Keenan®

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**	**2024 RATES Western Health Advantage Direct 1000/20/20% Prime**	**2024 RATES 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/Acupunture 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

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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