

Keenan

Redlands Unified School District

Kaiser HMO Plan Comparison

	Current	Current
Effective Date	07/01/2025	07/01/2025
Renewal Date	07/01/2026	07/01/2026
Carrier	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company
Plan Name	HMO 30 w/Chiro	DHMO 500 w/Chiro
Benefit Summary	All Employees	Eligible Employees
General Plan Information		
Annual Deductible/Individual	\$0	\$500
Annual Deductible/Family	\$0	\$1,000
Coinsurance	100%	80%
Office Visit/Exam	\$30 copay	\$20 copay
Outpatient Specialist Visit	\$30 copay	\$20 copay
Annual Out-of-Pocket Limit/Individual	\$1,500	\$3,000
Annual Out-of-Pocket Limit/Family	\$3,000	\$6,000
Deductible Included in Out-of-Pocket Limits	N/A	Yes
Lifetime Plan Maximum	Unlimited	Unlimited
Primary Care Physician Election Required	No	No
Outpatient Services		
Preventive Services		
Well-Child Care	100% through age 23 months	100% deductible waived through age 23 months
Immunizations	100%	100% deductible waived
Well Woman Exams	100%	100% deductible waived
Mammograms	100%	100% for preventive, deductible waived
Adult Periodic Exams with Preventive Tests	100%	100% deductible waived
Diagnostic X-Ray and Lab Tests	100% \$30 copay for MRI/CT/PET	\$10 copay per encounter after deductible; \$50 copay per procedure for MRI/CT/PET after deductible
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%



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Plan Name	HMO 30 w/Chiro	DHMO 500 w/Chiro
Benefit Summary	All Employees	Eligible Employees
Inpatient Hospital Services		
Inpatient Hospitalization	100%	80% after deductible
Pre-Authorization of Services Required	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	80% after deductible
Surgical Services		
Outpatient Facility Charge	\$30 copay per procedure	80% after deductible
Emergency Services		
Emergency Room	\$100 copay waived if admitted	80% after deductible
Ambulance		
Air	100%	\$150 copay per trip; after deductible
Ground	100%	\$150 copay per trip; after deductible
Urgent Care		
Urgent Care Facility	\$30 copay	\$20 copay; deductible waived
Mental Health Benefits		
Inpatient Care	100%	80% after deductible
Outpatient Care	\$30 copay	\$20 copay; deductible waived
Prescription Drug Benefits		
Prescription Drug Deductible		\$100 per Member/calendar year
Prescription Drug Annual Out-of-Pocket Limit/Individual		
Prescription Drug Annual Out-of-Pocket Limit/Family		
Generic	\$15 copay	\$10 copay; deductible waived
Brand (Formulary/Preferred)		
Brand (Non-Formulary/Non-preferred)	\$35 copay	\$30 copay; after \$100 prescription deductible
Number of Days Supply		

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 30 w/Chiro	DHMO 500 w/Chiro
Benefit Summary	All Employees	Eligible Employees
Mail Order		
Mail Order Mandatory		
Generic	N/A	
Brand (Formulary/Preferred)	\$30 copay	\$20 copay; deductible waived
Brand (Non-Formulary/Non-preferred)		
Number of Days Supply for Mail Order	\$70 copay	\$60 copay; after \$100 prescription deductible
Other Services and Supplies		
Durable Medical Equipment & Prosthetic Devices		
Home Health Care		
Skilled Nursing or Extended Care Facility	100%	80% deductible waived
Hospice Care	100% limited to 100 visits/calendar year	100% limited to 100 visits/calendar year; deductible waived
Chiropractic Services	100% limited to 100 days/benefit period	80% after deductible; limited to 100 days/benefit period
Acupuncture	100%	100% deductible waived