3485 option 8 for forms and questions.
<b>Benefit Percentage</b>	70% of the base weekly earnings, not to exceed the maximum benefit.
<b>Benefit Calculation:</b>	
Gross weekly maximum benefit	\$162.43
Less FICA tax	<u>- 12.43</u>
Net weekly maximum benefit	\$150.00
<b>(Federal and State Income Tax Not Withheld)</b>	

**SSA MEXICO PPO NETWORK**

**Optional Benefit Program For Medical, Dental and Vision Expenses**

The following benefits are covered at 100% of Allowed Amount, After your co-pay

If discharge planning is needed in the USA after a procedure, contact Medical Management Department for Care Coordination

<b>\$5.00 co-pay</b>	<ul style="list-style-type: none"><li>• Medical /Hospital Expenses</li></ul>
<b>\$5.00 co-pay</b>	<ul style="list-style-type: none"><li>• Dental / Vision Expenses</li></ul>
<b>\$3.00 co-pay</b>	<ul style="list-style-type: none"><li>• For each prescription</li><li>• Medications that do not require an RX in the United States, <b>will not be covered</b></li></ul>
Benefits will be paid to the appropriate provider through the SSA network <b><u>ONLY THE SERVICES WHICH ARE RENDERED BY THESE PROVIDERS WILL BE COVERED.</u></b>	
Contact the Fund Office with questions regarding your benefits	