Synopsys 2025 Medical Plan Comparison Chart

	Synopsys Health Savings (HS) Basic Plan (Includes Choice Plus, CA Select, and Harvard Pilgrim)		**Synopsys Health Savings (HS) Premium Plan** (Includes Choice Plus, CA Select, and Harvard Pilgrim)		**Synopsys 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 individual 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 Employee only $1,000 Family	$1,000 Employee only $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 Employee only $6,000 Family	$6,000 Employee only $12,000 Family	$1,500 Employee only $3,000 Family
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited
Coinsurance	• 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

**Synopsys 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 You pay $400 for hospitalization You pay $30 for lab or X-ray visits (for OR only)
Maternity: Physician Services (Delivery)	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	
	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	85% after deductible	70% after deductible	$30 copay Individual $15 copay Group
	50 visits/calendar year/type of therapy, combined in and out of network						
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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	Network Benefit	**Non-Network Benefit**	**Network Benefit**	**Non-Network Benefit**	**Network Benefit**	**Non-Network Benefit**	**Network Benefits Only**
Chiropractic Care	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	$15 copay *20 visit limit per 12-month period*
	20 visits per calendar year, combined in and out of network						
Mental Health and Substance Abuse - Inpatient and Outpatient Care	80% after deductible	60% after deductible	90% after deductible	70% after deductible	85% after deductible	70% after deductible	$400 copay Inpatient $30 copay Individual $15 copay Group
Infertility	• **NO benefit available out of network.** • Must enroll with Fertility Solutions through UnitedHealthcare for authorization and referral. • Synopsys pays 90% after deductible for those on the HS Premium Plan. • Synopsys pays 85% after deductible for those on the PPO Plan. • Synopsys 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	• Must obtain prior authorization. • Synopsys 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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	Network Benefit	**Non-Network**	**Network Benefit**	**Non-Network**	**Network Benefit**	**Non-Network**	**Network Benefits Only**
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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