



Summary of Benefits Significare PPO HSA-Compatible OH 2500 / 80

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)	\$2500 Individual \$5000 Family	\$5000 Individual \$10,000 Family
Physician Office Visits		
Physicians	80%	50%
Specialists	80%	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 \$500) Cholesterol, Osteoporosis, Diabetes screenings 	80% per service, includes: Physician Physician or Gynecologist Optometrist or Ophthalmologist	50% per service, includes: Physician Physician or Gynecologist Optometrist or Ophthalmologist
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 	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
Emergency Services		
Emergency Services Non-emergency services not covered	80%	80%
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 Testing ²	80%	50%
Hospital and Facility Services		
Urgent Care	80%	50%
Inpatient Hospitalization ²	80%	50%
Outpatient Surgical Care ²	80%	50%
Organ and Tissue Transplants ² (\$100,000 per lifetime)	80%	50%



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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 days)	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>			
	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.

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.