

Perris Union High School District

Kaiser HSA Plan Comparison - Certificated, Management, Confidential, Charter School & Board Members

Effective Date	07/01/2025
Renewal Date	07/01/2026
Carrier	Kaiser Permanente Insurance Company
Plan Name	DHMO HSA
General Plan Information	
Annual Deductible/Individual	\$1,650 medical/prescription combined
Annual Deductible/Family	\$3,300 medical/prescription combined
Coinsurance	90%
Office Visit/Exam	90% after deductible
Outpatient Specialist Visit	90% after deductible
Annual Out-of-Pocket Limit/Individual	\$3,200
Annual Out-of-Pocket Limit/Family	\$6,400
Deductible Included in Out-of-Pocket Limits	Yes
Lifetime Plan Maximum	Unlimited
Primary Care Physician Election Required	No
Outpatient Services	
Preventive Services	
Well-Child Care	100% through age 23 months; deductible waived
Immunizations	100% deductible waived
Well Woman Exams	100% deductible waived
Mammograms	100% for preventive; deductible waived for preventive
Adult Periodic Exams with Preventive Tests	100% deductible waived
Diagnostic X-Ray and Lab Tests	100% preventive X-rays deductible waived; other than preventive 90% after deductible
Maternity Care	
Pregnancy and Maternity Care (Pre-Natal Care)	100%
Inpatient Hospital Services	
Inpatient Hospitalization	90% after deductible
Pre-Authorization of Services Required	Yes
Semi-Private Room & Board; Including Services and Supplies	90% after deductible
Surgical Services	
Outpatient Facility Charge	90% after deductible
Emergency Services	
Emergency Room	90% after deductible
Ambulance	
Air	90% after deductible
Ground	90% after deductible

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Urgent Care	
Urgent Care Facility	90% after deductible
Mental Health Benefits	
Inpatient Care	90% after deductible
Outpatient Care	90% after deductible
Substance Abuse	
Inpatient Care	
Inpatient Hospitalization	90% after deductible
Inpatient Detoxification Services	90% after deductible
Outpatient Care	
Outpatient Services	90% after deductible
Prescription Drug Benefits	
Prescription Drug Deductible	\$1,650 ind/\$3,300 fam; medical/prescription combined
Prescription Drug Annual Out-of-Pocket Limit/Individual	\$1,000
Prescription Drug Annual Out-of-Pocket Limit/Family	\$2,000
Generic	\$10 copay; after deductible
Brand (Formulary/Preferred)	\$30 copay; after deductible
Number of Days Supply	30 days
Mail Order	
Generic	\$20 copay; after deductible
Brand (Formulary/Preferred)	\$60 copay; after deductible
Number of Days Supply for Mail Order	100 days
Other Services and Supplies	
Durable Medical Equipment & Prosthetic Devices	90% after deductible; limited to \$2,500 calendar year benefit
Home Health Care	100% after deductible; limited to 100 visits/calendar year
Skilled Nursing or Extended Care Facility	90% after deductible; limited to 100 days/benefit period
Hospice Care	100% after deductible
Chiropractic Services	Not covered
Acupuncture	Not covered

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Plan Name	DHMO HSA
Vision	
Copay	
Examination	100%
Benefit Frequency	
Examination	Once every 12 months
Hearing	
Screening	100%
Aid(s)	Not covered
Infertility	
Diagnosis	See plan certificate
Treatment	See plan certificate
Outpatient Rehabilitative Therapy Services	
Physical	90% after deductible
Occupational	90% after deductible
Speech	90% after deductible