EFFECTIVE IMMEDIATELY PLEASE NOTE OUR NEW BILLING ADDRESS:

2400 W. Dunlap Avenue Suite 250 Phoenix, AZ 85021

NM SMW SCHEDULE OF BENEFITS PLAN A
Group # 049

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	• No deductible • 100% of 1st $1000.00 when services are rendered within 72 hours following the accident • After the 1st $1000.00 benefits payable @ 80% or 60% - subject to deductible	80%	60%
Acupuncture	• Limited to $1500 per calendar year	80%	80%
Air Ambulance	• Requires medical necessity	80%	80%
Ambulance		80%	80%
Anesthesia		80%	60%
Assistant Surgeons	• Maximum of 20% of surgeon's allowance	80%	60%
Annual Calendar Year Maximum	• Through 3-31-12 $1,000,000 • Through 3-31-13 $1,250,000 • Through 3-31-14 $2,000,000		
Annual Out of Pocket/Coinsurance Maximum	• $15,000.00 maximum amount • Benefits payable @ 100% of allowable charges once maximum has been met, unless otherwise noted.		
Convalescent Care Facility • Not for custodial care	• Mandatory Pre-Certification required • Confinement must commence within 7 days of a hospital confinement at lease 5 days in duration • Not to exceed 50% of average semi-private room rate of the hospital in which the patient was confined immediately before confinement in the skilled nursing facility	80%	60%
Chiropractic Care	• Limited to $1500 per calendar year	80%	80%

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Benefit Description	**Explanation and Limitations**	**PPO Providers (In-Network)**	**Non-PPO Providers (Out of Network)**
Death Benefits	• Employee $10,000 • Accident Death $10,000 • Dismemberment – up to $10,000		
Deductible • Per calendar year	• $100.00 per person • No family deductible		
Diagnostic Outpatient •X-ray and Laboratory		80%	60%
Durable Medical Equipment (DME)	• Rental amount is allowed up to the purchase price	80%	60%
Emergency Room	• $100 deductible applies to each visit, waived if admitted as inpatient	80%	60%
Freestanding Surgical Facility	• Deductible waived	100%	80%
Hearing Benefit (Exam)	• One per two consecutive year period	100%	100%
Hearing Benefit (Aid)	• $500 maximum per ear during any two consecutive year period (Prior to 4-1-12) • $1,000 maximum per ear during any two consecutive year period (Effective 4-1-12)	100%	100%
Home Health Care • in lieu of hospitalization; not subject to deductible	• Mandatory Pre-Certification required	100%	100%
Hospice Care • in lieu of hospitalization; not subject to deductible	• Mandatory Pre-Certification required	100%	100%
Hospital (Inpatient)	• Mandatory Pre-Certification required • Subject to penalty reduction of 5% or $150, whichever is greater	80%	60%
Hospital – Other Charges		80%	60%
Immunizations	• Dependent children thru age 18 • Immunizations for enrollee and spouse see Physical Exam Benefit	100%	100%

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Benefit Description	**Explanation and Limitations**	**PPO Providers (In-Network)**	**Non-PPO Providers (Out of Network)**
Lifetime Maximum	• **$1,000,000.00 (PRIOR TO 04-01-11)** *****EFFECTIVE 04-01-11***** **LIFETIME MAX NO LONGER APPLIES SEE "CALENDAR YEAR MAXIMUMS"**		
Outpatient Surgical Facility	• Deductible waived	100%	80%
Physician Office Visits	• Deductible applies	80%	60%
Physical Exam/Wellness	• Deductible waived • Effective 9/1/06, Routine Mammograms and Pap Smears do not apply to the $300 maximum **EFFECTIVE 04-01-11** ****IF IN-NETWORK PROVIDER**** **No dollar limit and will cover the following at recommended frequencies, without a medical diagnosis** • **Physical Exams** • **Mammograms** • **Pap Smears** • **Colonoscopies** *****NON PPO PROVIDERS***** • **100% up to $300.00** • **Any amount above $300.00 will be subject to deductible & paid at 50%**	100% up to $300	100% up to $300

