

Synopsisys 2025 Medical Plan Comparison Chart

	Synopsisys Health Savings (HS) Basic Plan (Includes Choice Plus, CA Select, and Harvard Pilgrim)		Synopsisys Health Savings (HS) Premium Plan (Includes Choice Plus, CA Select, and Harvard Pilgrim)		Synopsisys Health PPO Plan (Includes Choice Plus and Harvard Pilgrim)		Kaiser HMO — California and Oregon
	Network Benefit	Non-Network Benefit	Network Benefit	Non-Network Benefit	Network Benefit	Non-Network Benefit	Network Benefits Only
Synopsys Annual Health Savings Account (HSA) Contribution*	None		\$1,000 employee only HSA contribution \$2,000 family HSA contribution		None (not an HSA-eligible plan)		None (not an HSA-eligible plan)
Calendar Year Deductible — Deductible cross applies in-network and out-of-network	\$2,250 Employee only \$4,500 Family	\$5,000 Employee only \$10,000 Family	\$1,750 Employee only \$3,500 Family	\$3,500 Employee only \$7,000 Family	\$500 Individual \$1,000 Family	\$1,000 Individual \$2,000 Family	None
Calendar Year Out-of-Pocket Maximum Includes deductibles and coinsurance, and copays. Does not apply to, penalties or excluded expenses.	\$3,500 Employee only \$7,000 Family	\$8,000 Employee only \$16,000 Family	\$3,000 Employee only \$6,000 Family	\$6,000 Employee only \$12,000 Family	\$3,000 Individual \$6,000 Family	\$6,000 Individual \$12,000 Family	\$1,500 Employee only \$3,000 Family
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited
Coinsurance	<ul style="list-style-type: none"> HS Basic Plan pays 80% of allowable charges and you pay 20%. HS Premium Plan pays 90% of allowable charges and you pay 10%. PPO Plan pays 85% of allowable charges and you pay 15%. Non-Network PPO and HS Premium Plan pays 70% of allowable charges and you pay 30% plus any amounts over the allowed amount. Non-Network HS Basic Plan pays 60% of allowable charges and you pay 40% plus any amount over the allowed amount 						You pay copays (or coinsurance) when you use Kaiser doctors and facilities; there is no coverage if you use providers outside of the Kaiser network.
Physician Office Visits	80% after deductible	60% after deductible	90% after deductible	70% after deductible	\$20 PCP \$30 Specialist	70% after deductible	\$30 PCP \$40 Specialist
Routine Physical Exams Immunizations including travel immunizations are covered	Covered at 100% (Travel immunizations covered after deductible)	60% after deductible	Covered at 100% (Travel immunizations covered after deductible)	70% after deductible	Covered at 100% (Travel immunizations covered 85% after deductible)	70% after deductible	Covered at 100%
Outpatient X-ray and Lab Services	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	CA: Plans pays 100% for most visits OR: \$30 copay
Emergency Room	Emergency: 80% after deductible Non-emergency: 60% after deductible		Emergency: 90% after deductible Non-emergency: 70% after deductible		Emergency: \$150 copay Non-emergency: \$150 copay		\$125 copay (waived if admitted, for OR only)
Urgent Care Centers	80% after deductible	60% after deductible	90% after deductible	70% after deductible	\$40 copay	70% after deductible	\$30 copay

*Synopsisys will make the full employer contribution to your Health Savings Account every January; new hire contributions will be prorated based on date of hire.

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	Network Benefit	Non-Network Benefit	Network Benefit	Non-Network Benefit	Network Benefit	Non-Network Benefit	Network Benefits Only
Outpatient Surgical (Provided in Doctor's Office)	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	\$40 copay
Inpatient and Outpatient Surgical (Provided outside of Doctor's Office)	80% after deductible (Must notify UHC)	60% after deductible Must notify UHC – Non-Notification Penalty \$500/incident	90% after deductible (Must notify UHC)	70% after deductible Must notify UHC – Non-Notification Penalty \$500/incident	85% after deductible (Must notify UHC)	70% after deductible Must notify UHC – Non-Notification Penalty \$500/incident	\$40 copay
Hospitalization Room & Board, Lab & X-ray, Anesthesiology, Pathology, Inpatient Prescriptions	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	\$400 per admission
Must notify UHC - Non-Notification Penalty is \$500/incident							
Maternity: Prenatal/Postpartum Routine Office Visits	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	Plan pays 100% for prenatal care
Maternity: Physician Services (Delivery)	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	You pay \$400 for hospitalization You pay \$30 for lab or X-ray visits (for OR only)
Must notify UHC if stay exceeds the 48/96 hour guidelines – Non-Notification Penalty is \$500/incident							
Well Baby/Well Child Immunizations are covered	Covered at 100%	60% after deductible	Covered at 100%	70% after deductible	Covered at 100%	70% after deductible	Plan pays 100%
Therapy: Physical, Speech, Occupational, Orthoptic and Cardiac	80% after deductible	60% after deductible	90% after deductible	70% after deductible	\$30 copay	70% after deductible	\$30 copay Individual \$15 copay Group
<i>50 visits/calendar year/type of therapy, combined in and out of network</i>							
Durable Medical Equipment (DME)	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	80%
Temporomandibular Joint Treatment (TMJ)	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	
Hearing Screenings	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	\$30 copay
Hearing Aid Fittings & Devices	In network and out of network plan benefits apply. \$2,000 maximum every two years						\$1,000 allowance for each ear every 36 months
Acupuncture	70% after in network deductible 20 visits per calendar year, combined in and out of network		80% after in deductible 20 visits per calendar year, combined in and out of network		80% after in deductible 20 visits per calendar year, combined in and out of network		\$30 copay

