

Benefits Per calendar year (unless specified)	Preferred Providers In Network	Non-Preferred Providers Out of Network
<b>Deductible<sup>1</sup></b> 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
<b>Physician Office Visits</b>		
Physicians	80%	50%
Specialists	80%	50%
<b>Coinsurance</b> The percentage of the cost Significa will pay for covered services	80%	50%
<b>Coinsurance Maximum</b> The maximum amount of coinsurance you will pay	\$2000 Individual \$4000 Family	\$4000 Individual \$8000 Family
<b>Pre-Existing Condition(s) Waiting Period</b>	12-months (unless eligible for Creditable Coverage)	
<b>Dependent Age Limit</b> Includes unmarried, unemployed and student dependents	Coverage ends on the last day of the month the dependent turns age 21	
<b>Lifetime Maximum</b>	\$5,000,000 for each covered individual	
<b>Preventive Care</b> Service limitations may apply.		
<b>Adult Care</b>		
<ul style="list-style-type: none"> <li>▪ <b>Preventive Office Visits (Deductible waived)</b> Routine physical exam Routine gynecological exam Routine vision exam</li> <li>▪ <b>Mandated routine screenings (Deductible waived)</b> Cervical cancer screening (Pap test) Breast cancer screening (Mammography) Colorectal cancer screening (Colonoscopy) Prostate cancer screening (PSA test)</li> <li>▪ <b>Other routine screenings, such as (Deductible waived up to \$500)</b> Cholesterol, Osteoporosis, Diabetes screenings</li> </ul>	80% per service, includes: Physician Physician or Gynecologist Optometrist or Ophthalmologist	50% per service, includes: Physician Physician or Gynecologist Optometrist or Ophthalmologist
<b>Child Care (Deductible waived)</b>		
<ul style="list-style-type: none"> <li>▪ Well child annual office visit (up to age 21)</li> <li>▪ Routine vision and hearing exams</li> <li>▪ Pediatric and childhood immunizations</li> </ul>	80% per service, includes: Physician or Pediatrician Physician or Pediatrician Physician or Pediatrician	50% per service, includes: Physician or Pediatrician Physician or Pediatrician Physician or Pediatrician
<b>Emergency Services</b>		
<b>Emergency Services</b> Non-emergency services not covered	80%	80%
<b>Ambulance (Includes emergency ground / water / air transport)</b> Non-emergency water and air transport services require pre-certification <sup>2</sup>	80%	80%
<b>Lab and Radiology Services</b>		
<b>Allergy Tests and Treatment</b>	80%	50%
<b>Diagnostic Lab Tests and X-rays</b>	80%	50%
<b>MRIs, CT / PET Scans and Major Diagnostic Testing<sup>2</sup></b>	80%	50%
<b>Hospital and Facility Services</b>		
<b>Urgent Care</b>	80%	50%
<b>Inpatient Hospitalization<sup>2</sup></b>	80%	50%
<b>Outpatient Surgical Care<sup>2</sup></b>	80%	50%
<b>Organ and Tissue Transplants<sup>2</sup> (\$100,000 per lifetime)</b>	80%	50%



# Summary of Benefits Significare PPO HSA-Compatible OH 1500

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

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

<sup>1</sup> Aggregate Family Deductible – Before benefits begin for anyone in the family, the Family Deductible amount must be met.

<sup>2</sup> 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.