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Benefit Description	**Explanation and Limitations**	**PPO Providers (In-Network)**	**Non-PPO Providers (Out of Network)**
Prescription Drugs (Retail & Specialty Drugs) **Retail (30 day supply):** **Envision Rx** **1-800-361-4542** **<u>Specialty Drug Pharmacy:</u>** **Costco Specialty Services** (exclusive provider of specialty drugs after first fill) 1-800-443-0060	• Generic Preferred • Brand • Non-Preferred Brand (without generic equivalent) • Non-Preferred Brand (with generic equivalent)	$10 copay $15 copay $30 copay $30 copay+ The difference between the generic and the brand name drug	80%, deductible applies
Prescription Drugs (Mail Order) **Mail Order (90 day supply):** **Costco Mail Order** 1-800-607-6861	• Generic Preferred • Brand • Non-Preferred Brand (without generic equivalent) • Non-Preferred Brand (with generic equivalent)	$20 copay $30 copay $60 copay $60 copay+ the difference between the generic and the brand name drug	80%, deductible applies
Psychiatric Services – Outpatient • Must be approved by WAP •1-800-343-3822	• Maximum of 52 visits per calendar year • Daycare treatment limited to 90 days per calendar year	80%	80%
Psychiatric Services – Inpatient •Must be approved by WAP •1-800-343-3822	• Limited to 30 days per calendar year	80%	80%
Routine Mammogram Benefits	• Covered under the Physical Exam Benefit		

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Benefit Description	Explanation and Limitations	PPO Providers (In-Network)	Non-PPO Providers (Out of Network)
Second Surgical Opinion Program •Subject to penalty reduction of 5% or $150, whichever is greater, if requirement is not met • **Mandatory Pre-Certification required** ***<u>EFFECTIVE 08-11-10</u>*** ***Second Surgical Opinion Requirement No Longer Applies to the Plan.***	**Specified procedures:** • Hemorrhoidectomy (removal of hemorrhoids- internal only) • Herniorrhaphy (repair of hernia • Cholecystectomy (removal of gall bladder) • Cataract Removal (removal of cloudy eye lens) • Meniscectomy (removal of meniscus cartilage of the knee) • Tonsillectomy (removal of tonsils) • Septoplast/Submucous Resection (repair of deviated septum) • Coronary Bypass (create a heart vessel passage) • Mastectomy (removal of a breast) • Hysterectomy (removal of a uterus) • Transurethral Resection (removal of part of the prostate through an instrument passed through the urethra)	100%	100%
Smoking Cessation	• See Substance Abuse		
Substance Abuse/Smoking Cessation (Inpatient and Outpatient) •Must be approved by WAP •1-800-343-3822	• $7500 calendar year maximum • $25,000 lifetime maximum **<u>***EFFECTIVE 04-01-11***</u>** **ABOVE MAXIMUMS NO LONGER APPLY**	80%	80%
Surgeon – Inpatient		80%	60%
Surgeon – Outpatient	• Deductible waived	100%	80%
TMJ (temporomandibular joint dysfunction)	• Mandatory Pre-Certification required • $5,000 lifetime maximum	80%	80%
Workers Assistance Program (WAP) •1-800-343-3822	• The treatment of substance abuse, emotional disorders, and mental illness will be monitored by the Workers Assistance program through a mandatory pre-approval program. • **Mandatory Pre-Certification required** **Treatment received without prior approval will not be covered.**		
All Other Covered Charges		80%	60%

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SCHEDULE OF DENTAL PLAN BENEFITS Plan A Note: This plan has contracted with a Dental Preferred Provider Organization (DPPO) United Concordia. 1-800-332-0366	
Deductible	$50 per person; $150 per family
Annual Dental Plan Maximum, includes Orthodontia	$1,500 **(Effective 04-01-11 Annual Dental Max no longer applies to dependants under the age of 18. Orthodontia calendar year maximum for dependents under the age of 18 is $1,500)**
Diagnostic & Preventative	100%, no deductible
Restorative	80%
Major	50%
Orthodontia	75%

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SCHEDULE OF VISION PLAN BENEFITS Plan A Allowances effective 4/1/09	
Percentage Payable	100%
Schedule of Maximum Vision Payments	
Vision Exam (one per calendar year)	$69
Lenses: per pair (one per calendar year)	Single $39 (Prior to 4-1-1 $52 (Eff. 4-1-12) Bi-Focal $66 (\Prior to 4-1-12) $88 (Eff. 4-1-12) Tri-Focal $91.50 (Prior to 4-1-12 $122 (Eff. 4-1-12)
Contact Lenses (cosmetic): per pair	$108 (Prior to 4-1-12) $144 (Eff. 4-1-12)
Contact lenses (following cataract surgery): per pair	$540
Frames	$54

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SCHEDULE OF DISABILITY INCOME BENEFITS Plan A See Rules and Regulations in the plan booklet for more information	
Non-occupational Injury or Illness	
Injury	• Payable from the 1st day
Illness	• Payable 1st day of Hospital Confinement or 8TH day of Disability
Maximum Benefit period	• 26 weeks
Benefit	$200

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