Nippon Life Benefits®

Plan Name	Option 2	
Nippon Life Benefits	Evolution Value 2 Plan Benefit Highlight Non Grandfathered Plan	
	Multiple Networks	
Provisions and Benefits	In-Network	Out-of-Network
Calendar Year Deductible	$0 Individual; $0 Family	$20000 Individual; $40000 Family
	In-Network Deductible & Out-of-Network Deductible does not cross apply	
Out-of-Pocket Maximum per Calendar Year	$500 Individual; $1500 Family OOP Maximum	$30000 Individual; $60000 Family OOP Maximum
(Includes Coinsurance, Deductibles and Co-payments and Co-payment under Prescription Drugs or Mail Order Prescription Drugs.)	OOP maximums do not cross-apply	
Hospital Inpatient Services Maternity Care is Included	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Hospital Outpatient Services	100% coinsurance, subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Transplant Services	100% coinsurance; subject to calendar year deductible (when treatment is received from our designated Transplant Network Provider)	50% coinsurance; subject to calendar year deductible; limited to $250,000 per transplant $500,000 lifetime.
Surgeon's Fees (Inpatient/Outpatient)	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Doctor Office Visits - Primary Care Doctor Office Visits - Specialists	$15 co-payment; $30 co-payment; 100% coinsurance	subject to calendar year deductible subject to calendar year deductible 50% coinsurance
Emergency Room Visits	$150 co-payment (waived if admitted) 100% coinsurance	$150 co-payment (waived if admitted) 100% coinsurance up to the Allowed Amount* Non-Emergency Services - 50% coinsurance Subject to calendar year deductible up to the Allowed Amount*
Ambulance	100% coinsurance; subject to calendar year deductible	100% coinsurance; subject to calendar year deductible up to the Allowed Amount* Non-Emergency Services - 50% coinsurance; subject to calendar year deductible up to the Allowed Amount*
Urgent Care Center	$50 copayment; then 100% coinsurance	50% coinsurance; subject to calendar year deductible
Diagnostic X-Ray Services - Doctor's Office or Clinic	$15/$30 co-payment	50% coinsurance; subject to calendar year deductible
Diagnostic X-Ray Services - Hospital (Inpatient and Outpatient)	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
MRIs, CATs, PETS and SPECTS	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible

Outpatient Laboratory Services - Non Hospital Facility	LabCard – 100% coinsurance, not subject to calendar year deductible or co-payment; Other In-Network, $15/$30 Copayment	50% coinsurance; subject to calendar year deductible
Hospice Care		
- No daily limit	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Home Health Care	100% coinsurance;	80% coinsurance; subject to separate $50 calendar year deductible
- 100 visits per calendar year		
Durable Medical Equipment	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Prosthetics and Orthotics	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Skilled Nursing Facility		
Covered Charge limited to 50% of hospital's room charge, 120 days for all confinements from the same condition	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Physical, Occupational and Speech Therapy - Up to 30 visits per calender year		
Outpatient Services	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Outpatient Hospital		
Doctor's Office or Clinic	$15/$30 co-payment	50% coinsurance; subject to calendar year deductible
Chiropractic Care	$30 co-payment	50% coinsurance; subject to calendar year deductible
Acupuncture (physician's office or clinic)$500 calendar year maximum; in/out network combined	$15/$30 co-payment	50% coinsurance; subject to calendar year deductible
Pediatric Vaccines through age 18	100% coinsurance, not subject to calendar year deductible or co-payment	100% coinsurance, not subject to calendar year deductible or co-payment
Preventative Care Services**	100% coinsurance; not subject to calendar year deductible or co-payment	Child to age 19- 50% coinsurance; subject to calendar year deductible** Persons age 19 or older – No benefits are provided
Women's Preventative Health**	100% coinsurance; not subject to calendar year deductible or co-payment	Most Contraceptives covered under prescription drugs; other services - 50% coinsurance; subject to calendar year deductible
Immunizations (for ages 19 and over)	100% coinsurance; not subject to calendar year deductible or co-payment	No Benefits
Wellness Services	An overall population health management program that addresses gaps in care and also includes an online wellness portal. Core package included in all medical plans. Buy up packages available for groups with 50+ employees.	

Mental Health or Behavioral, Alcohol or Drug Abuse

Inpatient Services	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible

Outpatient Services Outpatient Hospital	100% coinsurance; subject to calendar year deductible	50% coinsurance; subject to calendar year deductible
Doctor's Office or Clinic	$15/$15 co-payment	50% coinsurance; subject to calendar year deductible
Lifetime Maximum Benefit	Unlimited	Unlimited
Basis for Reimbursement	Negotiated Fee	Allowed Amount*
Prescription Drugs **CVS Caremark pharmacy network**	$15 Copay Generic (2 times for Mail Order Drugs) $30 Copay for Preferred Brand Name (2 times for Mail Order Drugs) $50 Copay for Non-Preferred Brand Name (2 times for Mail Order Drugs)	
Generic and single source contraceptives for women are covered at 100% coinsurance, not subject to calendar year deductible or copayment, at CVS Caremark pharmacy network. (Maximum allowable charge applies to brand name prescription drugs not written as "dispense as written" by the physician.) Reimbursement for prescriptions filled at a non CVS Caremark network pharmacy is limited to the cost of the drug if filled at a CVS Caremark network pharmacy minus the applicable co-payment.		

* The Allowed Amount is:

- For services provided by uncontrollable providers in a PPO facility, reimbursement will be provided at the 80th percentile prevailing fee. Uncontrollable providers include anesthesiologist, radiologist, pathologist or emergency room physician.
- For all other services - 125% of Medicare Fee Schedule (RBRVS)

** Preventive Services are the services defined in the federal health care reform act and include certain screenings, immunizations, tests and other types of preventive care.

· The above highlights are intended as an overview. In any discrepancy between the highlights and the master contract, the master contract will govern. These highlights do not guarantee benefits or eligibility. All terms, provisions, conditions, limitations and exclusions shown in the certificate-booklet and master policy will apply.

· Listed benefits are only covered if medically necessary. Pre-approval may be necessary. Failure to obtain this pre-approval may result in a reduction or full denial of benefits.

· Most injectables other than insulin are covered under the medical plan rather than the prescription drug plan.

· Dependent Child covered through age 25