

2027 SCA Medical Plans

* Amounts reflect employee cost

Plan Name	Anthem Core 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-Network Only	In-Network 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-Child(ren)/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 deductible	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	\$20	Not Covered	\$20	Not Covered	\$15	\$10
Formulary	\$60	Not Covered	\$60	Not Covered	\$35	\$45
Non-Formulary	\$120	Not Covered	\$120	Not Covered	\$35	\$45
Mail Order - Generic	\$40	Not Covered	\$40	Not Covered	\$30	\$20
Mail Order - Formulary	\$120	Not Covered	\$120	Not Covered	\$70	\$90
Mail Order - Non- Formulary	\$240	Not Covered	\$240	Not Covered	\$70	\$90