Keenan®

Davis Joint Unified School District - PPO Plan Options

CalPERS PPO Options

Plan Name	PERS Platinum		PERS Gold		CCCSIG United HealthCare PPO 90/60 Plan		CCCSIG United Healthcare PPO 80/60 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information								
Annual Deductible/Individual (Not transferable between plans)	$500	$2,000	$1,000	$2,500	$400		$1,000	
Annual Deductible/Family (Not transferable between plans)	$1,000	$4,000	$2,000	$5,000	$800		$2,000	
Office Visit/Specialist/Exam	$20 copay/$35 copay; no deductible	40% after deductible	$10 copay $35 copay Specialist	40% after deductible	$20 copay	40% after deductible	$25 copay	40% after deductible
Annual Out-of-Pocket Limit/Individual	$2,000	No Limit	$3,000 does not include Rx	No Limit	$2,000	$4,000	$4,000	$7,000
Annual Out-of-Pocket Limit/Family	$4,000	No Limit	$6,000 does not include Rx	No Limit	$4,000	$8,000	$8,000	$14,000
Outpatient Services								
Preventive Services (Adult Exams/Well Child Care/Immunizations/Well Woman visits/Vision-Hearing Screening)	$0	$0	$0	$0	$0	$0	$0	$0
Diagnostic X-Ray/ Lab Test (Non-Preventive)	10% after deductible	40% after deductible	20% after deductible	40% after deductible	$0	40% after deductible	No charge	40% after deductible
Outpatient Facility Charge - Services and supplies for certain outpatient surgeries may be limited if not done at an ambulatory surgery center. For example: Colonoscopy limited to $1,500 per procedure, Cataract surgery limited to $2,000 per procedure.	10% after deductible	40% after deductible (benefit limited to $350/visit)	20% after deductible	40% after deductible (benefit limited to $350/visit)	10% after deductible	40% (benefit limited to $760/visit)	20% after deductible	40% (benefit limited to $760/visit)
Inpatient Hospital Services								
Inpatient Hospitalization - Hip and Knee joint replacement surgery will be limited to $35,000 per procedure.	$250/admission + 10% after deductible	$250/admission + 40% after deductible	20% after deductible	40% after deductible	10% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Services								
Emergency Room	$50 copay/ER room; 10% after deductible all other services	$50 copay/ER room; 10% after deductible all other services	$50 copay waived if admitted; 20% after deductible for ER services rendered	$50 copay waived if admitted; 20% after deductible for ER services rendered	No charge, after $250 copay (waived, if admitted)		No charge, after $250 copay (waived, if admitted)	
Urgent Care Facility	$35 copay/physician services; 10% for other services rendered	40% after deductible	$35 copay no deductible; 20% after deductible for all other services	40% after deductible	$50 copay	40% after deductible	$25 copay	40% after deductible
Durable Medical Equipment & Prosthetic Devices	10% after deductible (pre-certification required for equipment $1,000+)	40% after deductible (pre-certification required for equipment $1,000+)	20% after deductible (pre-certification required on equipment)	40% after deductible (pre-certification required on equipment)	10% after deductible	Not covered	20% after deductible	Not covered
Chiropractic/Acupuncture	$15 copay Up to 20 visits/calendar year; combined w/Acupuncture	40% after deductible	$15 copay Up to 20 visits/calendar year; combined w/Acupuncture	40% after deductible	Acupuncture: $20 copay, up to 12 visits Chiropractic (manipulative): $20 up to 24 visits	Acupuncture: $20 copay, up to 12 visits Chiropractic (manipulative): $20 up to 24 visits	Acupuncture: $25 copay, up to 12 visits Chiropractic (manipulative): $25 up to 24 visits	Acupuncture: $25 copay, up to 12 visits Chiropractic (manipulative): $25 up to 24 visits

