

**Travis Unified School District
Kaiser Permanente Plan Benefit Comparisons**

Effective: July 1, 2025

Carrier Name	Kaiser	Kaiser	Kaiser	Kaiser	Kaiser	Kaiser
	HMO - \$10 Copay		Deductible HMO			
Plan Name	Closed to New Enrollment	HMO - \$30 Copay	Not HSA Compatible	HSA - \$1,800	HSA - \$3,300	Not HSA Compatible
			\$10 copay			Bronze - \$4,500
General Plan Information						
Annual Deductible/Individual	\$0	\$0	\$500	\$1,800	\$3,300	\$4,500
Annual Deductible/Two-Party/Family	\$0	\$0	\$500/\$1,000	\$3,300/\$3,600	\$3,300/\$6,600	\$9,000
Office Visit/Exam/Outpatient Specialist Visit	\$10 copay	\$30 copay	\$10 copay no deductible	\$0 copay after deductible	\$0 copay after deductible	\$50 copay after deductible
Annual Out-of-Pocket Limit/Individual	\$1,500	\$1,500	\$3,000	\$3,600	\$3,300	\$6,000
Annual Out-of-Pocket Limit/Two-Party/Family	\$1,500/\$3,000	\$1,500/\$3,000	\$3,000/\$6,000	\$3,700/\$7,400	\$3,300/\$6,600	\$6,000/\$12,000
Outpatient Services						
Well-Child Care	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Immunizations	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Well Woman Exams	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Mammograms	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Adult Periodic Exams with Preventive Tests	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Diagnostic X-Ray and Lab Tests	\$0 copay	\$0 copay	\$10 copay after deductible	\$0 copay after deductible	\$0 copay after deductible	40% coinsurance after deductible
Pregnancy and Maternity Care (Pre-Natal Care)	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Inpatient/Outpatient Hospital Services						
Inpatient Hospitalization	\$100 per admission	\$100 per admission	10% after deductible	\$0 copay after deductible	\$0 copay after deductible	40% coinsurance after deductible
Outpatient Facility Charge	\$10 copay	\$30 copay	10% after deductible	\$0 copay after deductible	\$0 copay after deductible	40% coinsurance after deductible
Emergency Services/Urgent Care						
Emergency Room	\$100 copay waived if admitted	\$100 copay waived if admitted	10% after deductible	\$0 copay after deductible	\$0 copay after deductible	\$250 copay after deductible (40% coinsurance if admitted)
Urgent Care Facility	\$10 copay	\$30 copay	\$10 copay no deductible	\$0 copay after deductible	\$0 copay after deductible	\$50 copay after deductible
Prescription Drug Benefits						
Retail Prescriptions						
Generic	\$10 copay	\$10 copay	\$10 copay no deductible	\$10 copay after deductible	\$0 copay after deductible	Deductible: \$250 \$15 copay no deductible
Brand (Formulary/Preferred)	\$30 copay	\$30 copay	\$30 copay no deductible	\$30 copay after deductible	\$0 copay after deductible	\$35 copay after drug deductible
Brand (Non-Formulary/Non-preferred)	\$30 copay	\$30 copay	\$30 copay no deductible	Same as Preferred Brand when approved through exception process	Same as Preferred Brand when approved through exception process	\$35 copay after drug deductible
Number of Days Supply	100 days	100 days	30 days	30 days	100 days	30 days
Mail Order Prescriptions						
Generic	\$10 copay	\$10 copay	\$20 copay no deductible	\$20 copay after deductible	\$0 copay after deductible	\$30 copay no drug deductible
Brand (Formulary/Preferred)	\$30 copay	\$30 copay	\$60 copay no deductible	\$60 copay after deductible	\$0 copay after deductible	\$70 copay after drug deductible
Brand (Non-Formulary/Non-preferred)	\$30 copay	\$30 copay	\$60 copay no deductible	Same as Preferred Brand when approved through exception process	\$0 copay after deductible	\$70 copay after drug deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days	100 days	100 days	100 days
	20% coinsurance, not to exceed \$150/Rx (Up to 30 day supply)	20% coinsurance, not to exceed \$150/Rx (Up to 30 days supply)	20% not to exceed \$150/Rx (Up to 30 days supply)	\$50 copay after deductible; (Up to 30 days supply)	\$0 copay after deductible; (Up to 30 days supply)	30% coinsurance, not to exceed \$150/Rx up to 30 day supply after drug deductible
Specialty Prescriptions						
Employee Premium - Less \$640 Employer Contribution						
SINGLE						
12 Months	\$796.97	\$674.42	\$407.43	\$202.29	\$179.37	\$50.89
11 Months	\$869.42	\$735.73	\$444.47	\$220.68	\$195.68	\$55.52
10 Months	\$956.36	\$809.30	\$488.92	\$242.75	\$215.24	\$61.07
TWO-PARTY						
12 Months	\$2,233.94	\$1,988.83	\$1,454.87	\$1,044.58	\$998.74	\$741.78
11 Months	\$2,437.03	\$2,169.63	\$1,587.13	\$1,139.54	\$1,089.53	\$809.21
10 Months	\$2,680.73	\$2,386.60	\$1,745.84	\$1,253.50	\$1,198.49	\$890.14
FAMILY						
12 Months	\$3,426.63	\$3,079.80	\$2,324.24	\$1,743.68	\$1,678.81	\$1,315.21
11 Months	\$3,738.14	\$3,359.78	\$2,535.53	\$1,902.20	\$1,831.43	\$1,434.77
10 Months	\$4,111.96	\$3,695.76	\$2,789.09	\$2,092.42	\$2,014.57	\$1,578.25

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