Perris Union High School District

Summary of HMO Plans

Effective Date	07/01/2016	07/01/2016
Renewal Date	07/01/2017	07/01/2017
Carrier Name	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**
Plan Name	HMO High Option 1	HMO Low Option 2
Eligible Class	Eligible Employees	Eligible Employees
General Plan Information		
Annual Deductible/Individual	$0	$500
Annual Deductible/Family	$0	$1,000
Coinsurance	100%	80%
Office Visit/Exam	$20 copay	$20 copay
Outpatient Specialist Visit	$20 copay	$20 copay
Annual Out-of-Pocket Limit/Individual	$1,500	$3,000
Annual Out-of-Pocket Limit/Family	$3,000	$6,000
Lifetime Plan Maximum	Unlimited	Unlimited
Inpatient Hospital Services		
Inpatient Hospitalization	100%	80% after deductible
Semi-Private Room & Board; Including Services and Supplies	100%	80% after deductible
Emergency Services		
Emergency Room	$100 copay waived if admitted	80% after deductible
Mental Health Benefits		
Inpatient Care	100%	80% after deductible
Outpatient Care	$20 copay	$20 copay; deductible waived
Alcohol Abuse		
Inpatient Care		
Inpatient Hospitalization	100%	80% after deductible
Inpatient Detoxification Services	100%	80% after deductible
Outpatient Care		
Outpatient Services	$20 copay	$20 copay; deductible waived
Outpatient Detoxification Services		
Substance Abuse		
Inpatient Care		
Inpatient Hospitalization	100%	80% after deductible
Inpatient Detoxification Services	100%	80% after deductible
Outpatient Care		
Outpatient Services	$20 copay	$20 copay; deductible waived
Outpatient Detoxification Services		

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Plan Name	HMO High Option 1	HMO Low Option 2
Eligible Class	Eligible Employees	Eligible Employees
Prescription Drug Benefits		
Prescription Drug Deductible	N/A	$100 per Member/calendar year
Generic	$10 copay	$10 copay; deductible waived
Brand (Formulary/Preferred)	$10 copay	$30 copay; after prescription deductible
Brand (Non-Formulary/Non-preferred)		
Number of Days Supply	100 days	100 days
Mail Order		
Mail Order Mandatory	No	
Generic	$10 copay	$10 copay; deductible waived
Brand (Formulary/Preferred)	$10 copay	$30 copay; after prescription deductible
Brand (Non-Formulary/Non-preferred)		
Number of Days Supply for Mail Order	100 days	100 days
Other Services and Supplies		
Chiropractic Services	Not covered	Not covered