

Next Generation HSA™

For Individuals & Families

Ohio Benefit Chart

| Plan Choice | 100% Plan | | 80% Plan | |
|---|--|--|--|--|
| | 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. | \$1,150* \$1,500 \$2,100 \$2,700 \$3,500 \$5,000 | \$2,300* \$3,000 \$4,200 \$5,400 \$7,000 \$10,000 | \$1,150* \$1,500 \$2,100 \$2,700 \$3,500 | \$2,300* \$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. | \$2,300* \$3,000 \$4,200 \$5,450 \$7,000 \$10,000 | \$4,600* \$6,000 \$8,400 \$10,900 \$14,000 \$20,000 | \$2,300* \$3,000 \$4,200 \$5,450 \$7,000 | \$4,600* \$6,000 \$8,400 \$10,900 \$14,000 |
| Lifetime Policy Maximum | \$5 million per person | | | |
| 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. |

| Physician Services | Network Coverage | Non-Network Coverage |
|---|---|----------------------|
| | Benefit Percentages Apply After The Deductible Is Met | |
| In Physician's Office and Urgent Care Centers • Office Visits • X-rays • Visits for Injury • Office Surgery • Laboratory Tests | 100% or 80% | 75% or 50% |
| In-Hospital Visits by a Physician | | |
| Allergy Testing, Serums and Injections \$500 benefit period maximum per person | | |
| Outpatient Spinal Manipulation \$500 benefit period maximum per person | | |
| 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) | | |
| Preventive Care \$300 benefit period maximum per person • Immunizations (age 10 and older) • Bone Density Test • Pap Smear • Routine Physical Exams (age 10 and older) • Colonoscopy • Routine Mammograms • Inoculations or Prophylactic Drugs for Travel • PSA Testing | | |

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| Benefit Percentages Apply After The Deductible Is Met | | |
| 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 • Non-routine Mammograms | 100% or 80% | 75% or 50% |

| Emergency Services | | |
|---|--|--|
| Emergency Room Services | Emergency sickness or injury subject to the Network deductible and Network benefit percentage of 100% or 80%. Non-emergency sickness is not covered. | |
| Including Ambulance and ER Physicians (see Accident Benefit on page 1) | | |

| Other Covered Services | | |
|--|--|---|
| Free-Standing Outpatient Surgery Center | | |
| Facility Charges | | |
| Radiology or Diagnostic Services Outside of the Hospital | | |
| <ul style="list-style-type: none"> • X-rays • MRIs • Non-routine Mammograms • Nuclear Medicine • Ultrasounds • Laboratory (including lab work sent by a physician to an independent laboratory) | | |
| Outpatient Physical, Occupational and Speech Therapy | | |
| Limited to 60 visits per person per benefit period (this is a combined total for all therapies) | | |
| Home Health Care | 100% or 80% | 75% or 50% |
| Limited to 20 visits per person per benefit period | | |
| Hospice | | |
| Up to \$200 per day, a lifetime maximum of \$15,000 or 6 months per person, whichever comes first, bereavement support services up to \$500 | | |
| Skilled Nursing Facility | | |
| 60 days per person per benefit period | | |
| Alcoholism Treatment | | |
| \$550 benefit period maximum per person | | |
| Outpatient Mental Health | | |
| \$550 benefit period maximum per person | | |
| Biologically Based Mental Illness | | |
| Inpatient & outpatient services | | |
| Prescription Drug Coverage | Discount Program, then 100% or 80% | 75% or 50% |
| 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 | 100% or 80% | 75% or 50% |
| Combined maximum lifetime benefit of \$1 million per person. Includes charges incurred at designated and non-designated transplant facilities. 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. | \$150,000 at a non-designated transplant facility |

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| Other Covered Services | | |
| Accidental Death & Dismemberment for Primary Insured Only | \$10,000 (Full Amount) | |
| Plan Options | | |
| Dental Benefit \$1,000 benefit period maximum per person. | 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 \$4,600 or higher. | |

Benefit Period

Benefit Period means the 12-month period beginning on the effective date of your certificate and reoccurring every 12 months thereafter.

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.

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 group policy.

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.

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.

Eligibility

The following are considered eligible for coverage:

- The key applicant and his or her spouse, and
- The key applicant's children and his or her spouse's children and adopted children (regardless of whether a final order granting adoption is ultimately issued), provided they are:
 - Not married
 - Dependent on the key applicant for at least 50% of their support
 - Less than 22 years of age at the time of application.

Underwriting

The health history provided on the application determines the certificate provisions and premium. Therefore, it is important that applicants answer all questions accurately and thoroughly.

If the agent assists in completing the application, the applicant should review the answers before signing. The applicant's signature attests to the completeness and accuracy of the answers.

Reviews conducted after the policy is issued may reveal health information that wasn't disclosed on the application. This may result in rescission of coverage, increased premiums, and/or exclusion riders or claims being denied under the group policy's pre-existing exclusion.

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 and supplies; 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 or as provided under the organ transplant benefit; 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 except as provided in the Alcoholism Treatment benefit; Examination, diagnosis or treatment of malocclusion or misalignment of the jaw; Treatment of sleep disorders; 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 group policy.

A complete list of exclusions and limitations is included in the Next Generation HSA Group Policy. See group policy form OTP-ICDHP-HSA issued to American's Individual Trust, for complete terms and conditions.

This benefit chart is intended to highlight certain provisions of the plan described. It is not a contract, an insurance policy or a summary plan description booklet. Please see the policy for complete details, terms, conditions and full provisions of coverage.



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