



## 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	<b>Kaiser Permanente Insurance Company</b>	<b>Kaiser Permanente Insurance Company</b>
Plan Name	HMO High Option 1	HMO Low Option 2
Eligible Class	Eligible Employees	Eligible Employees
<b>General Plan Information</b>		
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
<b>Inpatient Hospital Services</b>		
Inpatient Hospitalization	100%	80% after deductible
Semi-Private Room & Board; Including Services and Supplies	100%	80% after deductible
<b>Emergency Services</b>		
Emergency Room	\$100 copay waived if admitted	80% after deductible
<b>Mental Health Benefits</b>		
Inpatient Care	100%	80% after deductible
Outpatient Care	\$20 copay	\$20 copay; deductible waived
<b>Alcohol Abuse</b>		
<b>Inpatient Care</b>		
Inpatient Hospitalization	100%	80% after deductible
Inpatient Detoxification Services	100%	80% after deductible
<b>Outpatient Care</b>		
Outpatient Services	\$20 copay	\$20 copay; deductible waived
Outpatient Detoxification Services		
<b>Substance Abuse</b>		
<b>Inpatient Care</b>		
Inpatient Hospitalization	100%	80% after deductible
Inpatient Detoxification Services	100%	80% after deductible
<b>Outpatient Care</b>		
Outpatient Services	\$20 copay	\$20 copay; deductible waived
Outpatient Detoxification Services		

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.



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<b>Prescription Drug Benefits</b>		
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
<b>Mail Order</b>		
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
<b>Other Services and Supplies</b>		
Chiropractic Services	Not covered	Not covered