Medical & Dental
Claims Administrator

PPO Network SuperMed Plus

KENYON COLLEGE HEALTH PLAN

Benefits Comparison by Plan

This is a brief summary of your health plan See the Summary Plan Description (SPD) benefit booklet for details. If there is any difference between this summary and the SPD, the SPD benefit booklet will prevail.

Benefit Option	PREMIUM PLAN		BASIC PLAN	
Medical Benefits	**In Network You Pay**	**Out of Network You Pay**	**In Network You Pay**	**Out of Network You Pay**
Benefit Year Deductible ***Benefit year is 7/1-6/30***	Per Person: $250 Family Max: $500		Per Person: $500 Family Max: $1,000	
Out of Pocket Maximum *If a person pays this amount in a benefit year due to the deductible and coinsurance, the plan will pay 100% for the rest of the benefit year*	Per Person: $1,250 Family Max: $2,500	Per Person: $2,250 Family Max: $4,500	Per Person: $3,500 Family Max: $7,000	Per Person: $5,500 Family Max: $11,000
Overall Annual Maximum	$2,000,000		$2,000,000	
Office Visit (OV)	$15 co-pay Deductible Waived	40% after deduc	$20 co-pay Deductible Waived	n/a
Hospital Charges- Inpatient or Outpatient	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Emergency Room ER Physician	20% after deduc 20% after deduc	40% after deduc 20% after deduc	30% after deduc 30% after deduc	50% after deduc 30% after deduc
Physical Therapy, Speech Therapy, Occupational Therapy	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Ambulance	20% after deduc		30% after deduc	
Durable Medical Equipment	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Home Health Care	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Skilled Nursing Facilities	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Lab & X-ray	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Outpatient Surgery	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Mental/Nervous/Substance Abuse	Same as any other illness-Paid based on type of services received		Same as any other illness- Paid based on type of services received	
Preventive Care Benefits *Deductible Waived* Includes Well Child Care, Adult Routine Physical Exams, Colonoscopies, Immunizations, Mammograms and Pap Tests	$15 co-pay	$15 co-pay then 40% of balance Max of $350 per Benefit Year	$20 co-pay	$20 co-pay then 50% of balance Max of $350 per Benefit Year
Hospice Care	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Spinal Adjustment Therapy	20% after deduc	40% after deduc	30% after deduc	50% after deduc
Rx Coverage				
Benefit Year Deductible	$50 per person/$150 per family		$75 Per Person/$225 per Family	
After Deductible: Retail (30 Day Supply) Coinsurance (you pay)	20% ($150 max)		20% ($10 min/ $200 max)	
Mail Order (90 day supply) Generic Co-pay Preferred Brand Co-pay Non-Preferred Co-Pay	$15 co-pay $30 co-pay $45 co-pay		No Coverage	