Travis Unified School District
Kaiser Permanente Plan Benefit Comparisons
Effective: January 1, 2027

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 SUBJECT TO FINAL IRS LIMITS	HSA - $3,300 SUBJECT TO FINAL IRS LIMITS	Not HSA Compatible 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	$3,400/$3,600	$3,400/$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

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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 $668 Employer Contribution						
SINGLE						
12 Months	$983.01	$842.20	$535.45	$299.76	$273.42	$125.79
11 Months	$1,072.37	$918.76	$584.13	$327.01	$298.28	$137.23
10 Months	$1,179.61	$1,010.64	$642.54	$359.71	$328.10	$150.95
TWO-PARTY						
12 Months	$2,634.02	$2,352.40	$1,738.90	$1,267.50	$1,214.84	$919.58
11 Months	$2,873.48	$2,566.25	$1,896.98	$1,382.73	$1,325.28	$1,003.18
10 Months	$3,160.82	$2,822.88	$2,086.68	$1,521.00	$1,457.81	$1,103.50
FAMILY						
12 Months	$4,004.36	$3,605.87	$2,737.76	$2,070.73	$1,996.22	$1,578.43
11 Months	$4,368.39	$3,933.68	$2,986.65	$2,258.98	$2,177.69	$1,721.92
10 Months	$4,805.23	$4,327.04	$3,285.31	$2,484.88	$2,395.46	$1,894.12

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