Travis Unified School District
Sutter Health Plus Plan Benefit Comparisons
Effective: January 1, 2027

Carrier Name	Sutter Health Plus	Sutter Health Plus	Sutter Health Plus	Sutter Health Plus
Plan Name	LG18 HMO - $20 Copay Closed to New Enrollment	Peak LG23 HMO - $20 Copay	Peak LG26 HMO - $20 Copay	Vista HL18 HSA $2,500 SUBJECT TO FINAL IRS LIMITS
General Plan Information				
Annual Deductible/Individual	$0	$500	$2,500	$2,500
Annual Deductible/Two-Party/Family	$0	$500/$1,000	$2,500/$5,000	$3,500/$5,000
Office Visit/Exam/ Outpatient Specialist Visit	$20/$40 copay	$20/$40 copay no deductible	$20/$40 copay no deductible	20% after deductible
Telehelath Visits - PCP, Specialist, MH/SUD	$10/$20 copay	$10/$20 copay no deductible	$10/$20 copay no deductible	$10 copay no deductible
Annual Out-of-Pocket Limit/Individual	$1,500	$3,000	$5,000	$4,000
Annual Out-of-Pocket Limit/Two-Party/Family	$1,500/$3,000	$3,000/$6,000	$5,000/$10,000	$4,000/$8,000
Outpatient Services				
Well-Child Care	$0 copay	$0 copay no deductible	$0 copay no deductible	$0 copay no deductible
Immunizations	$0 copay	$0 copay no deductible	$0 copay no deductible	$0 copay no deductible
Well Woman Exams/ Mammograms	$0 copay	$0 copay no deductible	$0 copay no deductible	$0 copay no deductible
Adult Periodic Exams with Preventive Tests	$0 copay	$0 copay no deductible	$0 copay no deductible	$0 copay no deductible
Diagnostic X-Ray and Lab Tests	$10 copay	$10 copay no deductible	$10 copay no deductible	20% after deductible
Pregnancy and Maternity Care (Pre-Natal Care)	$0 copay	$0 copay no deductible	$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	20% after deductible
Outpatient Facility Charge	$50 copay	10% after deductible	20% 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, waived if admitted	20% after deductible
Urgent Care Facility	$40 copay	$40 copay no deductible	$40 copay no deductible	20% after deductible
Prescription Drug Benefits				
Retail Prescriptions				
Generic	$10 copay no deductible	$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 no deductible	$30 copay after deductible
Brand (Non-Formulary/Non-preferred)	$75 copay no deductible	$75 copay no deductible	$75 copay no deductible	$75 copay after deductible
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order Prescriptions				
Generic	$20 copay no deductible	$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 no deductible	$60 copay after deductible
Brand (Non-Formulary/Non-preferred)	$150 copay no deductible	$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	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% not to exceed $250/Rx no deductible (30 day supply)	20% after deductible not to exceed $250/RX (30 day supply)
Employee Premium - Less $668 Employer Contribution				
SINGLE				
12 Months	$910.90	$703.90	$600.70	$299.76
11 Months	$993.71	$767.89	$655.31	$327.01
10 Months	$1,093.08	$844.68	$720.84	$359.71
TWO-PARTY				
12 Months	$2,553.00	$2,130.70	$1,920.20	$1,267.50
11 Months	$2,785.09	$2,324.40	$2,094.76	$1,382.73
10 Months	$3,063.60	$2,556.84	$2,304.24	$1,521.00
FAMILY				
12 Months	$2,805.60	$2,350.20	$2,123.20	$2,070.73
11 Months	$3,060.65	$2,563.85	$2,316.22	$2,258.98
10 Months	$3,366.72	$2,820.24	$2,547.84	$2,484.88

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