



Next Generation HSA™
For Individuals and Families

Benefit Chart and Plan
for Ohio

Ohio

Plan Choice	100%		80%	
	Network	Non-Network	Network	Non-Network
Individual Benefit Period Deductible The network and non-network benefit period deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	\$1,050* \$1,500 \$2,100* \$2,700* \$3,500 \$5,000	\$2,100* \$3,000 \$4,200* \$5,400* \$7,000 \$10,000	\$1,050* \$1,500 \$2,100* \$2,700* \$3,500	\$2,100* \$3,000 \$4,200* \$5,400* \$7,000
Family Benefit Period Deductible The network and non-network benefit period deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	\$2,100* \$3,000 \$4,200* \$5,450* \$7,000 \$10,000	\$4,200* \$6,000 \$8,400* \$10,900* \$14,000 \$20,000	\$2,100* \$3,000 \$4,200* \$5,450* \$7,000	\$4,200* \$6,000 \$8,400* \$10,900* \$14,000
Lifetime Policy Maximum	\$5 million			
Networks Available	PHCS-SuperMed Plus			

*These may be adjusted annually for changes in the U.S. Consumer Price Index (CPI)

	Network Coverage	Non-Network Coverage
	Benefit Percentages Apply After The Deductible Is Met	
Individual Benefit Percentage/Out-Of-Pocket Maximum After Deductible	100% / NA 80% / \$1,000	75% / \$4,000 50% / \$4,000
Family Benefit Percentage/Out-Of-Pocket Maximum After Deductible	100% / NA 80% / \$2,000	75% / \$4,000 50% / \$8,000

Accident Benefit	
Accident	We will waive the deductible and pay the covered charges at the benefit percentage shown on the policy schedule for services incurred within 30 days of an injury. The deductible will be applied to any covered charges incurred after the 30-day limit has been met.

	Network Coverage	Non-Network Coverage
	Benefit Percentages Apply After The Deductible Is Met	
Physician Services		
In Physician's Office and Urgent Care Centers <ul style="list-style-type: none"> • Office Visits • X-rays • Visits for Injury • Office Surgery • Laboratory Tests 		
In-Hospital Visits by a Physician		
Outpatient Spinal Manipulation \$500 benefit period maximum per family member		
Well Child Care Benefit \$500 first year of life, including hearing screening (limited to \$75), \$150 per year for second through ninth year of life (deductible waived)	100% or 80%	75% or 50%
Allergy Testing, Serums and Injections \$500 benefit period maximum per family member		
Preventive Care \$300 benefit period maximum per family member <ul style="list-style-type: none"> • Immunizations • Bone Density Test • Pap Smear • Routine Physical Exams • Colonoscopy • Routine Mammograms • Inoculations or Prophylactic Drugs for Travel • PSA Testing 		

Hospital Services	
Inpatient Services	
Outpatient Surgery	
Diagnostic Services <ul style="list-style-type: none"> • Pre-admission Testing • X-rays • Nuclear Medicine • Ultrasounds • Laboratory Tests • MRIs • Mammograms 	100% or 80% 75% or 50%

	Network Coverage	Non-Network Coverage
Benefit Percentages Apply After The Deductible Is Met		
Emergency Services		
Emergency Room Services Including Ambulance and ER Physicians	Emergency sickness or injury covered at the network benefit percentage of 100% or 80%. Non-emergency sickness is not covered.	

Other Covered Services		
Free-Standing Outpatient Surgery Center Facility Charges	100% or 80%	75% or 50%
Radiology or Diagnostic Services Outside of the Hospital <ul style="list-style-type: none"> • X-rays • MRIs • Mammograms • Nuclear Medicine <ul style="list-style-type: none"> • Ultrasounds • Laboratory (including lab work sent by a physician to an independent laboratory) 		
Outpatient Physical, Occupational and Speech Therapy Limited to 60 visits per benefit period (this is a combined total for all therapies)		
Home Health Care Limited to 20 visits per benefit period		
Hospice Up to \$200 per day, a lifetime maximum of \$15,000 or 6 months, whichever comes first		
Skilled Nursing Facility \$75 per day, 60 days per benefit period	Discount Program, then 100% or 80%	75% or 50%
Prescription Drug Coverage Includes the discount drug card for use at network retail pharmacies, up to a 30-day supply. The mail order program also provides discounts for up to a 90-day supply of maintenance medications.		
Organ Transplants Combined maximum benefit of \$1 million. A designated transplant facility is a medically proven exceptional success rate facility for organ transplants that has agreed to provide approved transplant services to our policyholders.	\$1 million at a designated transplant facility with up to \$10,000 for travel and lodging for the insured and one companion. Meals and lodging are limited to \$150 per person per day. 100% or 80%	\$150,000 at a non-designated transplant facility 75% or 50%
Accidental Death and Dismemberment for Primary Insured Only	\$10,000 (Full Amount)	

