

**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 501 D

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)
Accident – Supplemental	<ul style="list-style-type: none"> 100% of 1st \$300.00 per accident if treated within 30 days of accident and charge is incurred within 6 months of the accident After the 1st \$300.00 benefits subject to deductible and co-insurance. 	80%	60%
Acupuncture	<ul style="list-style-type: none"> Payable when administered by a Physician Subject to deductible 	80%	60%
Ambulance	<ul style="list-style-type: none"> Air – Per Trip Surface – Maximum of \$600.00 per trip Subject to deductible 	80%	60%
Anesthesia	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
Annual Calendar Year Max	<ul style="list-style-type: none"> \$1,250,000 (effective 1/1/2012) 		
Annual Out of Pocket Maximum	<ul style="list-style-type: none"> Individual annual OOP maximum Each maximum is separate and amounts do not apply to each other 	\$4,500	\$8,000
Assistant Surgeons	<ul style="list-style-type: none"> Maximum of 20% of surgeon’s benefit Subject to deductible 	80%	60%
Blood transfusions and blood products	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
Chemotherapy	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
Chiropractic Care <ul style="list-style-type: none"> Manipulations and x-rays only 	<ul style="list-style-type: none"> Maximum allowance: \$40 per visit Max 25 visits per year Subject to deductible 	50%	50%
COB -Carve Out Method	<ul style="list-style-type: none"> Applies to Medical claims only 	N/A	N/A
Convalescent Care Facility <ul style="list-style-type: none"> Not for custodial care Pre-Certification Required	<ul style="list-style-type: none"> Max 60 days per calendar year Must be preceded by hospitalization in a covered facility. Subject to deductible 	80%	60%
Death Benefits	<ul style="list-style-type: none"> Employee \$5,000.00 Dependent \$1,000.00 	N/A	N/A
Deductible <ul style="list-style-type: none"> Per calendar year 	<p align="center"><u>EFFECTIVE 02-01-12</u></p> <p align="center">PPO and Non-PPO deductibles are separate and do not apply to each other.</p>	\$350.00 Indv \$950.00 Fam	\$500.00 Indv \$1,000 Fam

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Diagnostic Outpatient • X-ray and Laboratory	<ul style="list-style-type: none"> 100% of the 1st \$200.00 After the 1st \$200.00 benefits subject to deductible and co-insurance. 	80%	60%
Diabetic Supplies	<ul style="list-style-type: none"> Diabetic Supply Program through Nations Health– mail order, No co-pay, no deductible; paid at 100% - call 1-800-354-1653 	80%	60%
Dialysis	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
Dietary/Nutritional/Herbal	<ul style="list-style-type: none"> 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. No over-the-counter drugs are reimbursed 	N/A	N/A
Disability	<ul style="list-style-type: none"> No Benefit 	N/A	N/A
Durable Medical Equipment (DME)	<ul style="list-style-type: none"> 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. Subject to deductible 	80%	60%
Emergency Room (ER)	<ul style="list-style-type: none"> Subject to deductible 	80%	80%
Experimental Treatment	<ul style="list-style-type: none"> Vax-D, IDD and any other experimental treatment is not covered. 	0%	0%
Hearing Benefit	<ul style="list-style-type: none"> No Benefit 	N/A	N/A
Home Health Care	<ul style="list-style-type: none"> Maximum of 60 visits per year Subject to deductible 	80%	60%
Hospice Care	<ul style="list-style-type: none"> Treatment for terminal illnesses for individuals whose life expectancy is six months or less Subject to deductible 	80%	60%
Hospital (Inpatient) (Pre-Certification)	<ul style="list-style-type: none"> Room and Board Intensive Care Unit Subject to deductible 	80%	60%
Hospital – Other Charges	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
Infertility	<ul style="list-style-type: none"> Lifetime maximum \$10,000 for covered expenses Subject to deductible 	80%	60%

