

2026 SCA Medical Plans

* Amounts reflect employee cost

Plan Name	Anthem HSA Plan		Anthem PPO Plan		Kaiser-Northern and Southern California	Kaiser Hawaii
Network Identifier	In Network	Out of Network	In Network	Out of Network	In Netowrk Only	In Netowrk Only
Accumulation Method (Ded)	Aggregate		Embedded		Aggregate	Embedded
Deductible - Single	\$1,800	\$6,000	\$700	\$2,000	\$0	\$0
Deductible - Family	\$3,600	\$12,000	\$1,400	\$4,000	\$0	\$0
Annual Company Contribution-Single/Family (bi-weekly contr.)	\$500		n/a		n/a	n/a
Wellness Incentives	Up to \$500		Up to \$500			
General Coinsurance	20% after deductible *	50% after deductible *	20% after deductible *	40% after deductible *	20% after dedutable	Varies depending on service
Accumulation Method (OOP)	Embedded		Embedded		Aggregate	Embedded
Max OOP - Single	\$6,000	\$10,000	\$3,000	\$7,000	\$1,500	\$2,500
Max OOP - Family	\$12,000	\$20,000	\$6,000	\$14,000	\$3,000	\$7,500
Preventive Services	\$0	50% after deductible	\$0	40% after deductible	\$0	\$0
Office Visit - Primary Care	20% after deductible	50% after deductible	\$30 copay	40% after deductible	\$35 copay	\$15
Office Visit - Specialty	20% after deductible	50% after deductible	\$60 copay	40% after deductible	\$35 copay	\$15
Urgent Care	20% after deductible	50% after deductible	\$75 copay	40% after deductible	\$35 per visit	\$15
Emergency Room	20% after deductible		\$500 copay		\$100	\$100
Inpatient Hospital	20% after deductible	50% after deductible	20% after deductible	40% after deductible	\$500 per admission	10% coinsurance
Lab work	20% after deductible	50% after deductible	20% after deductible	40% after deductible	No charge	\$15
X-rays	20% after deductible	50% after deductible	20% after deductible	40% after deductible	No charge	\$15
Pharmacy						
Rx Deductible - Single	Combined with medical	Not Covered	No Deductible	Not Covered		
Rx Deductible - Family	Combined with medical	Not Covered	No Deductible	Not Covered		
Generic	\$10	Not Covered	\$10	Not Covered	\$15	\$10
Formulary	\$30	Not Covered	\$30	Not Covered	\$35	\$45
Non-Formulary	\$60	Not Covered	\$60	Not Covered	\$35	\$45
Mail Order - Generic	\$20	Not Covered	\$20	Not Covered	\$30	\$20
Mail Order - Formulary	\$60	Not Covered	\$60	Not Covered	\$70	\$90
Mail Order - Non- Formulary	\$120	Not Covered	\$120	Not Covered	\$70	\$90