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Chiropractic Care	80% after deductible	60% after deductible	90% after deductible	70% after deductible	\$30 copay	70% after deductible	\$15 copay <i>20 visit limit per 12-month period</i>
Mental Health and Substance Abuse - Inpatient and Outpatient Care	80% after deductible	60% after deductible	90% after deductible	70% after deductible	\$20 copay	70% after deductible	\$400 copay Inpatient \$30 copay Individual \$15 copay Group
Infertility	<ul style="list-style-type: none"> • NO benefit available out of network. • Must enroll with Fertility Solutions through UnitedHealthcare for authorization and referral. • Synopsisys pays 90% after deductible for those on the HS Premium Plan. • Synopsisys pays 85% after deductible for those on the PPO Plan. • Synopsisys pays 80% after deductible for those on the HS Basic Plan. • Coverage for services to create a pregnancy, including, but not limited to: artificial insemination, In Vitro and GIFT limited to \$20,000 lifetime per covered member. • Prescriptions covered at 50% after deductible to \$10,000 lifetime maximum. 						\$40 copay
Transplants	<ul style="list-style-type: none"> • Must obtain prior authorization. • Synopsisys pays 100% after in network deductible when services are received at a Designated Provider. • No benefit available from a non-Designated Provider. • T&L limited to 10,000 LTM \$100 per day for lodging for individual and \$200 for family. • Travel benefits covered only when using a Designated Provider. 						

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Prescription Drugs – Retail 31-day supply ** A \$20.00 copay will apply to specialty drugs that fall within the UHC Specialty Drug Program for prescriptions up to 31 days.	PREVENTIVE CARE DRUGS: Deductible WAIVED Tier 1: \$5 Tier 2: 20% (\$50 max.) Tier 3: 20% (\$75 max.) NON-PREVENTIVE DRUGS: After Deductible Tier 1: \$5 Tier 2: 20% (\$50 max.) Tier 3: 20% (\$75 max.)	60% after deductible	PREVENTIVE CARE DRUGS: Deductible WAIVED Tier 1: \$5 Tier 2: 10% (\$50 max.) Tier 3: 10% (\$75 max.) NON-PREVENTIVE DRUGS: After Deductible Tier 1: \$5 Tier 2: 10% (\$50 max.) Tier 3: 10% (\$75 max.)	70% after deductible	Tier 1: \$10 Tier 2: \$30 Tier 3: \$60	70% after deductible	You pay: \$10 generic \$30 brand (up to a 30-day supply)
Prescription Drugs – Mail Order 90-day supply	PREVENTIVE CARE DRUGS: Deductible WAIVED Tier 1: \$10 Tier 2: 20% (\$100 max.) Tier 3: 20% (\$150 max.) NON-PREVENTIVE DRUGS: After Deductible Tier 1: \$10 Tier 2: 20% (\$100 max.) Tier 3: 20% (\$150 max.)	Not available	PREVENTIVE CARE DRUGS: Deductible WAIVED Tier 1: \$10 Tier 2: 10% \$100 max.) Tier 3: 10% (\$150 max.) NON-PREVENTIVE DRUGS: After Deductible Tier 1: \$10 Tier 2: 10% (\$100 max.) Tier 3: 10% (\$150 max.)	Not available	Tier 1: \$20 Tier 2: \$60 Tier 3: \$120	Not available	You pay: \$20 generic \$60 brand (up to a 90-day supply for OR and up to a 100-day supply for CA)

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