

FlexChoice — Ohio Small Group

Plan Design

Unless otherwise noted, all deductibles, coinsurance maximums and benefit amounts are applied per person.

In-Network Calendar Year Deductible Individual Choices Family	(You Pay)	\$500, \$1,000, \$1,500, \$2,000, \$2,500, \$3,500, \$5,000 2 x individual In-Network calendar year deductible
Out-of-Network Calendar Year Deductible Individual Choices Family	(You Pay)	\$1,000, \$2,000, \$3,000, \$4,000, \$5,000, \$7,000, \$10,000 2 x individual Out-of-Network calendar year deductible
Benefit Percentage Choices	(Plan Pays)	100%*, 90%, 80%, 70%
Coinsurance Percentages	(You Pay)	0%, 10%, 20%, 30%
In-Network Coinsurance Max Per Calendar Year Individual Choices Family	(You Pay)	\$2,000, \$3,000, \$4,000, \$5,000 or \$10,000 2 x individual coinsurance maximum
Out-of-Network Coinsurance Max Per Calendar Year		2 x In-Network coinsurance maximum
Primary Care Office Visit Copay Choices	(You Pay)	\$25, \$35, \$45. Benefits paid at 100% after copay up to \$500, then deductible and plan benefit percentage.
Specialist Office Visit Copay	(You Pay)	\$50. Benefits paid at 100% after copay up to \$500, then deductible and plan benefit percentage.
Emergency Care (In- and Out-of-Network)		If OV Copay selected, \$150 copay then 100% of: • In-Network - negotiated fee, • Out-of-Network - prevailing charge
Urgent Care		If OV Copay selected, In-Network: \$50 copay then 100%; Out-of-Network: deductible then plan benefit percentage.
Preventive Care (In-Network)		100%**
Maternity Choices (Under 15 lives)		Same as any illness for complications only
Outpatient Surgery		Calendar year deductible and coinsurance apply whether services are provided at a hospital, an ambulatory surgery center or a physician's office.
Prescription Drug Coverage Choices		\$15/\$25/\$50 or \$25/\$50/\$75 (Combined preferred and non-preferred drug deductible of \$250 or \$500, then applicable copay)

- Plans without copay — Deductible and benefit percentages will be applied in lieu of copays for any medical expenses.
- Calendar Year Deductible — Separate in-network and out-of-network deductibles apply. Charges that apply to one do not apply to the other.
- Coinsurance maximum — Deductibles and copays do not apply.
- Out-of-Network Prevailing Charge — Services from out-of-network providers are screened at the 70th percentile, reasonable and customary. Option for out-of-network services to be screened at 125% of RBRVS (Resource Based Relative Value Scale).

* 100% option available with \$1,500 deductible and above only.

**For grandfathered plans, benefits paid at 100% after copay.

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