AUTODESK

2027 Benefits Plan Comparison

Anthem Medical Plans

Glossary of common terms

		Anthem PPO	Anthem HDHP (HSA compatible)
Overview	**Payment level**	After calendar-year deductible, Plan generally pays 90% for network, 70% for non-network.	After calendar-year deductible, Plan generally pays 80% for network, 60% for non-network.
	Calendar year deductible	[1] Network: $500 Individual/ $1,000 Family Non-network: $1,000 Individual/$2,000 Family Does not apply to services with copay, retail pharmacy, or preventive care services. Unless noted otherwise, the deductible will apply to all other network and non-network services.	[3] Network: $1,750 Individual/Employee/Single, $3,500 Family Non-network: $3,500 Individual/Employee/Single, $7,000 Family Deductible applies to all network and non-network services other than preventive care services.
	Coinsurance	Network: 90%; Non-network: 70%	Network: 80%; Non-network: 60%
	Out-of-pocket maximum - the most you pay per calendar year	[2] Network: $2,000 Individual, $4,000 Family Non-network: $4,000 Individual, $8,000 Family Includes copays, deductibles, and coinsurance	[4] Network: $3,500 Individual/Employee/Single, $7,000 Family Non-network: $7,000 Individual/Employee/Single, $14,000 Family Includes deductibles and coinsurance
	Preauthorization	Required for hospital, skilled nursing facilities, certain outpatient procedures, home health, hospice, private duty nursing, and some prescriptions.	Required for hospital, skilled nursing facilities, certain outpatient procedures, home health, hospice, private duty nursing, and some prescriptions.
At the doctor's office	**Primary care**	Network: $25 copay; non-network:70%	Network: 80%; non-network: 60%
	Specialist	Network: $35 copay; non-network:70%	Network: 80%; non-network: 60%
	Routine physicals (PCP)	100% including associated x-ray and lab services; non-network: 80%	Network: 100% including associated X-ray and lab services; non-network: 80%
	Well-baby/child care	100% including associated x-ray and lab services; non-network: 80%	100% including associated X-ray and lab services; non-network: 80%
	X-ray and lab services	Doctor's Office: 100%, deductible waived Network: 90%; non-network: 70%	Network: 80%; non-network: 60%
Urgent care clinic	**Physician fees may apply**	Network: 90%; non-network:70%	Network: 80%; non-network: 60%
Hospitalization	**Semiprivate room/board**	Network: 90%; non-network:70%	Network: 80%; non-network: 60%
	X-Ray and lab services	Network: 90%; non-network:70%	Network: 80%; non-network: 60%
	Surgery	Network: 90%; non-network: 70%	Network: 80%; non-network: 60%
	Emergency room	90% after meeting Network deductible	80% after meeting Network deductible

[1] **Applies to PPO:** If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
[2] **Applies to PPO:** If you have other family members on the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
[3] **Applies to HDHP:** If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay – the Individual deductible doesn't apply if you cover two or more people (including yourself).
[4] **Applies to HDHP:** If you have other family members on the plan, the overall family out-of-pocket limits must be met – the individual out-of-pocket limit doesn't apply if you cover two or more people (including yourself).

Coverage as of 1/1/2027

AUTODESK

Anthem Medical Plans (continued)

Glossary of common terms

		Anthem PPO	Anthem HDHP (HSA compatible)
Maternity	**Including prenatal care, delivery, and routine nursery charges (non-specialists). Does not include hospitalization.**	Network: 90% Non-network: 70%	Network: 80% Non-network: 60%
Prescriptions (administered by ExpressScripts)	**Network pharmacy** - **Tier 1** - **Tier 2** - **Tier 3** - **Specialty**	[1]90% - member pays 10%, up to the maximum listed below - $20 - $50 - $80 - $100	Network 80% **Non-network 60%**
	Mail order - **Tier 1** - **Tier 2** - **Tier 3** - **Specialty**	[2]90% - member pays 10%, up to the maximum listed below - $40 - $100 - $160 - N/A	80%
Mental health/ substance use	**Outpatient office visit**	Network: $25 copay; non-network: 70%	Network: 80%; non-network: 60%
	Outpatient-other services (including ABA therapy)	Network: 90%; non-network: 70%	Network: 80%; non-network: 60%
	Inpatient	Network: 90%; non-network: 70%	Network: 80%; non-network: 60%
Other services	**Acupuncture**	Network: $35 copay; non-network: 70%; 26 visits per calendar year maximum	Network: 80%; non-network: 60%; 26 visits per calendar year maximum
	Chiropractic care	Network: $35 copay; non-network: 70%; 26 visits per calendar year maximum	Network: 80%; non-network: 60%; 26 visits per calendar year maximum
	Doula support	Up to $2,500 per pregnancy	Up to $2,500 per pregnancy
	Infertility and Fertility treatment	Services for the diagnosis and medical treatment of the underlying cause of infertility are covered as described above. Therapeutic services to support fertility—such as ART, IVF, AI, and IUI—are also covered.	Services for the diagnosis and medical treatment of the underlying cause of infertility are covered as described above. Therapeutic services to support fertility—such as ART, IVF, AI, and IUI—are also covered.

