Keenan Associates

Redland Unified School District

Summary of Kaiser HMO Plans	Current	New Offering
Effective Date	**7/1/2015**	**07/01/2015**
Renewal Date	**7/1/2016**	**07/01/2016**
Carrier Name	**Kaiser Permanente Insurance Company**	**Kaiser Permanente Insurance Company**
Plan Name	**HMO**	**HMO Low Option 2 w/Chiro**
Eligible Class	**Eligible Employees**	**Eligible Employees**
General Plan Information		
Annual Deductible/Individual	$0	$500
Annual Deductible/Family	$0	$1,000
Coinsurance	N/A	80%
Office Visit/Exam	$40 copay	$20 copay
Outpatient Specialist Visit	$40 copay	$20 copay
Annual Out-of-Pocket Limit/Individual	$3,000	$3,000
Annual Out-of-Pocket Limit/Family	$6,000	$6,000
Deductible Included in Out-of-Pocket Limits	N/A	Yes (except prescription drugs)
Lifetime Plan Maximum	Unlimited	Unlimited
Outpatient Services		
Preventive Services		
Well-Child Care	100% 23 months or younger	100% through age 23 months
Immunizations	100%	100%
Well Woman Exams	100%	100%
Mammograms	100%	100% for preventive
Adult Periodic Exams with Preventive Tests	100%	100%
Diagnostic X-Ray and Lab Tests	100%	$10 copay per encounter after deductible; $50 copay per procedure after deductible for MRI/CT/PET
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal Care)	100%	100%
Inpatient Hospital Services		
Inpatient Hospitalization	100%	80% after deductible
Pre-Authorization of Services Required	Yes	Yes
Semi-Private Rm & Board; Incl. Services & Supplies	$250 per admission	80% after deductible
Surgical Services		
Outpatient Facility Charge	$30 copay	80% after deductible
Emergency Services		
Emergency Room	$100 copay waived if admitted	80% after deductible
Ambulance		
Air/Ground	100%	$150 copay per trip; after deductible
Urgent Care		
Urgent Care Facility	$40 copay	$20 copay; deductible waived
Mental Health Benefits		
Inpatient Care	$250 per admission	80% after deductible
Outpatient Care	$40 copay individual visit/ $20 copay group visit	$20 copay; deductible waived
Substance Abuse		
Inpatient Care		
Inpatient Hospitalization	$250 per admission	80% after deductible
Outpatient Care		
Outpatient Services	$40 copay individual visit/ $5 copay group visit	$20 copay; deductible waived

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Eligible Class	**Eligible Employees**	**Eligible Employees**
Prescription Drug Benefits		
Prescription Drug Deductible	$0	$100 per Member/calendar year
Annual Out-of-Pocket Limit/Individual	$1,000	
Out-of-Pocket Limit/Family	$2,000	
Generic	$15 for up to 30 day supply	$10 copay; deductible waived
Brand (Formulary/Preferred)	$30 copay for up to 30 day supply	$30 copay; after prescription deductible
Number of Days Supply	30 days	100 days
Mail Order		
Generic	$30 for up to 100 day supply	$10 copay; deductible waived
Brand (Formulary/Preferred)	$60 copay for up to 100 day supply	$30 copay; after prescription deductible
Number of Days Supply for Mail Order	100 days	100 days
Other Services and Supplies		
Durable Medical Equipment & Prosthetic Devices	100%	80% deductible waived
Home Health Care	100% limited to 100 visits per calendar year	100% limited to 100 visits/calendar year
Skilled Nursing or Extended Care Facility	100% limited to 100 days per benefit period	80% after deductible; limited to 100 days/benefit period
Hospice Care	100%	100%
Chiropractic Services	$10 copay 20 visits per calendar year	$10 copay; 30 visits/calendar year; provided through American Specialty Health
Acupuncture	Not covered	Not covered
Vision		
Copay		
Examination	100% Evaluation only	100%
Materials	provided by MES	provided by MES
Benefit Frequency		
Examination	Once every 12 months	Once every 12 months
Hearing		
Screening	100%	100%
Aid(s)	Up to $2,000 allowance per aid every 36 months	Not covered
Outpatient Rehabilitative Therapy Services		
Physical, Occupational & Speech	$40 copay	$20 copay; after deductible