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Laboratory Services	<ul style="list-style-type: none"> Subject to deductible after 1st \$200 	80%	60%
Lasik (RK)	<ul style="list-style-type: none"> No Benefit 	N/A	N/A
Mammogram Benefit <ul style="list-style-type: none"> No deductible 	<ul style="list-style-type: none"> Women Ages 30 – 39: One single baseline mammogram during that ten year period, payable up to \$300.00. Women age 40 & over: One mammogram every calendar year payable up to \$300.00. <p>**CHARGES THAT EXCEED \$300.00 SUBJECT TO CO-INSURANCE/NO DEDUCTIBLE**</p>	80%	60%
Maternity For employee or legal spouse only	<ul style="list-style-type: none"> Maternity charges are paid @ global rate at time of delivery Lab charges, ultrasound or non-fetal stress test not included in global charges Healthy Maternity Program: Initial OB Care – Call the Fund Office to enroll 	80%	60%
Nutritional/ Dietary	<ul style="list-style-type: none"> 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. 	N/A	N/A
Outpatient Expenses	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
Outpatient Surgical Facility	<ul style="list-style-type: none"> No pre-certification required for in-network facilities. In a hospital-based or Free standing surgery center Subject to deductible 	80%	60%
Orthopedic Equipment Orthotics & Braces (Must have RX)	<ul style="list-style-type: none"> Charges for prescribed orthopedic shoes and other supportive appliance Includes replacement once every 12 months Includes replacement once every 6 months for 19 years or under Subject to deductible 	80%	60%
Physician And Health Care Practitioner Office Services	<ul style="list-style-type: none"> One co-pay per office visit Charges for other services provided at the physician’s office subject to deductible and co-insurance. 	100% less the \$30 co-pay	60% Deductible Applies

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Physical Exam No Deductible	<ul style="list-style-type: none"> • Paid at 100% up to \$200 charges that exceed \$200 subject to co-insurance/No deductible • Includes routine evaluations, lab charges, x-rays 	80%	60%
Physical, Occupational, Vision & Osteopathic Manipulative Therapy	<ul style="list-style-type: none"> • Payable when rendered by a Registered Physical Therapist or a Registered Occupational Therapist • Prescription for frequency and duration required by a Physician (M.D. or D.O.) • 16 visits per calendar year combined • Does not include maintenance or Industrial care • Subject to deductible 	80%	60%
Pre-Certification/Authorization	<ul style="list-style-type: none"> • Also required for SNF admits & Transplants – Call Medical Management, (602) 249-3582 		
Pre-Existing	<ul style="list-style-type: none"> • \$1,000.00 (Age 19 & Over only) 	80%	60%
Prescription Drugs (Outpatient) Informed RX 1-800-880-1188 Ascend Specialty RX 1-800-850-9122 <i>Ascend Specialty Rx Medications for Oncology or Transplant Treatment <u>obtained at the pharmacy</u></i>	Informed RX 1-800-880-1188 Ascend Specialty RX 1-800-850-9122 <ul style="list-style-type: none"> • Generic • Brand Name (no generic equivalent) • Brand Name (with generic equivalent) • 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 provide coverage of non prescription medications that would otherwise not be covered by the plan • Effective 02-01-12 prior auth & quantity limits apply. Go to www.southwestservicetpa.com for details. 	In-Network Retail Pharmacy <ul style="list-style-type: none"> • \$17 co-pay • \$40 co-pay • \$17 + Difference between Generic/Brand Cost 	Out of Network Pharmacy 60%
Preventive (Wellness) Services	<ul style="list-style-type: none"> • Go to www.southwestservicetpa.com for a complete list. 	80%	60%

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Prosthetic Appliances	<ul style="list-style-type: none"> Items replacing a missing body part, such as an artificial limb Prescription of medical necessity required Subject to deductible 	80%	60%
Radiology and Nuclear Medicine Services	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
Smoking Cessation	<ul style="list-style-type: none"> No Benefit 	N/A	N/A
Speech Therapy	<ul style="list-style-type: none"> Payable when rendered by a Licensed Speech Pathologist Covered for patients who have had an injury or surgery affecting speech for 90 days following the event. Speech therapy benefits are available for dependent children under age 17 for diagnoses listed in the Plan Booklet. (Pre-certification required). Up to 32 visits per calendar year Prescription for frequency and duration required by a Physician Subject to deductible 	80%	60%
Surgeons	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
TMJ (temporomandibular joint dysfunction)	<ul style="list-style-type: none"> Subject to deductible 	80%	60%
Well Baby Care (Co-Pay applies to Office Visit)	<ul style="list-style-type: none"> Immunization through age 18 and other treatment Subject to deductible 	80%	60%
Working Spouse Reduction	<ul style="list-style-type: none"> Benefit rate payable for spouse's charges when other insurance is offered through their employer but is declined 	40%	40%
All Other Covered Charges	<ul style="list-style-type: none"> Subject to deductible 	80%	60%