[1] Up to 31-day supply
[2] Up to 90-day supply

Kaiser Medical Plans

Glossary of common terms

		Kaiser HMO (California)	Kaiser HMO (San Francisco only)	Kaiser HMO (Oregon)
Overview	**Payment level**	Plan generally pays 100% after out-of-pocket maximum is met	Plan generally pays 100% after out-of-pocket maximum is met	Plan generally pays 100% after out-of-pocket maximum is met
	Calendar year deductible	None	None	None
	Out-of-pocket maximum for the year	$1,500 Individual/$3,000 Family; includes copays	$3,000 Individual/$6,000 Family; includes copays	$1,500 Individual/$3,000 Family
	Preauthorization	N/A	N/A	N/A
At the doctor's office	**Primary care**	$25 copay	$40 copay	$25 copay
	Specialist	$35 copay	$50 copay	$35 copay
	Routine physicals (PCP)	No charge	No charge	No charge
	Well-baby/child care	No charge	No charge	No charge
	X-ray and lab services	No charge	$10 per encounter	$15 copay
Urgent care clinic	**Physician fees may apply**	$25 copay/visit	$40 copay/visit	$25 copay
Hospitalization	**Semiprivate room/board**	$150 copay per admission	$500 copay per day	$150 copay per admission
	X-ray and lab services	Included in inpatient hospital copay	Included in inpatient hospital copay	Included in inpatient hospital copay
Emergency room (not covered for non- emergencies)	**Surgery**	Included in inpatient hospital copay /$30 copay for outpatient surgery	Included in inpatient hospital copay /$250 copay for outpatient surgery	Included in inpatient hospital copay/$30 copay for outpatient
	Emergency room	$75 copay (waived if admitted)	$200 copay (waived if admitted)	$75 copay (waived if admitted)
Prescriptions	**Network pharmacy**	Generic: $10 copay Brand: $20 Specialty: $20 (up to 30-day supply)	Generic: $10 copay after pharmacy deductible Brand: $35 copay after pharmacy deductible Specialty: 20% Coinsurance up to a maximum of $150 after Pharmacy deductible (Pharmacy Deductible $250)	Generic: $10 copay Brand: $20 copay Specialty: $20 (up to 30-day supply)
	Non-network pharmacy	Not covered	Not covered	Not covered—unless qualifying emergency
	Mail order	$20 copay (generic)/$40 copay (brand) up to 100-day supply	$10 copay (generic)/$35 copay (brand and non-preferred brand up to 100-day supply	$20 (generic)/$40 (formulary brand) for 90-day supply
Maternity	**Including prenatal care, delivery, and routine nursery charges (non-specialists). Does not include hospitalization.**	No charge for prenatal and postnatal visits $150 per Maternity Inpatient	Routine prenatal care No Charge Maternity Inpatient $500 per day	No charge for prenatal and postnatal visits $150 per Maternity Inpatient
Mental health/ Substance use	**Outpatient**	Mental health: $20 copay individual/$10 copay group visit; Substance use disorder: $25 copay individual/$5 copay group visit	Outpatient individual therapy visits $40 per visit Outpatient group therapy visits $20 per visit, Substance use: Outpatient individual therapy visits $40 per visit Outpatient group therapy visits $5 per visit	Mental health: $20 copay individual/$10 copay group visit; Substance use disorder: $20 copay individual/$5 copay group visit
	Inpatient	Mental health: $150 hospital admission copay; Substance use disorder: $150 hospital admission copay (detox only)	Inpatient psychiatric care $500 per day Inpatient detoxification $500 per day	Mental health: $150 hospital admission copay; Substance use disorder: $150 hospital admission copay (detox only)
Other medical care	**Fertility medical treatment**	Cost share is determined by place of service. Includes IVF, GIFT & ZIFT. Includes Infertility drugs at applicable Pharmacy Cost Shares	Cost share is determined by place of service. Includes IVF, GIFT & ZIFT. Includes Infertility drugs at applicable Pharmacy Cost Shares	50% Coinsurance. Includes IVF, GIFT & ZIFT and Infertility Rx up to $30,000 per lifetime
	Chiropractic/Acupuncture	CHIROPRACTIC: $15 per visit / 30 visit limit per accumulation period ACUPUNCTURE: $15 per visit / 30 visit limit per accumulation period	CHIROPRACTIC: Not Included ACUPUNCTURE: Not Included	CHIROPRACTIC: $15 per visit / 30 visit limit per accumulation period (combined with acupuncture) ACUPUNCTURE: $15 per visit / 30 visit limit per accumulation period (combined with chiropractic)

