Kent Health Plan-Plan C
The Affordable Health Care Option
For Small Businesses.

KENT HEALTH PLAN

Plan C

SCHEDULE OF MEDICAL COVERAGE

Benefits (Employee and Spouse Only; Children Not Covered)

In-Network benefits are based on the Preferred Provider Organization's approved amount. Out-of-Network benefits are not provided except for life-threatening emergencies and are then based on the US Health and Life fee schedule. Benefits are determined after an applicable Copay and Coinsurance, and are subject to Daily, Annual, Lifetime, and Other Maximums, General Exclusions and other applicable limitations.

Annual Maximum, All Benefits Combined, regardless of individual service maximums	**$35,000**
Lifetime Maximum, All Benefits Combined, regardless of individual service maximums	**$200,000**

***Benefits are provided Out-of-Network only for Life-Threatening Emergencies**	**In-Network (PPOM) Plan Pays after Member's Copay and Coinsurance**	**Out-of-Network *Benefits are provided Out-of-Network only for Life-Threatening Emergencies**
Inpatient Hospital Services (Semi-Private Room and Board, Intensive Care Unit, Ancillary Services)		
• General Conditions $25000 Annual Maximum 20 Day Annual Maximum	$100 Copay per Admission	Not Covered*
• Psychiatric Treatment 15 Day Annual Maximum	$100 Copay per Admission	Not Covered*
• Substance Abuse care $5000 Annual Maximum 10 Day Annual	$100 Copay per Admission	Not Covered*
• Maternity Per Delivery Maximum of $3,000, 4 Day Annual Maximum	$100 Copay per Admission	Not Covered*
• Newborn, including Nursery	Not Covered	Not Covered
Emergency Services	$1,000 Annual Maximum, regardless of individual maximum	
Emergency Room ($1,000 Per Visit Maximum)	$50 Copay	Not Covered
Outpatient Services	$3,500 Annual Maximum, regardless of individual maximum	
Urgent Care Center	$25 Copay per visit	Not Covered*
Ambulance	10% Coinsurance	Not Covered*
Surgery Facility (includes Anesthesia) Charge, $1,500 per Surgery Maximum	No Copay or Coinsurance	Not Covered*
Laboratory, X-ray, Radiology, Pathology	No Copay or Coinsurance	Not Covered*
Prosthetic Devices, Durable Medical Equipment and Medical Supplies $1,500 Annual Maximum	No Copay	Not Covered*
Physical, Speech and Occupational Therapy	Not Covered	Not Covered*
Private Duty Nursing (R.N. only)	No Copay or Coinsurance	Not Covered*
Extended Care Facility	No Copay or Coinsurance	Not Covered*
Hospice Care Program	No Copay or Coinsurance	Not Covered*
Home Health Agency, 10 visit Annual maximum	No Copay or Coinsurance	Not Covered*
Psychiatric Services (including testing), 10 visits Annual Maximum	$15 Copay	Not Covered*
Physician Surgical procedures, $10,000 Annual Maximum	No Copay or Coinsurance	Not Covered*
Physician Services- anesthesia, $2,500 Annual Maximum	No Copay or Coinsurance	Not Covered*
Physician in Hospital Consultations & Emergency Room	No Copay or Coinsurance	Not Covered*
Physician Office Visits	$15 Copay	Not Covered*
Physician Maternity care including pre & postnatal	No Copay or Coinsurance	Not Covered*
Chiropractic Care, including x-rays, $250 Annual maximum	$15 Copay	Not Covered*
Non-Surgical Podiatric Care, all services $250 Annual maximum	$15 Copay	Not Covered*
Services (not included elsewhere)		
Intermediate/Outpatient Substance Abuse Care, $3,500 Annual Maximum	20% Coinsurance	Not Covered*
Wellness/Preventive Care Benefits	Not Covered	Not Covered
Prescription Drugs $2,500 Annual Maximum	CLAIMSPRO	
(Kent Health Plan B Formulary Only)		
Brand Name	50% Coinsurance	Not Covered
Generic	$5 Copay	Not Covered