



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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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
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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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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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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2. CCCSIG requires a 3 year commitment.
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