



**Davis Joint Unified School District
Sutter Health Plus Plan Options**

CaIPERS

Carrier	2024 CaIPERS UHC SignatureValue Alliance HMO	Sutter Health Plus Summit ML67	Sutter Health Plus Summit ML62	Sutter Health Plus Summit ML66	Sutter Health Plus Peak ML68	Sutter Health Plus Ridge ML75	Sutter Health Plus Peak ML69	Sutter Health Plus Peak ML70
General Plan Information								
Annual Deductible/Individual	\$0	\$0	\$0	\$0	\$500	\$1,000	\$1,000	\$1,500
Annual Deductible/Family	\$0	\$0	\$0	\$0	\$1,000	\$2,000	\$2,000	\$3,000
Office Visit/Specialist Visit/Urgent Care/Televisit	\$15/\$15/\$15 copay	\$15/\$15/\$15 copay	\$25/\$25/\$25 copay	\$40/\$40/\$40/\$20 copay	\$20/\$20/\$20 copay	\$40/\$40/\$40/\$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)	\$2,500 (includes Rx)	\$3,000 (includes Rx)	\$3,000 (includes Rx)	\$3,000 (includes Rx)	\$3,000 (includes Rx)	\$4,000 (includes Rx)
Annual Out-of-Pocket Limit/Family	\$3,000 (does not include Rx)	\$3,000 (includes Rx)	\$5,000 (includes Rx)	\$6,000 (includes Rx)	\$6,000 (includes Rx)	\$6,000 (includes Rx)	\$6,000 (includes Rx)	\$8,000 (includes Rx)
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 Tests (Non-Preventive)	\$0	\$0	Lab \$25 copay, X-ray \$15 copay	Lab \$10 copay, X-ray \$10 copay	Lab \$20 copay, X-ray \$10 copay	Lab \$40 copay, X-ray \$0 copay	Lab \$20 copay, X-ray \$10 copay	Lab \$20 copay, X-ray \$10 copay
Outpatient Facility Charge	\$0	\$15 copay	\$10 copay per visit	\$100 copay per visit	10%, after deductible	\$250 per visit after deductible	20%, after deductible	20%, after deductible
Inpatient Hospitalization	\$0	\$0	\$500 copay per admission	\$500 copay per admission	10%, after deductible	\$500 copay per admission after deductible	20%, after deductible	20%, after deductible
Emergency Room	\$50 copay waived if admitted	\$35 copay, waived if admitted	\$150 copay; waived if admitted	\$150 copay; waived if admitted	10%, after deductible	\$100 copay after deductible; waived if admitted	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	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	\$15 copay, up to 20 visits/combined with acupuncture	\$15 copay, up to 20 visits/combined with acupuncture
Prescription Drug Benefits								
Prescription Drug Annual Out-of-Pocket Limit/Individual	\$7,950 (in addition to medical OOP limit)	None	None	None	None	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	None	None	None	None
Retail								
Generic	\$5 copay	\$10 copay	\$10 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	\$30 copay	\$30 copay
Brand (Non-Formulary/Non-preferred)	\$50 copay	\$35 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay
Specialty	Same as Brand	20%, up to \$100 per prescription	20% up to \$100	20% up to \$100	10% up to \$100	30% up to \$100	20% up to \$100	20% up to \$100
Number of Days Supply	30 days	30 days	30 days	30 days	30 days	30 days	30 days	30 days
Mail Order								
Generic	\$10 copay	\$20 copay	\$20 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	\$60 copay	\$60 copay
Brand (Non-Formulary/Non-preferred)	\$100 copay	\$70 copay	\$120 copay	\$120 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	90 days	90 days
2024 RATES - 2025 RATES WILL BE REQUESTED LATE SPRING 2024								
Employee Only	\$1,091.13	\$924.40	\$858.20	\$824.10	\$794.10	\$744.10	\$763.50	\$740.50
Two-Party	\$2,182.26	\$1,849.00	\$1,716.40	\$1,648.20	\$1,588.40	\$1,488.20	\$1,527.20	\$1,481.20
Family	\$2,836.94	\$2,404.40	\$2,231.30	\$2,142.70	\$2,065.60	\$1,934.70	\$1,986.10	\$1,926.30

* CaIPERS Rates are UHC Alliance for comparison



**Davis Joint Unified School District
Sutter Health Plus Plan Options**

CaIPERS

Carrier	2024 CaIPERS UHC SignatureValue Alliance HMO	Sutter Health Plus Peak ML71	Sutter Health Plus Vista 26 HDHP	Sutter Health Plus Vista 24 HDHP
General Plan Information				
Annual Deductible/Individual	\$0	\$2,500	\$1,500/\$3,000	\$2,500/\$3,000
Annual Deductible/Family	\$0	\$5,000	\$3,000	\$5,000
Office Visit/Specialist Visit/Urgent Care/Televisit	\$15/\$15/\$15 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)	\$5,000 (includes Rx)	\$3,000 (includes Rx)	\$5,000 (includes Rx)
Annual Out-of-Pocket Limit/Family	\$3,000 (does not include Rx)	\$10,000 (includes Rx)	\$6,000 (includes Rx)	\$10,000 (includes Rx)
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	Lab \$20 copay, X-ray \$10 copay	No charge after deductible	No charge after deductible
Outpatient Facility Charge	\$0	20%, after deductible	No charge after deductible	No charge after deductible
Inpatient Hospitalization	\$0	20%, after deductible	\$50 copay per admission after deductible	\$50 copay per admission after deductible
Emergency Room	\$50 copay waived if admitted	20%, after deductible	No charge after deductible	No charge after deductible
Durable Medical Equipment & Prosthetic Devices	\$0	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/combined with acupuncture	Not covered	Not Covered
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	No charge after deductible	No charge after deductible
Brand (Formulary/Preferred)	\$20 copay	\$30 copay	No charge after deductible	No charge after deductible
Brand (Non-Formulary/Non-preferred)	\$50 copay	\$60 copay	No charge after deductible	\$60 copay after deductible
Specialty	Same as Brand	10%	No charge after deductible	No charge after deductible
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
Generic	\$10 copay	\$20 copay	No charge after deductible	No charge after deductible
Brand (Formulary/Preferred)	\$40 copay	\$60 copay	No charge after deductible	No charge after deductible
Brand (Non-Formulary/Non-preferred)	\$100 copay	\$120 copay	No charge after deductible	\$120 copay after deductible
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	\$1,091.13	\$712.40	\$733.00	\$710.80
Two-Party	\$2,182.26	\$1,425.00	\$1,546.00	\$1,421.60
Family	\$2,836.94	\$1,853.20	\$2,009.80	\$1,848.10

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