In Network



Secondary Wrap Network



SCHEDULE OF BEHAVIORAL HEALTH BENEFITS

Plan 501D

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)
Deductible	<ul style="list-style-type: none"> • \$350.00 Per Person • \$950.00 Per Family 	<ul style="list-style-type: none"> • \$500.00 per Person • \$1000.00 per Family
Psychiatric	<ul style="list-style-type: none"> • Deductible applies • Hospital – 80% of EMAP approved treatment • Professional Fees- 80% of EMAP approved treatment 	<ul style="list-style-type: none"> • Deductible applies • Hospital – 60% of EMAP approved treatment • Professional Fees- 60% of EMAP approved treatment
Alcohol/ Drug	<ul style="list-style-type: none"> • Deductible Applies • Hospital – 80% of EMAP approved treatment for first treatment • Professional Fees – 80% of EMAP approved treatment for first treatment 	<ul style="list-style-type: none"> • Deductible Applies • Hospital – 60% of EMAP approved treatment for first treatment • Professional Fees – 60% of EMAP approved treatment for first treatment
Outpatient Treatment	<ul style="list-style-type: none"> • First 8 visits no co-pay, no deductible • After 8 visits co-pay applies: \$30 co-pay for Master level, Psychologist & MD's 	<ul style="list-style-type: none"> • Deductible applies • 60% of EMAP negotiated rates

SCHEDULE OF INDEMNITY DENTAL PLAN BENEFITS

Plan 501-D

Group # UF-108



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

Deductible	\$100.00
Annual Dental Plan Maximum	\$750.00 (Applies to age 19 & Over Only)
Surgical Treatment <ul style="list-style-type: none"> • Excision of bony impacted teeth • Root canals with apicoectomy • Osseous surgery with graft or gingivectomy 	50% of Allowable expenses
Diagnostic & Preventative <ul style="list-style-type: none"> • Exams (2 per calendar year) • Fluoride Treatment (2 per calendar year) • Prophylaxis (2 per calendar year) • Bitewing X-Rays (2 per calendar year) • Additional Single Film X-Rays Require A Tooth Number • Sealants • Space Maintainers 	80% of Allowable expenses
Restorative & Surgical Treatment <ul style="list-style-type: none"> • Fillings • Extractions • Oral Surgery • Anesthesia • Periodontal Services • Endodontics 	50% of Allowable expenses
Prosthetic Treatment <ul style="list-style-type: none"> • Crowns • Bridges • Dentures (Replacements limited to every 5 years) 	50% of Allowable expenses
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.
Orthodontic	No Benefit

SCHEDULE OF VISION PLAN BENEFITS 501 D

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.

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

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

\$15.00 co-pay	• Medical /Hospital Expenses (excluding ER)
\$50.00 co-pay	•Emergency Room Expenses
\$20.00 co-pay	• Dental / Vision Expenses
<ul style="list-style-type: none"> • \$5.00 Co-Pay for Generic • \$15.00 Co-Pay for Brand No Generic available (Prior to 1/1/11) • \$8.00 CO-Pay for Brand No Generic available (Effective 1/1/11) • No coverage for brand name drugs purchased when there is a generic equivalent available. 	<ul style="list-style-type: none"> • Erectile Dysfunction Drugs i.e. Viagra, Cialis, etc are no longer covered. • No more than a 30-days supply of prescription drugs is eligible at a time. <ul style="list-style-type: none"> •Co-Pays are for each prescribed medication. • Medications that do not require an RX in the United States, will not be covered

Benefits will be paid to the appropriate provider through the SSA network

ONLY THE SERVICES WHICH ARE RENDERED BY THESE PROVIDERS WILL BE COVERED.

Contact the Fund Office with questions regarding your benefits