

Perris Union High School District

Kaiser HMO20, HMO30 & DHMO500 Plan Comparison -

Certificated, Management, Confidential, Board Members & Charter School Employees

Effective Date	07/01/2025	07/01/2025	07/01/2025
Renewal Date	07/01/2026	07/01/2026	07/01/2026
Carrier	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company	Kaiser Permanente Insurance Company
Plan Name	HMO 20	HMO 30	DHMO 500
General Plan Information			
Annual Deductible/Individual	\$0	\$0	\$500
Annual Deductible/Family	\$0	\$0	\$1,000
Coinsurance	100%	100%	80%
Office Visit/Exam	\$20 copay	\$30 copay	\$20 copay
Outpatient Specialist Visit	\$20 copay	\$30 copay	\$20 copay
Annual Out-of-Pocket Limit/Individual	\$1,500	\$1,500	\$3,000
Annual Out-of-Pocket Limit/Family	\$3,000	\$3,000	\$6,000
Deductible Included in Out-of-Pocket Limits	N/A	N/A	Yes
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Primary Care Physician Election Required	Yes	Yes	Yes
Outpatient Services			
Preventive Services			
Well-Child Care	100% through age 23 months	100% through age 23 months	100% deductible waived through age 23 months
Immunizations	100%	100%	100% deductible waived
Well Woman Exams	100%	100%	100% deductible waived
Mammograms	100%	100%	100% for preventive, deductible waived
Adult Periodic Exams with Preventive Tests	100%	100%	100% deductible waived
Diagnostic X-Ray and Lab Tests	100% \$20 copay for MRI/CT/PET	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%	100%

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Plan Name	HMO 20	HMO 30	DHMO 500
Inpatient Hospital Services			
Inpatient Hospitalization	100%	100%	80% after deductible
Pre-Authorization of Services Required	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	100%	100%	80% after deductible
Surgical Services			
Outpatient Facility Charge	\$20 copay per procedure	\$30 copay per procedure	80% after deductible
Emergency Services			
Emergency Room	\$100 copay waived if admitted	\$100 copay waived if admitted	80% after deductible
Ambulance			
Air	100%	100%	\$150 copay per trip; after deductible
Ground	100%	100%	\$150 copay per trip; after deductible
Urgent Care			
Urgent Care Facility	\$20 copay	\$30 copay	\$20 copay; deductible waived
Mental Health Benefits			
Inpatient Care	100%	100%	80% after deductible
Outpatient Care	\$20 copay	\$30 copay	\$20 copay; deductible waived
Substance Abuse			
Inpatient Care			
Inpatient Hospitalization	100%	100%	80% after deductible
Inpatient Detoxification Services	100%	100%	80% after deductible
Outpatient Care			
Outpatient Services	\$20 copay	\$30 copay	\$20 copay; deductible waived
Prescription Drug Benefits			
Prescription Drug Deductible			\$100 per member/calendar year
Generic	\$10 copay	\$15 copay	\$10 copay; deductible waived
Brand (Formulary/Preferred)	\$20 copay	\$35 copay	\$30 copay; after \$100 prescription deductible
Number of Days Supply	30 days	30 days	30 days
Mail Order			
Generic	\$20 copay	\$30 copay	\$20 copay; deductible waived
Brand (Formulary/Preferred)	\$40 copay	\$70 copay	\$60 copay; after \$100 prescription deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days

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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Other Services and Supplies			
Durable Medical Equipment & Prosthetic Devices	100%	100%	80% deductible waived
Home Health Care	100% limited to 100 visits/calendar year	100% limited to 100 visits/calendar year	100% limited to 100 visits/calendar year; deductible waived
Skilled Nursing or Extended Care Facility	100% limited to 100 days/benefit period	100% limited to 100 days/benefit period	80% after deductible; limited to 100 days/benefit period
Hospice Care	100%	100%	100% deductible waived
Chiropractic Services	Not covered	Not covered	Not covered
Acupuncture	Not covered	Not covered	Not covered
Vision			
Copay			
Deductible Amount			
Annual Allowance Amount			
Examination	100%	100%	100%
Benefit Frequency			
Examination	Once every 12 months	Once every 12 months	Once every 12 months
Hearing			
Screening	100%	100%	100%
Aid(s)	Not covered	Not covered	Not covered
Infertility			
Diagnosis	See plan certificate	See plan certificate	See plan certificate
Treatment	See plan certificate	See plan certificate	See plan certificate
Outpatient Rehabilitative Therapy Services			
Physical	\$20 copay	\$30 copay	\$20 copay; after deductible
Occupational	\$20 copay	\$30 copay	\$20 copay; after deductible
Speech	\$20 copay	\$30 copay	\$20 copay; after deductible