

Benefits Per calendar year (unless specified)	Preferred Providers In Network	Non-Preferred Providers Out of Network
Deductible¹ The amount you must pay first, before Significa will cover your care Applies to all services (unless specified)	\$1500 Individual \$3000 Family	\$3000 Individual \$6000 Family
Physician Office Visits Physicians Specialists	\$25 copayment \$50 copayment	50% 50%
Coinsurance The percentage of the cost Significa will pay for covered services	80%	50%
Coinsurance Maximum The maximum amount of coinsurance you will pay	\$2000 Individual \$4000 Family	\$4000 Individual \$8000 Family
Pre-Existing Condition(s) Waiting Period	12-months (unless eligible for Creditable Coverage)	
Dependent Age Limit Includes unmarried, unemployed and student dependents	Coverage ends on the last day of the month the dependent turns age 21	
Lifetime Maximum	\$5,000,000 for each covered individual	
Preventive Care Service limitations may apply.		
Adult Care		
<ul style="list-style-type: none"> ▪ Preventive Office Visits (Deductible waived) Routine physical exam Routine gynecological exam Routine vision exam ▪ Mandated routine screenings (Deductible waived) Cervical cancer screening (Pap test) Breast cancer screening (Mammography) Colorectal cancer screening (Colonoscopy) Prostate cancer screening (PSA test) ▪ Other routine screenings, such as (Deductible waived up to first \$500) Cholesterol, Osteoporosis, Diabetes screenings 	\$25 copayment per exam, includes: Physician Physician or Gynecologist Optometrist or Ophthalmologist 80% 80% 80% 80% 80%	50% per service, includes: Physician Physician or Gynecologist Optometrist or Ophthalmologist 50% 50% 50% 50% 50%
Child Care (Deductible waived)		
<ul style="list-style-type: none"> ▪ Well child annual office visit (up to age 21) ▪ Routine vision and hearing exams ▪ Pediatric and childhood immunizations 	\$25 copayment per date of service: Physician or Pediatrician Physician or Pediatrician Physician or Pediatrician	50% per service, includes: Physician or Pediatrician Physician or Pediatrician Physician or Pediatrician
Emergency Services		
Emergency Services Non-emergency services not covered	80% with a \$150 Emergency Room copayment (waived if admitted)	80% with a \$150 Emergency Room copayment (waived if admitted)
Ambulance (Includes emergency ground / water / air transport) Non-emergency water and air transport services require pre-certification ²	80%	80%
Lab and Radiology Services		
Allergy Tests and Treatment	80%	50%
Diagnostic Lab Tests and X-rays	80%	50%
MRIs, CT / PET Scans and Major Diagnostic Testing²	80%	50%
Hospital and Facility Services		
Urgent Care (Deductible waived)	\$50 copayment	50%
Inpatient Hospitalization²	80%	50%
Outpatient Surgical Care²	80%	50%
Organ and Tissue Transplants² (\$100,000 per lifetime)	80%	50%



Summary of Benefits Significare PPO Copay Plan OH 1500

Benefits (continued) Per calendar year (unless specified)	Preferred Providers In Network	Non-Preferred Providers Out of Network	
Skilled Nursing Facility Care ² (60 days)	80%	50%	
Hospice (180 days per lifetime)	80%	50%	
Complications of Pregnancy	80%	50%	
Other Diagnostic, Surgical and Anesthesia Services ² Physician care outside a doctor's office	80%	50%	
Therapeutic Services / Equipment			
Dialysis, Chemotherapy and Radiation Therapy ²	80%	50%	
Outpatient Therapies (45 visits combined) Respiratory, Cardiac, Pulmonary, Physical, Speech ² , Occupational and Chiropractic Therapies	80%	50%	
Durable Medical Equipment, Orthotics and Prosthetics ² (\$2,000 maximum)	80%	50%	
Oxygen and Related Equipment and Supplies ²	80%	50%	
Home Health Care Services			
Home Health Visits ² (60 visits)	80%	50%	
Home Infusion Therapy ²	80%	50%	
Mental Health Care and Substance Abuse Treatment			
Inpatient ² and Outpatient (30 days; \$5,000 maximum; \$25,000 per lifetime)	80%	50%	
Prescription Drugs <i>through Express Scripts</i>			
Copayments	Retail (30-day Supply)	Mail Order (90-day Supply)	Non-Preferred Providers
Tier 0: Generic Maintenance ³	Tier 0 \$0	Tier 0 \$0	No drug coverage when obtained from Non-Participating Pharmacies (out of network)
Tier 1: Generics Preferred ⁴	Tier 1 \$10	Tier 1 \$20	
Tier 2: Preferred Formulary	Tier 2 \$40	Tier 2 \$100	
Tier 3: Non-Preferred (Specialty drugs through CuraScript)	Tier 3 \$80	Tier 3 \$240	

Optional Maternity Rider	Preferred Providers In Network	Non-Preferred Providers Out of Network
Deductible	\$1500 deductible applies to all services	
Waiting Period	270-day waiting period applies to all services	
Obstetrician's Office and Hospital Visits	80%	50%
Inpatient Facility Care ²	80%	50%

Exclusions and limitations may apply. Refer to the Policy for a complete listing of covered services, exclusions and limitations.

¹ **Embedded Family Deductible** – Benefits begin for an individual family member once that member meets the Individual Deductible amount or once the Family Deductible is met, whichever comes first.

² **Pre-Certification Required** – For failure to obtain pre-approval (pre-certification), you will be charged a penalty of up to the first \$500 of covered charges. When using a non-preferred provider, you may be billed for the penalty AND the full cost of any services received.

³ **Generic Maintenance Drugs** – For these chronic conditions: asthma, diabetes, high cholesterol and hypertension.

⁴ **Generics Preferred** – If a generic-equivalent exists, but the brand name drug is requested, you pay the brand copay *plus* the difference in cost between the generic and brand-name drug.