Travis Unified School District
Sutter Health Plus Plan Benefit Comparisons

Effective: January 1, 2026

Carrier Name Plan Name	Sutter Health Plus LG18 HMO - $20 Copay Closed to New Enrollment	Sutter Health Plus Peak LG23 HMO - $20 Copay	Sutter Health Plus Vista HL13 HSA $2,500
General Plan Information			
Annual Deductible/Individual	$0	$500	$2,500
Annual Deductible/Two-Party/Family	$0	$500/$1,000	$3,400/$5,000
Office Visit/Exam/ Outpatient Specialist Visit	$20/$40 copay	$20/$40 copay no deductible	20% after deductible
Telehelath Visits - PCP, Specialist, MH/SUD	$10/$20 copay	$10/$20 copay no deductible	$10 copay no deductible
Annual Out-of-Pocket Limit/Individual	$1,500	$3,000	$4,000
Annual Out-of-Pocket Limit/Two-Party/Family	$1,500/$3,000	$3,000/$6,000	$4,000/$8,000
Outpatient Services			
Well-Child Care	$0 copay	$0 copay no deductible	$0 copay no deductible
Immunizations	$0 copay	$0 copay no deductible	$0 copay no deductible
Well Woman Exams/ Mammograms	$0 copay	$0 copay no deductible	$0 copay no deductible
Adult Periodic Exams with Preventive Tests	$0 copay	$0 copay no deductible	$0 copay no deductible
Diagnostic X-Ray and Lab Tests	$10 copay	$10 copay no deductible	20% after deductible
Pregnancy and Maternity Care (Pre-Natal Care)	$0 copay	$0 copay no deductible	$0 copay no deductible
Inpatient/Outpatient Hospital Services			
Inpatient Hospitalization	$250 copay per day, up to 5 days	10% after deductible	20% after deductible
Outpatient Facility Charge	$50 copay	10% after deductible	20% after deductible
Emergency Services/Urgent Care			
Emergency Room	$200 copay waived if admitted	10% after deductible, waived if admitted	20% after deductible
Urgent Care Facility	$40 copay	$40 copay no deductible	20% after deductible
Prescription Drug Benefits			
Retail Prescriptions			
Generic	$10 copay no deductible	$10 copay no deductible	$10 copay after deductible
Brand (Formulary/Preferred)	$30 copay no deductible	$30 copay no deductible	$30 copay after deductible
Brand (Non-Formulary/Non-preferred)	$75 copay no deductible	$75 copay no deductible	$75 copay after deductible
Number of Days Supply	30 days	30 days	30 days
Mail Order Prescriptions			
Generic	$20 copay no deductible	$20 copay no deductible	$20 copay after deductible
Brand (Formulary/Preferred)	$60 copay no deductible	$60 copay no deductible	$60 copay after deductible
Brand (Non-Formulary/Non-preferred)	$150 copay no deductible	$150 copay no deductible	$150 copay after deductible
Number of Days Supply for Mail Order	up to 100 days	up to 100 days	100 days
Specialty Prescriptions	10% not to exceed $250/Rx no deductible (30 day supply)	10% not to exceed $250/Rx no deductible (30 day supply)	20% after deductible not to exceed $250/RX (30 day supply)
Employee Premium - Less $640 Employer Contribution			
SINGLE			
12 Months	$772.50	$557.00	$406.00
11 Months	$842.73	$607.64	$442.91
10 Months	$927.00	$668.40	$487.20
TWO-PARTY			
12 Months	$2,241.70	$1,801.90	$1,493.90
11 Months	$2,445.49	$1,965.71	$1,629.71
10 Months	$2,690.04	$2,162.28	$1,792.68
FAMILY			
12 Months	$2,467.40	$1,993.40	$1,661.20
11 Months	$2,691.71	$2,174.62	$1,812.22
10 Months	$2,960.88	$2,392.08	$1,993.44

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