



**Next Generation HSA™**  
*For Individuals and Families*

Benefit Chart and Plan  
for Indiana

*Indiana*

Plan Choice	100% Plan		80% Plan	
	Network	Non-Network	Network	Non-Network
<b>Individual Benefit Period Deductible</b> 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
<b>Family Benefit Period Deductible</b> 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
<b>Lifetime Policy Maximum</b>	\$5 million			
<b>Networks Available</b>	PHCS~Sagamore			

*\*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	
<b>Individual Benefit Percentage/Out-Of-Pocket Maximum After Deductible</b>	100% / NA 80% / \$1,000	75% / \$4,000 50% / \$4,000
<b>Family Benefit Percentage/Out-Of-Pocket Maximum After Deductible</b>	100% / NA 80% / \$2,000	75% / \$4,000 50% / \$8,000

Accident Benefit	
<b>Accident</b>	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	
<b>Physician Services</b>		
<b>In Physician's Office and Urgent Care Centers</b> • Office Visits • Office Surgery • X-rays • Laboratory Tests • Visits for Injury	100% or 80%	75% or 50%
<b>In-Hospital Visits by a Physician</b>		
<b>Outpatient Spinal Manipulation</b> \$500 benefit period maximum per family member		
<b>Allergy Testing, Serums and Injections</b> \$500 benefit period maximum per family member		
<b>Preventive Care</b> \$300 benefit period maximum per family member • Immunizations • Routine Mammograms • Bone Density Test • Inoculations or Prophylactic • Pap Smear • Drugs for Travel • Routine Physical Exams • PSA Testing • Colonoscopy	100% or 80%	Not Covered

Hospital Services		
<b>Inpatient Services</b>	100% or 80%	75% or 50%
<b>Outpatient Surgery</b>		
<b>Diagnostic Services</b> • Pre-admission Testing • Laboratory Tests • X-rays • MRIs • Nuclear Medicine • Mammograms • Ultrasounds		

Emergency Services	
<b>Emergency Room Services</b> Including Ambulance and ER Physicians	Emergency sickness or injury covered at the <b>network</b> benefit percentage of 100% or 80%. Non-emergency sickness is not covered.

	Network Coverage	Non-Network Coverage
Benefit Percentages Apply After The Deductible Is Met		
<b>Other Covered Services</b>		
<b>Free-Standing Outpatient Surgery Center</b> Facility Charges		
<b>Radiology or Diagnostic Services</b> Outside of the Hospital <ul style="list-style-type: none"> <li>• X-rays</li> <li>• MRIs</li> <li>• Mammograms</li> <li>• Nuclear Medicine</li> <li>• Ultrasounds</li> <li>• Laboratory (including lab work sent by a physician to an independent laboratory)</li> </ul>	100% or 80%	75% or 50%
<b>Outpatient Physical, Occupational and Speech Therapy</b> Limited to 60 visits per benefit period (this is a combined total for all therapies)		
<b>Home Health Care</b> Limited to 20 visits per benefit period		
<b>Hospice</b> Up to \$200 per day, a lifetime maximum of \$15,000 or six months, whichever comes first		
<b>Skilled Nursing Facility</b> \$75 per day, 60 days per benefit period		
<b>Prescription Drug Coverage</b> 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.	Discount Program, then 100% or 80%	75% or 50%
<b>Organ Transplants</b> 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%
<b>Accidental Death and Dismemberment for Primary Insured Only</b>	\$10,000 (Full Amount)	

<b>Plan Options</b>		
<b>Dental Benefit</b> Benefit period maximum benefit is \$1,000	<b>Type I procedures:</b> 6-month waiting period, then 80% <b>Type II procedures:</b> 12-month waiting period, \$100 benefit period deductible, then 50%	
<b>Maternity Benefit for Insured and Spouse Only</b> 270-day waiting period from the effective date of the maternity coverage. To be covered, pregnancy must begin after the waiting period.	100% or 80%	75% or 50%
<b>Embedded Deductible for Family Plans</b>	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.	

<b>Other Covered Services (Mandates)</b>	
<b>Diabetes</b>	Medically necessary treatment, supplies, and equipment. Self management training prescribed by physician or podiatrist, provided by licensed healthcare professional with specialist training in diabetes management.
<b>Pervasive Developmental Disorder</b>	Treatment prescribed by a physician in accordance with a prescribed treatment plan.
<b>If Maternity Benefit is Chosen: At home post-delivery care for mother and newborn</b>	Minimum length of stay recommended in the Guidelines for Perinatal Care (the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists). May be shortened if infant is medically stable, the mother is able to take care of the infant, and follow up care is available. Within 48 hours of discharge, one post-partum visit in home or in physician's office (at mother's discretion).
<b>Prosthesis, Reconstructive Surgery (Mastectomy)</b>	Prosthetic devices, reconstructive surgery incident to a mastectomy, including other breast for symmetry.

### **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 for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months prior to the effective date of a family member's coverage; or
- A sickness that produced symptoms within 12 months prior to the effective date of a family member's coverage that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment; or
- A pregnancy on the effective date of a family member's coverage.

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.

Having a history of or being a victim of domestic or sexual abuse is not a pre-existing condition.

The 12-month period will be reduced for any family member by the amount of time the family member had continuously served under a pre-existing condition clause for a policy of accident and sickness insurance issued under the Indiana Small Employer Group Health Insurance laws, if the family member applies for the policy not more than 30 days after coverage issued under said laws expires.

### **Medicare Coordination, Third Party Reimbursement, Subrogation and Insurance with Other Insurers**

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 of a mental or nervous disorder or emotional conditions, even if court ordered; Treatment for substance abuse; 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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