

Severino Trucking, Inc.

Medical Benefits for Group BE6 Effective 1/1/2018

Network Only (LP)

Deductible & Out-of-Pocket	
Calendar Year Deductible	Individual \$3,000 Family \$9,000
Out-Of-Pocket Maximum	Individual \$6,500 Family \$13,000
Preventive Care	
Routine Physical	100%
Routine GYN Exam	100%
Routine Well Child Care (includes immunizations, blood lead screening & all charges billed at time of visit)	100%
Routine Colonoscopy	100%
Routine Pap Smear	100%
Routine Mammogram	100%
Routine Vision Exam (one exam per calendar year)	\$25 copay then 100%
Hospital Services	
Inpatient Hospital Charges**	
Hospital Room & Board	100% after deductible
Surgical Facility & Supplies	100% after deductible
Miscellaneous Hospital Charges	100% after deductible
Outpatient Hospital Charges	
Outpatient Surgery	100% after deductible
Outpatient Surgery – LP Providers	\$100 copay then 100%
Emergency Room (copay waived if admitted)	Subject to deductible, then \$250 copay
Urgent Care	
Convenience Care	\$25 copay then 100%
Urgent Care Clinic	\$50 copay then 100%
Hospital Urgent Care	Subject to deductible, then \$75 copay
Physician Services – including but not limited to:	
Primary Care Office Visits	\$25 copay then 100%
Specialist Office Visits	\$50 copay then 100%
Mental Health Disorders/Substance Abuse	
Inpatient**	100% deductible waived
Office Visit	
Group Therapy	\$10 copay then 100%
Individual Therapy	\$25 copay then 100%
Other Services	
Ambulance Services	100% after deductible
Allergy Testing	100% after deductible
Allergy Treatment	\$5 copay then 100%
Anesthesia	100% after deductible
Chiropractor	\$25 copay then 100%
Home Health Care**	100% deductible waived
Skilled Nursing** (100 days per calendar year combined with rehab hospital)	100% after deductible
Outpatient Hospice Care**	100% deductible waived
Diagnostic Lab/X-rays	100% after deductible
Diagnostic Lab – LP Providers	100% deductible waived
CAT Scans/ PET Scans/ MRI'S	100% after deductible
Physical Therapy (60 visits combined with OT & ST)	\$50 copay then 100%
Occupational Therapy (60 visits combined with PT & ST)	\$50 copay then 100%
Speech Therapy (60 visits combined with PT & OT)	\$50 copay then 100%
Durable Medical Equipment	\$100 DME deductible then 80%
Prescription Drug Benefit- Administered by Magellan	
Retail (up to a 30 day supply)	
\$10 Generic / \$30 Preferred Brand / \$50 Non-Preferred Brand	
Mail Order (up to a 90 day supply)	
\$30 Generic / \$60 Preferred Brand / \$150 Non-Preferred Brand	

Benefits are Unlimited per Plan Year

****UTILIZATION REVIEW/HOSPITAL PRE-CERTIFICATION/COMPLEX CASE MANAGEMENT** is provided by Care Management Services (CMS). The CMS toll-free number is located on your ID Card.

Charges for services rendered by Non-Participating Providers are not covered under this Plan except for emergency medical care received outside the service area from non-participating providers and for limited ancillary charges (i.e. lab, x-rays, anesthesia, etc.) when referred by an In-Network Provider. This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Plan Document and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern.