Davis Jt. USD - Marketing Plan Compare

HMO/DHMO/H.S.A.

	CalPERS				
Plan Name	**HMO**	**$15 CalPERS 'Look-Alike' Plan**	**High Plan Option**	**Mid Plan Option**	**Low Plan Option**
General Plan Information					
Annual Deductible/Individual	$0	$0	$0	$500/$1000/$1500/$2000	$3000/$4000
Annual Deductible/Family	$0	$0	$0	$1000/$2000/$3000/$4000	$6000/$8000
Coinsurance	100%	100%	100%	80%/90%	60%/70%
Office Visit/Exam	$15 copay	$15 copay	$20/$30/$40	deductible)	$40/$50 (no deductible)
Annual Out-of-Pocket Limit/Individual	$1,500 **(does not include Rx)**	$1,500 (includes Rx)	$1,500 (includes Rx)	$3,000 (includes Rx)	$6,000 (includes Rx)
Annual Out-of-Pocket Limit/Family	$3,000 **(does not include Rx)**	$3,000 (includes Rx)	$3,000 (includes Rx)	$6,000 (includes Rx)	$12,000 (includes Rx)
Outpatient Services					
Preventive Services (Adult Periodic Exams/Well-Child Care/Immunizations/Well Woman/Mammogram Exams/Hearing-Vision Screening)	100%	100%	100%	100%	100%
Diagnostic X-Ray/Lab Tests (Non-Preventive)	100% **(some procedures may require a copay)**	100%	$10/$20	$10/$20	$10/$20
Outpatient Facility Charge	$15 copay	$15 copay	$20/$30/$40	80%/90% after deductible	60%/70%, after deductible
Inpatient Hospital (Pre-Auth. Required)					
Inpatient Hospitalization	100%	100%	$100/$150/$250/$500	80%/90% after deductible	70%, after deductible
Emergency Services					
Emergency Room	$50 copay waived if admitted	$50 copay waived if admitted	$50/$75/$100/$150	80%/90% after deductible	70%, after deductible
Urgent Care Facility	$15 copay	$15 copay	$20/$30/$40	deductible)	$40/$50

Davis Jt. USD - Marketing Plan Compare

HMO/DHMO/H.S.A.

	CalPERS				
Plan Name	**HMO**	**$15 CalPERS 'Look-Alike' Plan**	**High Plan Option**	**Mid Plan Option**	**Low Plan Option**
Other Services and Supplies					
Durable Medical Equipment & Prosthetic Devices	100%	100%	100%/80%	100%/80%	100%/80%
Chiropractic Services	$15 copay (when medically necessary); Up to 20 visits/calendar year; combined w/Acupuncture	$15 copay Up to 20 visits/calendar year; combined w/Acupuncture	$15/$20 - 20 visits	$15/$20 - 20 visits	$15/$20 - 20 visits
Acupuncture	$15 copay (when medically necessary); Up to 20 visits/calendar year; combined w/Chiropractic	$15 copay Up to 20 visits/calendar year; combined w/Chiropractic	$15/$20 Visits	$15/$20 Visits	$15/$20 Visits
Prescription Drug Benefits					
Prescription Drug Annual Out-of-Pocket Limit/Individual	**$7,200 (in addition to Medical OOP limit)**	**None**	**None**	**None**	**None**
Prescription Drug Annual Out-of-Pocket Limit/Family	**$14,400 (in addition to Medical OOP limit)**	**None**	**None**	**None**	**None**
Retail					
Generic	$5 copay	$5 copay	$10/$15	$10/$15	$10/$15
Brand (Formulary/Preferred)	$20 copay	$20 copay	$20/$30	$20/$30	$20/$30
Brand (Non-Formulary/Non-preferred)	$20 copay	$20 copay	$30/$50/$60	$30/$50/$60	$30/$50/$60
Number of Days Supply	30 days	30 days	30 days	30 days	30 days
Mail Order					
Generic	$10 copay	$10 copay	$20/$30	$20/$30	$20/$30
Brand (Formulary/Preferred)	$40 copay	$40 copay	$40/$60	$40/$60	$40/$60
Brand (Non-Formulary/Non-preferred)	$40 copay	$40 copay	$60/$100/$120	$60/$100/$120	$60/$100/$120
Number of Days Supply for Mail Order	for certain drugs)	100 days	100 days	100 days	100 days

