



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 | | |

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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| 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 |