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Benefits								
Prescription Drug Deductible	N/A	N/A	N/A	N/A	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)	No Limit	$2,000 ($1,000 OOP/member required for Mail Order)	No Limit	None	None	None	None
Prescription Drug Annual Out-of-Pocket Limit/Family	$4,000 ($1,000 OOP/member required for Mail Order)	No Limit	$4,000 ($1,000 OOP/member required for Mail Order)	No Limit	None	None	None	None
Retail (Managed by OptumRX)								
Generic	$5 copay	Not covered	$5 copay	Not covered	$7 copay	$7 copay	$10 copay	$10 copay
Brand (Formulary/Preferred)	$20 copay	Not covered	$20 copay	Not covered	$20 copay	$20 copay	$30 copay	$30 copay
Brand (Non-Formulary/Non-preferred)	$50 copay	Not covered	$50 copay	Not covered	$35 copay	$35 copay	$60 copay	$60 copay
Number of Days Supply	30 days	N/A	30 days	N/A	31 days	31 days	31 days	31 days
Mail Order								
Generic	$10 copay	Not covered	$10 copay	Not covered	$0 copay	$0 copay	$20 copay	$20 copay
Brand (Formulary/Preferred)	$40 copay	Not covered	$40 copay	Not covered	$40 copay	$40 copay	$60 copay	$60 copay
Brand (Non-Formulary/Non-preferred)	$100 copay	Not covered	$100 copay	Not covered	$70 copay	$70 copay	$120 copay	$120 copay
Number of Days Supply	90 days	N/A	90 days	N/A	31 days	31 days	31 days	31 days
2024 RATES - 2025 RATES WILL BE REQUESTED LATE SPRING 2024								
Employee Only	$1,314.27		$914.82		$1,549.20		$1,437.72	
Two-Party	$2,628.54		$1,829.64		$1,828.64		$1,697.05	
Family	$3,417.10		$2,378.53		$3,657.28		$3,394.10	

Note:
1. PPO Plans are through CCCSIG (Contra Costa County Schools Insurance Group) JPA.
2. CCCSIG requires a 3 year commitment.
3. Subject to any plan changes JPA passes action on.

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Davis Joint Unified School District - PPO Plan Options

CalPERS PPO Options

Plan Name	PERS Platinum		PERS Gold		CCCSIG United Healthcare PPO Plan 70/50		CCCSIG United Healthcare H.S.A. Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information								
Annual Deductible/Individual (Not transferable between plans)	$500	$2,000	$1,000	$2,500	$1,000	$2,000	$5,000	
Annual Deductible/Family (Not transferable between plans)	$1,000	$4,000	$2,000	$5,000	$2,000	$4,000	$10,000	
Office Visit/Specialist/Exam	$20 copay/$35 copay; no deductible	40% after deductible	$10 copay $35 copay Specialist	40% after deductible	$25 copay	50% after deductible	$20 copay	40% after deductible
Annual Out-of-Pocket Limit/Individual	$2,000	No Limit	$3,000 does not include Rx	No Limit	$4,000	$10,000	$6,500	$6,500
Annual Out-of-Pocket Limit/Family	$4,000	No Limit	$6,000 does not include Rx	No Limit	$8,000	$20,000	$13,000	$13,000
Outpatient Services								
Preventive Services (Adult Exams/Well Child Care/Immunizations/Well Woman visits/Vision-Hearing Screening)	$0	$0	$0	$0	$0	$0	$0	$0
Diagnostic X-Ray/ Lab Test (Non-Preventive)	10% after deductible	40% after deductible	20% after deductible	40% after deductible	No charge	50% after deductible	No charge	40% after deductible
Outpatient Facility Charge - Services and supplies for certain outpatient surgeries may be limited if not done at an ambulatory surgery center. For example: Colonoscopy limited to $1,500 per procedure, Cataract surgery limited to $2,000 per procedure.	10% after deductible	40% after deductible (benefit limited to $350/visit)	20% after deductible	40% after deductible (benefit limited to $350/visit)	30% after deductible	50% after deductible	20% after deductible	40% (benefit limited to $760/visit)
Inpatient Hospital Services								
Inpatient Hospitalization - Hip and Knee joint replacement surgery will be limited to $35,000 per procedure.	$250/admission + 10% after deductible	$250/admission + 40% after deductible	20% after deductible	40% after deductible	30% after deductible	50% after deductible	20% after deductible	40% after deductible
Emergency Services								
Emergency Room	$50 copay/ER room; 10% after deductible all other services	$50 copay/ER room; 10% after deductible all other services	$50 copay waived if admitted; 20% after deductible for ER services rendered	$50 copay waived if admitted; 20% after deductible for ER services rendered	No charge, after $250 copay (waived, if admitted)		20% after deductible	20% after deductible
Urgent Care Facility	$35 copay/physician services; 10% for other services rendered	40% after deductible	$35 copay no deductible; 20% after deductible for all other services	40% after deductible	$125 copay	50% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment & Prosthetic Devices	10% after deductible (pre-certification required for equipment $1,000+)	40% after deductible (pre-certification required for equipment $1,000+)	20% after deductible (pre-certification required on equipment)	40% after deductible (pre-certification required on equipment)	30% after deductible	Not covered	20% after deductible	Not covered
Chiropractic/Acupuncture	$15 copay Up to 20 visits/calendar year; combined w/Acupuncture	40% after deductible	$15 copay Up to 20 visits/calendar year; combined w/Acupuncture	40% after deductible	Acupuncture: $25 copay, up to 12 visits Chiropractic (manipulative): $25 up to 24 visits	Acupuncture: $25 copay, up to 12 visits Chiropractic (manipulative): $25 up to 24 visits	Acupuncture: $20 copay after deductible, up to 12 visits Chiropractic (manipulative): $20 after deductible, up to 24 visits	Acupuncture: $20 copay after deductible, up to 12 visits Chiropractic (manipulative): $20 after deductible, up to 24 visits