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PPO

CalPERS PPO/CalPERS Look-Alike Option

Plan Name	PERS Platinum		PERS Gold	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information				
Annual Deductible/Individual (Not transferable between plans)	$500	$500	$1,000	$1,000
Annual Deductible/Family (Not transferable between plans)	$1,000	$1,000	$2,000	$2,000
Coinsurance	90%	60%	80%	60%
Office Visit/Exam	$20/$35 (Specialist) copay	60%	$35 copay (non-PCP); $10 copay/PCP enrolled; (deductible does not apply)/$35 Specialist	60%
Annual Out-of-Pocket Limit/Individual	$5,900 (includes $2,000 co-insurance max; does not include Rx OOP)	No Limit	$3,000 (does not include Rx OOP)	No Limit
Annual Out-of-Pocket Limit/Family	$11,800 (includes $4,000 co-insurance max; does not include Rx OOP)	No Limit	$6,000 (does not include Rx OOP)	No Limit
Outpatient Services				
Preventive Services (Adult Periodic Exams/Well-Child Care/Immunizations/Well Woman/Mammogram Exams/Hearing-Vision Screening)	100%	60%	100%	60%
Diagnostic X-Ray/Lab Test (Non-Preventive)	90%	60%	80%	60%
Outpatient Facility Charge	90%	60% (benefit limited to $350/visit)	80% for Tier 1 facility; 70% for Tier 2 facility (services & supplies limited for certain procedures)	60% (benefit limited to $350/visit)
Inpatient Hospital Services				
Inpatient Hospitalization	$250/admission + 90%	$250/admission + 60%	80%	60%

Davis Jt. USD - Marketing Plan Compare

PPO

CalPERS PPO/CalPERS Look-Alike Option

Plan Name	PERS Platinum		PERS Gold	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Services				
Emergency Room	$50 copay/ER room; 90% all other services	$50 copay/ER room; 90% all other services	$50 copay waived if admitted; 80% for ER services rendered	$50 copay waived if admitted; 80% for ER services rendered
Urgent Care Facility	$35 copay/physician services; 90% for other services rendered	60%	$35 copay (deductible does not apply)	60%
Mental Health/Substance Abuse Benefits				
Inpatient Care	90% after $250 admit fee	60% after $250 admit fee	80% for Tier 1 facility; 70% for Tier 2 facility	60%
Other Services and Supplies				
Durable Medical Equipment & Prosthetic Devices	90% (pre-certification required for equipment $1,000+)	60% (pre-certification required for equipment $1,000+)	80% (pre-certification required on equipment)	60% (pre-certification required on equipment)
Chiropractic/Acupuncture (Up to 20 visits/year combined)	$15 copay	60%	$15 copay	60%
Infertility - Diagnosis & Treatment	Not covered	Not covered	Not covered	Not covered
Hearing - Screening	90%	60%	80%	60%
Hearing Aid(s)	90% (Up to $1,000 every 36 months)	60% (Up to $1,000 every 36 months)	80% (Up to $1,000 every 36 months)	60% (Up to $1,000 every 36 months)

Davis Jt. USD - Marketing Plan Compare

PPO

CalPERS PPO/CalPERS Look-Alike Option

Plan Name	PERS Platinum		PERS Gold	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Benefits				
Prescription Drug Deductible	N/A	N/A	N/A	N/A
Prescription Drug Annual Out-of-Pocket Limit/Individual	$2,000 ($1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit	$2,000 ($1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit
Prescription Drug Annual Out-of-Pocket Limit/Family	$4,000 ($1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit	$4,000 ($1,000 OOP/member required for Mail Order; in addition to Medical OOP limit)	No Limit
Retail				
Generic	$5 copay	Not covered	$5 copay	Not covered
Brand (Formulary/Preferred)	$20 copay		$20 copay	
Brand (Non-Formulary/Non-preferred)	$50 copay		$50 copay	
Number of Days Supply	34 days		30 days	
Mail Order				
Generic	$10 copay ($1,000 OOP max/member; included in Rx OOP; excludes non-preferred brands)	Not covered	$10 copay ($1,000 OOP/member; included in Rx OOP; excludes non-preferred brands)	Not covered
Brand	$40 copay ($1,000 OOP max/member; included in Rx OOP; excludes non-preferred brands)	Not covered	$40 copay ($1,000 OOP/member; included in Rx OOP; excludes non-preferred brands)	Not covered
Brand (Non-Formulary/Non-preferred)	$100 copay	Not covered	$100 copay	Not covered
Number of Days Supply	90 days		90 days	