Travis Unified School District
Kaiser Permanente Plan Benefit Comparisons
Effective: January 1, 2026

Carrier Name	Kaiser	Kaiser	Kaiser	Kaiser	Kaiser	Kaiser
Plan Name	HMO - $10 Copay Closed to New Enrollment	HMO - $30 Copay	Deductible HMO Not HSA Compatible $10 copay	HSA - $1,800	HSA - $3,400	Not HSA Compatible Bronze - $4,500
General Plan Information						
Annual Deductible/Individual	$0	$0	$500	$1,800	$3,400	$4,500
Annual Deductible/Two-Party/Family	$0	$0	$500/$1,000	$3,400/$3,600	$3,400/$6,800	$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	$3,700	$3,400	$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	$3,400/$6,800	$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						Deductible: $250
Generic	$10 copay	$10 copay	$10 copay no deductible	$10 copay after deductible	$0 copay after deductible	$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
Specialty Prescriptions	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)
Employee Premium - Less $640 Employer Contribution						
SINGLE						
12 Months	$783.81	$662.38	$397.84	$194.58	$171.87	$44.56
11 Months	$855.07	$722.60	$434.01	$212.27	$187.49	$48.61
10 Months	$940.57	$794.86	$477.41	$233.50	$206.24	$53.47
TWO-PARTY						
12 Months	$2,207.62	$1,964.76	$1,435.68	$1,029.16	$983.74	$729.12
11 Months	$2,408.31	$2,143.37	$1,566.20	$1,122.72	$1,073.17	$795.40
10 Months	$2,649.14	$2,357.71	$1,722.82	$1,234.99	$1,180.49	$874.94
FAMILY						
12 Months	$3,389.38	$3,045.74	$2,297.09	$1,721.86	$1,657.59	$1,297.30
11 Months	$3,697.51	$3,322.63	$2,505.92	$1,878.39	$1,808.28	$1,415.24
10 Months	$4,067.26	$3,654.89	$2,756.51	$2,066.23	$1,989.11	$1,556.76