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Plan Name	PERS Platinum		PERS Gold		CCCSIG United Healthcare PPO Plan 70/50		CCCSIG United Healthcare H.S.A. Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Benefits								
Prescription Drug Deductible	N/A	N/A	N/A	N/A	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)	No Limit	$2,000 ($1,000 OOP/member required for Mail Order)	No Limit	None	None	None	None
Prescription Drug Annual Out-of-Pocket Limit/Family	$4,000 ($1,000 OOP/member required for Mail Order)	No Limit	$4,000 ($1,000 OOP/member required for Mail Order)	No Limit	None	None	None	None
Retail (Managed by OptumRX)								
Generic	$5 copay	Not covered	$5 copay	Not covered	$7 copay	$7 copay	$7 copay	$7 copay
Brand (Formulary/Preferred)	$20 copay	Not covered	$20 copay	Not covered	$20 copay	$20 copay	$25 copay	$25 copay
Brand (Non-Formulary/Non-preferred)	$50 copay	Not covered	$50 copay	Not covered	$35 copay	$35 copay	$45 copay	$45 copay
Number of Days Supply	30 days	N/A	30 days	N/A	31 days	31 days	31 days	31 days
Mail Order								
Generic	$10 copay	Not covered	$10 copay	Not covered	$0 copay	$0 copay	$14 copay	$14 copay
Brand (Formulary/Preferred)	$40 copay	Not covered	$40 copay	Not covered	$40 copay	$40 copay	$50 copay	$50 copay
Brand (Non-Formulary/Non-preferred)	$100 copay	Not covered	$100 copay	Not covered	$70 copay	$70 copay	$90 copay	$90 copay
Number of Days Supply	90 days	N/A	90 days	N/A	31 days	31 days	31 days	31 days
2024 RATES - 2025 RATES WILL BE REQUESTED LATE SPRING 2024								
Employee Only	$1,314.27		$914.82		$1,390.10		$997.34	
Two-Party	$2,628.54		$1,829.64		$1,640.84		$1,177.24	
Family	$3,417.10		$2,378.53		$3,281.68		$2,354.47	

Note:
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