



**Davis Joint Unified School District
Western Health Advantage Plan Options**

CalPERS

Carrier	2024 CalPERS UHC SignatureValue Alliance HMO	2024 RATES Western Health Advantage Direct Premier 0/15/0	2024 RATES Western Health Advantage Direct Premier 0/20/0	2024 RATES Western Health Advantage Direct Premier 0/40/0	2024 RATES Western Health Advantage Direct Western 1000/20/20%	2024 RATES Western Health Advantage Direct 2500/40/500 Prime	2024 RATES Western Health Advantage Direct Western 1800/0/0 HDHP	2024 RATES Western Health Advantage Direct 2800/0/0 HDHP
General Plan Information								
Annual Deductible/Individual	\$0	\$0	\$0	\$0	\$1,000	\$2,500	\$1,800/\$3,000	\$2,800/\$3,000
Annual Deductible/Family	\$0	\$0	\$0	\$0	\$2,000	\$5,000	\$3,600	\$5,600
Office Visit/Specialist Visit/Virtual Office Visit/Urgent Care Virtual/Urgent Care	\$15/\$15/\$15 copay	\$15/\$15/\$15 copay	\$20/\$20/\$20/\$25/\$35 copay	\$40/\$40/\$40/\$45/\$50 copay	\$20/\$20/\$20 copay	\$40/\$40/\$40 copay	No charge after deductible	No charge after deductible
Annual Out-of-Pocket Limit/Individual	\$1,500 (does not include Rx)	\$1,500 (includes Rx)	\$1,500 (includes Rx)	\$1,500 (includes Rx)	\$3,000 (includes Rx)	\$5,000	\$3,600/\$3,600 (includes Rx)	\$2,800/\$3,000
Annual Out-of-Pocket Limit/Family	\$3,000 (does not include Rx)	\$2,500 (includes Rx)	\$2,500 (includes Rx)	\$2,500 (includes Rx)	\$6,000 (includes Rx)	\$10,000	\$7,200 (includes Rx)	\$5,600
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	\$0	\$0	\$0	\$0	No charge after deductible	No charge after deductible
Outpatient Facility Charge	\$0	\$15 copay	\$100 copay	\$100 copay	\$250 copay after deductible	\$250 copay, after deductible	No charge after deductible	No charge after deductible
Inpatient Hospitalization	\$0	\$0	\$0	\$0	20%, after deductible	\$500 copay/day, after deductible	No charge after deductible	No charge after deductible
Emergency Room	\$50 copay waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted	20%, after deductible	\$100 copay, after deductible	No charge after deductible	No charge after deductible
Durable Medical Equipment & Prosthetic Devices	\$0	20%	20% coinsurance	20%	20%, after deductible	20%, after deductible	No charge after deductible	No charge 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/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	Not covered	Not covered



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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	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	No charge after deductible	No charge after deductible
Brand (Formulary/Preferred)	\$20 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay, after Rx deductible	\$30 copay after deductible	No charge after deductible
Brand (Non-Formulary/Non-preferred)	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay, after Rx deductible	\$50 copay after deductible	No charge after deductible
Specialty	Same as Brand	20%, up to \$100 for self-injectables	20%, up to \$100 for self-injectables	20%, up to \$100 for self-injectables	20% up to \$100 for self-injectables	Subject to Retail copays; Not Covered through Mail Order	20% up to \$100 for self-injectables	No charge after deductible
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	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	No charge after deductible	No charge after deductible
Brand (Formulary/Preferred)	\$40 copay	\$75 copay	\$75 copay	\$75 copay	\$75 copay	\$75 copay	\$60 copay after deductible	No charge after deductible
Brand (Non-Formulary/Non-preferred)	\$100 copay	\$125 copay	\$125 copay	\$125 copay	\$125 copay	\$125 copay	\$100 copay after deductible	No charge after deductible
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	\$867.68	\$848.27	\$817.25	\$632.92	\$582.82	\$613.70	\$562.31
Two-Party	\$2,182.26	\$1,735.36	\$1,696.54	\$1,634.50	\$1,265.84	\$1,165.64	\$1,227.40	\$1,124.62
Family	\$2,836.94	\$2,603.04	\$2,544.81	\$2,451.75	\$1,898.76	\$1,748.46	\$1,841.10	\$1,686.93