Ralph L. Wadsworth Construction Company
October 2012 to September 2013 Schedule of Medical Benefits
In and Out of Network Plan

SF137

Auths - American Health 1-866-363-0957

WC05A

Address - PO Box 71570 SLC, UT 84171

PPO Networks:
UT-Health Utah
Outside Utah - First Health

Coverage begins for hourly employees the first day of the month following 90 days of employment and if terminated, coverage ends last day of month.

Coverage begins for salaried employees the first day of the month following hire date and if terminated coverage ends the last day of month.

Minimum weekly hours for full time: 30 hrs

Lifetime Maximum: None	Network Providers	Non-Network Providers	Benefit Limits
Annual Deductibles (does not include co-pays)	Individual $ 250 Family $ 500	Individual $ 500 Family $ 1,000	**Note: Limits are per person per calendar year.**
Annual Co-Insurance Out of Pocket Maximums (does not include deductible or co-pays)	Individual $ 2,000 Family $ 4,000	Individual $ 3,000 Family $ 6,000	

	Service	Network Providers	Non-Network Providers	Benefit Limits
	Office Visits - Primary Care (exams or consultations)	$20 co-pay, then Plan pays 100%	Deductible, then 70% of the ***allowed*** amount	
	Office Visits - Specialist (exams or consultations)	$30 co-pay, then Plan pays 100%	Deductible, then 70% of the ***allowed*** amount	
	Wellness Care (child to age 11)	$20 co-pay, then Plan pays 100%	Deductible, then 70% of the ***allowed*** amount	
	Wellness Care (12 to adult)	$20 co-pay, then Plan pays 100%	Deductible, then 70% of the ***allowed*** amount	
	Wellness Care includes, but not limited to: pap smear, mammogram, prostate screening, gynecological exam, routine physical exam, routine vision exam, routine hearing exam, immunizations and related laboratory blood tests.			
	Accidental Dental Services	Deductible, then Plan pays 50%	Deductible, then 50% of the ***allowed*** amount	Limited to $1000
	Allergy Treatment - Injections & Testing	$30 co-pay, then Plan pays 100%	Deductible, then 70% of the ***allowed*** amount	
	Allergy Treatment - Serum	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
	Ambulance	Deductible, then Plan pays 80%	Deductible, then 80% of the ***allowed*** amount	
	Birth Control- Non-Oral	**No Benefit**	**No Benefit**	Oral only covered
	Chiropractic Services	$30 co-pay, then Plan pays 100%	**No Benefit**	20 visits per year
AHH	Chemical Dependency - Inpatient *	Deductible, then Plan pays 80%	**No Benefit**	
	Chemical Dependency - Outpatient	$30 co-pay, then Plan pays 100%	**No Benefit**	
	Colonoscopy - Medical (and other endoscopic services)	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
	Diagnostic X-ray, Lab (MRI, CAT, etc)	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
	Diagnostic X-ray, Lab (minor-related to office visit)	Plan pays 100%	Deductible, then 70% of the ***allowed*** amount	
	Durable Medical Equipment (includes orthotics & prosthetics)	Plan pays 80%	Deductible, then 50% of the ***allowed*** amount	
	Emergency Room Services	$100 co-pay, then Plan pays 100%	$200 co-pay, then Plan pays 100%	
	Gastric Bypass Surgery / Lap Banding	**No Benefit**	**No Benefit**	
	Home Health Care	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
AHH	Hospice Care *	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
AHH	Hospital - Inpatient Services *	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
	Hospital - Outpatient Services	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
	Infertility Services (Testing only)	Deductible, then Plan pays 50%	Deductible, then 50% of the ***allowed*** amount	$1,500 / year $5,000 lifetime
	Maternity - (including birthing center or mid-wife)	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	Dependent Maternity covered. Grandchildren not covered
	Medical Supplies	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	Insulin, Diabetic Test Strips, etc.
AHH	Mental Health - Inpatient *	Deductible, then Plan pays 80%	**No Benefit**	

	Mental Health - Outpatient	$30 co-pay, then Plan pays 100%	**No Benefit**	
	Outpatient Rehab Therapy - office Physical, Speech, Occupational	$30 co-pay, then Plan pays 100%	Deductible, then 70% of the ***allowed*** amount	20 visits per year
	Outpatient Rehab Therapy - outpatient Physical, Speech, Occupational	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
AHH	Outpatient Surgery *	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
AHH	Skilled Nursing *	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
	TMJ and Orthognathic	Deductible, then Plan pays 50%	Deductible, then 50% of the ***allowed*** amount	$1000 per year
AHH	Transplant *	Deductible, then Plan pays 80%	Deductible, then 70% of the ***allowed*** amount	
	Urgent Care Center & 24 Hour Clinic	$30 co-pay, then Plan pays 100%	Deductible, then 70% of the ***allowed*** amount	
	Covered Prescription Drugs - Informed RX Customer Service 1-800-880-1188 Rx Bin - 601577	Generic $10 Formulary Brand - $20 Non-formulary brand - $40	**No Benefit**	
	Mail Order Drugs Customer Service 1-800-880-1188 90-day supply	Generic - $20 Formulary Brand - $40 Non-formulary brand - $80	**No Benefit**	

*** Pre-certification required. See Section IV. “Pre-Certification Requirements” in plan booklet.**

10/1/2012

Note: Any non-allowed or not covered amounts or services are the responsibility of the patient and are not included in the Out-of-Pocket Maximum.

Dependents Covered to Age 26 Regardless of student or marital status, if they have no other coverage available to them.

Timely Filing - 12 months

Life Threatening OON ER = INN

COB - Non duplicating

www.talltreehealth.com

Rural area - 30 miles

Pre-existing does not apply to children under age 19

We believe this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (PPACA)