Optional Benefits		
Dental Benefit Benefit period maximum benefit is \$1,000	Type I procedures: 6-month waiting period, then 80% Type II procedures: 12-month waiting period, \$100 benefit period deductible, then 50%	
Maternity Benefit for all Females on the Policy 270-day waiting period from the effective date of the maternity coverage	100% or 80%	75% or 50%
Embedded Deductible for Family Plans	Allows a single family member to begin receiving benefits at the network/non-network levels as appropriate after that family member's single deductible amount has been reached. Available for a family deductible of \$4,200 or higher.	

Other Covered Services (Mandates)	
Post-Delivery Care	If maternity benefits are selected, coverage for inpatient care (48/96 hours) and follow-up care for a mother and her newborn. Covered services include education and training, assessment of home support systems, performance of medically necessary tests and any other recommended services. Coverage for doctor office visits and home healthcare visits.
Prosthesis, Reconstructive Surgery (Mastectomy)	Reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, two prostheses, and coverage of physical complications at all stages of mastectomy, including lymphedemas.

Pre-Existing Conditions Limitation

The plan does not pay for any expense incurred due to a pre-existing condition during the 12-month period starting on the effective date of coverage.

Pre-existing condition means a sickness or injury that:

- Is diagnosed or treated by a physician within 6 months prior to the effective date of a family member's coverage, or
- Produced symptoms within six months prior to the effective date of a family member's coverage that would cause a reasonably prudent person to seek medical advice, diagnosis, care or treatment.

A sickness that appeared or an injury sustained prior to the effective date of the family member's coverage, that was fully disclosed on the application and was not excluded from coverage by a rider, is not a pre-existing condition.

The 12-month period will be reduced for any family member by the length of time the family member had prior coverage, which was continuous to a date not more than 30 days before the effective date of coverage under the policy.

Third Party Reimbursement, Standard Coordination of Benefits (COB), Medicare Coordination, and Subrogation

Next Generation HSA contains certain provisions that may reduce benefits under the plan; a full description is contained in the policy.

General Exclusions and Limitations

Some of the services that the Next Generation HSA Plan does NOT cover include:

Pre-existing conditions for the 12-month period starting on the effective date of coverage; Charges in excess of the usual, customary, and reasonable charges for non-network services; Charges for services that are experimental, investigational, unproven or for research; Charges arising from war, commission of a felony, or participation in a riot or insurrection; Any sickness contracted or injury received while a member of the military; Charges for sickness or injury that are covered by Workers' Compensation Insurance or similar laws; Travel expenses, except for professional ambulance service; Preventive medical care, except when provided by the preventive care benefit, or if listed under covered charges; Charges for dental services or supplies, unless the dental benefit rider is purchased; Cosmetic treatment, except as provided in the policy; Care covered under a government program; Eyeglasses; Contact lenses; Eye exams; Hearing aids; Contraceptives; Pregnancy, unless the maternity benefit rider is purchased; Sterilization; Abortion; Treatment for hair restoration; Treatment of acne; Treatment for substance abuse; Treatment for mental or nervous disorders or illnesses, or emotional conditions; Examination, diagnosis or treatment of malocclusion or misalignment of the jaw; Charges for services that are not medically necessary; Treatment received in a hospital emergency room for a non-emergency sickness; Charges for which benefits are not provided in the policy.

A complete list of exclusions and limitations is included in the Next Generation HSA policy. See policy form ICDHP-HSA for complete terms and conditions.



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