



**Davis Joint Unified School District -  
Non-Kaiser Sutter Health Plus Plan Options**

**CaIPERS**

Carrier	Non-Kaiser *	Sutter Health Plus Summit ML67	Sutter Health Plus Peak ML68	Sutter Health Plus Peak ML69	Sutter Health Plus Peak ML70	Sutter Health Plus Peak ML71
<b>General Plan Information</b>						
Annual Deductible/Individual	\$0	\$0	\$500	\$1,000	\$1,500	\$2,500
Annual Deductible/Family	\$0	\$0	\$1,000	\$2,000	\$3,000	\$5,000
Office Visit/Specialist Visit/Urgent Care	\$15/\$15/\$15 copay	\$15/\$15/\$15 copay	\$20/\$20/\$20 copay	\$20/\$20/\$20 copay	\$20/\$20/\$20 copay	\$20/\$20/\$20 copay
Annual Out-of-Pocket Limit/Individual	\$1,500 (does not include Rx)	\$1,500 (includes Rx)	\$3,000 (includes Rx)	\$3,000 (includes Rx)	\$4,000 (includes Rx)	\$5,000 (includes Rx)
Annual Out-of-Pocket Limit/Family	\$3,000 (does not include Rx)	\$3,000 (includes Rx)	\$6,000 (includes Rx)	\$6,000 (includes Rx)	\$8,000 (includes Rx)	\$10,000 (includes Rx)
<b>Services</b>						
Preventive Services (Adult Exams/Well Child Care/Immunizations/Well Woman visits/Vision-Hearing Screening)	\$0	\$0	\$0	\$0	\$0	\$0
Diagnostic X-Ray/Lab Tests (Non-Preventive)	\$0	\$0	Lab \$20 copay, X-ray \$10 copay	Lab \$20 copay, X-ray \$10 copay	Lab \$20 copay, X-ray \$10 copay	Lab \$20 copay, X-ray \$10 copay
Outpatient Facility Charge	\$0	\$15 copay	10%, after deductible	20%, after deductible	20%, after deductible	20%, after deductible
Inpatient Hospitalization	\$0	\$0	10%, after deductible	20%, after deductible	20%, after deductible	20%, after deductible
Emergency Room	\$50 copay waived if admitted	\$35 copay, waived if admitted	10%, after deductible	20%, after deductible	20%, after deductible	20%, after deductible
Durable Medical Equipment & Prosthetic Devices	\$0	\$0	20%, after deductible	20%, after deductible	20%, after deductible	20%, after deductible
Chiropractic/Acupuncture Services	\$15 copay Up to 20 visits/calendar year combined	\$15 copay, up to 20 visits/year combined	\$15 copay, up to 20 visits/combined with acupuncture	\$15 copay, up to 20 visits/combined with acupuncture	\$15 copay, up to 20 visits/combined with acupuncture	\$15 copay, up to 20 visits/combined with acupuncture

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.



**Davis Joint Unified School District -  
Non-Kaiser Sutter Health Plus Plan Options**

**CaIPERS**

Carrier	Non-Kaiser *	Sutter Health Plus Summit ML67	Sutter Health Plus Peak ML68	Sutter Health Plus Peak ML69	Sutter Health Plus Peak ML70	Sutter Health Plus Peak ML71
<b>Prescription Drug Benefits</b>						
Prescription Drug Annual Out-of-Pocket Limit/Individual **	<b>\$7,950</b> (in addition to medical OOP limit)	None	None	None	None	None
Prescription Drug Annual Out-of-Pocket Limit/Family **	<b>\$15,900</b> (Mail-order OOP: \$1,000/family in addition to Medical OOP limit)	None	None	None	None	None
<b>Retail</b>						
Generic	\$5 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Brand (Formulary/Preferred)	\$20 copay	\$20 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
Brand (Non-Formulary/Non-preferred)	\$50 copay	\$35 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay
Specialty	Same as Brand	20%, up to \$100 per prescription	10% up to \$100	20% up to \$100	20% up to \$100	10%
Number of Days Supply	30 days	30 days	30 days	30 days	30 days	30 days
<b>Mail Order</b>						
Generic	\$10 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Brand (Formulary/Preferred)	\$40 copay	\$40 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay
Brand (Non-Formulary/Non-preferred)	\$100 copay	\$70 copay	\$120 copay	\$120 copay	\$120 copay	\$120 copay
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days	90 days	90 days
<b>2024 RATES - 2025 RATES WILL BE REQUESTED LATE SPRING 2024</b>						
Employee Only		\$924.40	\$794.10	\$763.50	\$740.50	\$712.40
Two-Party		\$1,849.00	\$1,588.40	\$1,527.20	\$1,481.20	\$1,425.00
Family		\$2,404.40	\$2,065.60	\$1,986.10	\$1,926.30	\$1,853.20

\* Includes: Anthem Blue Cross Traditional, Anthem Blue Cross Select, Blue Shield Access+, Blue Shield Trio, United Healthcare

\*\* Anthem Blue Cross Select: \$7,600/\$15,200