



**Davis Joint Unified School District -
Western Health Advantage Plan Options**

CalPERS Recommended Plans in line w/Kaiser & Sutter

Carrier	2024 CalPERS Western Health Advantage	2024 RATES		
		Western Health Advantage Direct 0/15/0 Prime	Western Health Advantage Direct 1000/20/20% Prime	Western Health Advantage Direct 2500/40/500 Prime
General Plan Information				
Annual Deductible/Individual	\$0	\$0	\$1,000	\$2,500
Annual Deductible/Family	\$0	\$0	\$2,000	\$5,000
Office Visit/Specialist Visit/Urgent Care	\$15/\$15/\$15 copay	\$15/\$15/\$15 copay	\$20/\$20/\$20 copay	\$40/\$40/\$40 copay
Annual Out-of-Pocket Limit/Individual	\$1,500 (does not include Rx)	\$1,500 (includes Rx)	\$3,000 (includes Rx)	\$5,000
Annual Out-of-Pocket Limit/Family	\$3,000 (does not include Rx)	\$2,500 (includes Rx)	\$6,000 (includes Rx)	\$10,000
Services				
Preventive Services (Adult Exams/Well Child Care/Immunizations/Well Woman visits/Vision-Hearing Screening)	\$0	\$0	\$0	\$0
Diagnostic X-Ray/Lab Tests (Non-Preventive)	\$0	\$0	\$0	\$0
Outpatient Facility Charge	\$0	\$15 copay	\$250 copay after deductible	\$250 copay, after deductible
Inpatient Hospitalization	\$0	\$0	20%, after deductible	\$500 copay/day, after deductible
Emergency Room	\$50 copay waived if admitted	\$100 copay, waived if admitted	20%, after deductible	\$100 copay, after deductible
Durable Medical Equipment & Prosthetic Devices	\$0	20%	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

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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Prescription Drug Benefits				
Prescription Drug Annual Out-of-Pocket Limit/Individual **	\$7,950 (in addition to medical OOP limit)	None	None	None
Prescription Drug Annual Out-of-Pocket Limit/Family **	\$15,900 (Mail-order OOP: \$1,000/family in addition to Medical OOP limit)	None	None	None
Retail				
Generic	\$5 copay	\$10 copay	\$10 copay	\$10 copay
Brand (Formulary/Preferred)	\$20 copay	\$30 copay	\$30 copay	\$30 copay, after Rx deductible
Brand (Non-Formulary/Non-preferred)	\$50 copay	\$50 copay	\$50 copay	\$50 copay, after Rx deductible
Specialty	Same as Brand	20%, up to \$100 for self-injectables	20% up to \$100 for self-injectables	Subject to Retail copays; Not Covered through Mail Order
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
Generic	\$10 copay	\$25 copay	\$25 copay	\$25 copay
Brand (Formulary/Preferred)	\$40 copay	\$75 copay	\$75 copay	\$75 copay
Brand (Non-Formulary/Non-preferred)	\$100 copay	\$125 copay	\$125 copay	\$125 copay
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days
2024 RATES - 2025 RATES WILL BE REQUESTED LATE SPRING 2024				
Employee Only	\$807.23	\$867.68	\$632.92	\$582.82
Two-Party	\$1,614.46	\$1,735.36	\$1,265.84	\$1,165.64
Family	\$2,098.80	\$2,603.04	\$1,898.76	\$1,748.46

* 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