



# Summary of Benefits Significare PPO Copay Plan AZ 2500

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 <b>Applies to all services (unless specified)</b>	\$2500 Individual \$5000 Family	\$5000 Individual \$10,000 Family
<b>Physician Office Visits</b> Physicians (includes Chiropractors) Specialists	\$25 copayment \$50 copayment	60% 60%
<b>Coinsurance</b> The percentage of the cost Significa will pay for covered services	80%	60%
<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 19	
<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>	\$25 copayment per exam, includes: Physician Physician or Gynecologist Optometrist or Ophthalmologist  80% 80% 80% 80%  80%	60% per service, includes: Physician Physician or Gynecologist Optometrist or Ophthalmologist  60% 60% 60% 60%  60%
2501 / 04012009		
<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>	\$25 copayment per date of service: Physician or Pediatrician Physician or Pediatrician Physician or Pediatrician	60% 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% with a \$150 Emergency Room copayment (waived if admitted)	80% with a \$150 Emergency Room copayment (waived if admitted)
<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%	60%
<b>Diagnostic Lab Tests and X-rays</b>	80%	60%
<b>MRIs, CT / PET Scans and Major Diagnostic Testing<sup>2</sup></b>	80%	60%
<b>Hospital and Facility Services</b>		
<b>Urgent Care (Deductible waived)</b>	\$50 copayment	60%
<b>Inpatient Hospitalization<sup>2</sup></b>	80%	60%
<b>Outpatient Surgical Care<sup>2</sup></b>	80%	60%
<b>Organ and Tissue Transplants<sup>2</sup> (\$100,000 per lifetime)</b>	80%	60%



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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 <sup>2</sup> (60 days)	80%	60%	
Hospice (180 days per lifetime)	80%	60%	
Complications of Pregnancy	80%	60%	
Other Diagnostic, Surgical and Anesthesia Services <sup>2</sup> Physician care outside a doctor's office	80%	60%	
<b>Therapeutic Services / Equipment</b>			
Dialysis, Chemotherapy and Radiation Therapy <sup>2</sup>	80%	60%	
Outpatient Therapies (45 visits combined) Respiratory, Cardiac, Pulmonary, Physical, Speech <sup>2</sup> , Occupational	80%	60%	
Durable Medical Equipment, Orthotics and Prosthetics <sup>2</sup> (\$2,000 maximum)	80%	60%	
Oxygen and Related Equipment and Supplies <sup>2</sup>	80%	60%	
<b>Home Health Care Services</b>			
Home Health Visits <sup>2</sup>	80%	60%	
Home Infusion Therapy <sup>2</sup>	80%	60%	
<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%	60%	
<b>Prescription Drugs <i>through Express Scripts</i></b>			
Copayments	Retail (30-day Supply)	Mail Order (90-day Supply)	Non-Preferred Providers
Tier 0: Generic Maintenance <sup>3</sup>	Tier 0 \$0	Tier 0 \$0	No drug coverage when obtained from Non-Participating Pharmacies (out of network)
Tier 1: Generics Preferred <sup>4</sup>	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	12-month waiting period applies to all services	
Obstetrician's Office and Hospital Visits	80%	60%
Inpatient Facility Care <sup>2</sup>	80%	60%

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

<sup>1</sup> **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.

<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.

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

<sup>4</sup> **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.