

**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 RETIREES

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"> No Benefit Allowed charges paid under major medical 	N/A	N/A
Acupuncture	<ul style="list-style-type: none"> Payable when administered by a Physician Subject to deductible 	90%	65%
Ambulance	<ul style="list-style-type: none"> Air – Per Trip Surface – Maximum of \$600.00 per trip Subject to deductible 	90%	65%
Anesthesia	<ul style="list-style-type: none"> Subject to deductible 	90%	65%
Annual Calendar Year Max	<ul style="list-style-type: none"> \$100,000.00 		
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 	\$3,000	\$7,000
Assistant Surgeons	<ul style="list-style-type: none"> Maximum of 20% of surgeon's benefit Subject to deductible 	90%	65%
Blood transfusions and blood products	<ul style="list-style-type: none"> Subject to deductible 	90%	65%
Convalescent Care Facility • 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%	65%
Chemotherapy	<ul style="list-style-type: none"> Subject to deductible 	90%	65%
Chiropractic Care • Manipulations and x-rays only	<ul style="list-style-type: none"> Maximum allowance: \$40 per visit Max 13 visits per year Subject to deductible 	50%	50%
Death Benefits	<ul style="list-style-type: none"> No Benefits 	N/A	N/A
Deductible • Per calendar year	<u>EFFECTIVE 02-01-12</u> PPO and Non-PPO deductibles are separate and do not apply to each other.	\$350.00	500.00
Dental	<ul style="list-style-type: none"> No Benefits 	N/A	N/A
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. 	90%	65%
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 	90%	65%
Dialysis	<ul style="list-style-type: none"> Subject to deductible 	90%	65%

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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 Charges made for oxygen, its administration and the rental of oxygen equipment, not to exceed the purchase price of such equipment Subject to deductible 	90%	65%
Emergency Room (ER)	<ul style="list-style-type: none"> Subject to deductible 	90%	90%
Experimental Treatment	<ul style="list-style-type: none"> Vax-D, IDD and any other experimental treatment is not covered. 	0%	0%
Hearing Benefit • Allowable charges only	<ul style="list-style-type: none"> Examination (Subject to deductible & Co-Insurance) <u>Per Calendar Year Maximums:</u> \$75 for repair (excludes batteries) \$850 for pair of hearing appliances(every 3years) Subject to deductible 	90%	65%
Home Health Care	<ul style="list-style-type: none"> Maximum of 60 visits per year Subject to deductible 	90%	65%
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 	90%	65%
Hospital (Inpatient) (Pre-Certification)	<ul style="list-style-type: none"> Room and Board – Maximum per day \$280.00 for Non-PPO Subject to deductible 	90%	65%
Hospital Intensive Care Unit	<ul style="list-style-type: none"> Room and Board – Maximum per day \$700.00 for Non-PPO Subject to deductible 	90%	65%
Hospital – Other Charges	<ul style="list-style-type: none"> Subject to deductible 	90%	65%
Infertility	<ul style="list-style-type: none"> No Benefit 	N/A	N/A
Laboratory Services	<ul style="list-style-type: none"> Subject to deductible after 1st \$200 	90%	65%

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Mammogram Benefit <ul style="list-style-type: none"> • No deductible (Effective 01/01/08)	<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. **CHARGES THAT EXCEED \$300.00 SUBJECT TO CO-INSURANCE/NO DEDUCTIBLE**	90%	65%
Maternity	<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 	90%	65%
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
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 • Subject to deductible 	90%	65%
Outpatient Expenses	<ul style="list-style-type: none"> • Subject to deductible 	90%	65%
Outpatient Surgical Facility	<ul style="list-style-type: none"> • No pre-authorization required for in-network facilities • No Deductible • In a hospital-based or Free standing surgery center 	100%	100%
Physician And Health Care Practitioner Office Services	<ul style="list-style-type: none"> • One co-pay per office visit • Maximum of 26 visits per year • Charges for other services provided at the physician’s office subject to deductible and co-insurance. 	100% less the \$20 co-pay	65% Deductible Applies
Physical Exam No deductible	<ul style="list-style-type: none"> • Paid at 100% up to \$100 charges that exceed \$100 subject to co-insurance/No deductible • Includes routine evaluations, lab charges, x-rays 	90%	65%

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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 	90%	65%
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"> None 	N/A	N/A
Prescription Drugs (Outpatient) <i>Ascend Specialty Rx</i> <ul style="list-style-type: none"> Medications for Oncology or Transplant Treatment <u>obtained at the pharmacy</u> 	<p>Informed RX 1-800-880-1188 Ascend Specialty Rx 1-800-850-9122</p> <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. 	<p>In-Network Retail Pharmacy</p> <ul style="list-style-type: none"> \$12 co-pay \$40 co-pay \$12 + Difference in price for Brand name drugs with a generic available 	65%
Preventative (Wellness) Services	<ul style="list-style-type: none"> Go to www.southwestservicetpa.com for a complete list. 	100%	65%
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 	90%	65%
Lasik (RK)	<ul style="list-style-type: none"> No Benefit 	N/A	N/A
Radiology and Nuclear Medicine Services	<ul style="list-style-type: none"> Subject to deductible 	90%	65%

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Smoking Cessation	<ul style="list-style-type: none"> No Deductible Lifetime Benefit 100% up to \$250 maximum 	Up to max benefit	Up to max benefit
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 	90%	65%
Surgeons	<ul style="list-style-type: none"> Subject to deductible 	90%	65%
Surgical Facility	<ul style="list-style-type: none"> Free standing or Outpatient 	100%	100%
TMJ (temporo-mandibular joint dysfunction)	<ul style="list-style-type: none"> Subject to deductible 	90%	65%
Vision	<ul style="list-style-type: none"> No Benefit 	N/A	N/A
All Other Covered Charges	<ul style="list-style-type: none"> Subject to deductible 	90%	65%

In Network



Secondary Wrap Network



**SCHEDULE OF BEHAVIORAL HEALTH BENEFITS
RETIREE
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 	<ul style="list-style-type: none"> • \$500.00 per Person
Psychiatric	<ul style="list-style-type: none"> • Deductible applies • Hospital – 90% of EMAP approved treatment • Professional Fees- 90% of EMAP approved treatment 	<ul style="list-style-type: none"> • Deductible applies • Hospital – 65% of EMAP approved treatment • Professional Fees- 65% of EMAP approved treatment
Alcohol/ Drug	<ul style="list-style-type: none"> • Deductible Applies • Hospital – 90% of EMAP approved treatment for first treatment • Professional Fees – 90% of EMAP approved treatment for first treatment 	<ul style="list-style-type: none"> • Deductible Applies • Hospital – 65% of EMAP approved treatment for first treatment • Professional Fees – 65% of EMAP approved treatment for first treatment
Outpatient Treatment <ul style="list-style-type: none"> • Limited to 26 visits per calendar year. 	<ul style="list-style-type: none"> • First 8 visits no co-pay, no deductible • After 8 visits co-pay applies: \$20 co-pay for Master level, Psychologist & MD's 	<ul style="list-style-type: none"> • Deductible applies • 65% of EMAP negotiated rates

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

\$5.00 co-pay	<ul style="list-style-type: none">• Medical /Hospital Expenses
\$5.00 co-pay	<ul style="list-style-type: none">• Dental / Vision Expenses
\$3.00 co-pay	<ul style="list-style-type: none">• For each prescription• 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 <u>ONLY THE SERVICES WHICH ARE RENDERED BY THESE PROVIDERS WILL BE COVERED.</u>	
Contact the Fund Office with questions regarding your benefits	