AUTODESK

2027 Benefits Plan Comparison

Delta Dental dental plans

Glossary of common terms

Overview	Basic Preferred Provider Organization (PPO)	Plus Preferred Provider Organization (PPO)
Summary	Enrollees may use any provider Participating PPO dentists provide dental services at reduced fee schedule Participating Premier dentists provide dental services at a reduced fee schedule however going to an in-network PPO dentist will offer the lower cost	Enrollees may use any provider Participating PPO dentists provide dental services at a reduced fee schedule Participating Premier dentists provide dental services at a reduced fee schedule however going to an in-network PPO dentist will offer the lower cost
Benefit basis	Reasonable and customary (maximum paid based on the most common costs for services or procedures in a specific geographic area)	Reasonable and customary (maximum paid based on the most common costs for services or procedures in a specific geographic area)
Calendar year maximum benefit	$1,500 per covered member Preventive services are not applied to the calendar year maximum benefit	$3,000 per covered member Preventive services are not applied to the calendar year maximum benefit
Calendar year deductible **Per person** **Per family**	Individual deductible waived for preventive care and orthodontia $50 $150	Individual deductible waived for preventive care and orthodontia $50 $150
Preventive care	100%; exams, cleaning, fluoride for children, bitewing x-rays, space maintainers Prophylaxis limited to three (3) times per calendar year for adults and two (2) times per calendar year for children	100%; exams, cleaning, fluoride for children, bitewing x-rays, space maintainers Prophylaxis limited to three (3) times per calendar year for adults and two (2) times per calendar year for children
Basic care	80%; extractions, fillings, periodontics, minor restorations, other x-rays	90%; extractions, fillings, periodontics, minor restorations, other x-rays
Major care	50%; inlays, onlays, crowns, bridgework, dentures, implants, endodontics	60%; inlays, onlays, crowns, bridgework, dentures, implants, endodontics
Orthodontia, adults and children	Not covered	60% $3,000 lifetime maximum benefit per covered member

AUTODESK

2027 Benefits Plan Comparison

VSP vision plans

Glossary of common terms

	Basic Plan	Plus Plan
	Frequency	
Exams	Once every calendar year No copay for Exam	Once every calendar year No copay for Exam
Lenses*	Once every calendar year	Once every calendar year
Frames	Once every other calendar year	Once every calendar year
Contacts*	Once every other calendar year	Once every calendar year
Lens enhancements - covered in full	Polycarbonate lenses for children Standard progressives	Anti-glare coating High index lenses Polycarbonate lenses Standard progressives Tints/light-reactive UV coating
	Copays	
Lens & Frame copay	$30	$20
Retinal screening copay	$15	$15
Computer VisionCare **(Benefit available to employees only; not available to enrolled dependents)**	$10 copay for services Exam & lenses every calendar year Frames every other calendar year $80 Allowance for frame Anti-glare coating	$10 copay for services Exam & lenses every calendar year Frames every calendar year $90 Allowance for frame Anti-glare coating
LightCare	One pair of non-prescription sunglasses or non-prescription blue light filtering glasses, in lieu of prescription frame/lens benefit	One pair of non-prescription sunglasses or non-prescription blue light filtering glasses, in lieu of prescription frame/lens benefit

*You can get either glasses or contacts (but not both) every calendar year or every other calendar year.

AUTODESK

VSP vision plans (continued)

	Basic Plan and Plus Plan	
	In-network maximum	**Out-of-network maximum**
Exam	Covered	Covered up to: $42
Retinal screening	Covered	Not Covered
Single vision lenses	Covered	Covered up to: $40
Lined bifocal lenses	Covered	Covered up to: $60
Lined trifocal lenses	Covered	Covered up to: $80
Progressive lenses	Covered	Covered up to: $80
Frames	Basic Plan: Covered up to $180 Plus Plan: Covered up to $250	Covered up to $70
Contact lenses	Basic Plan: Covered up to $105 Plus Plan: Covered up to $250	Basic Plan: Covered up to $105 Plus Plan: Covered up to $250

In addition to the features covered in the chart, VSP members are eligible for discounts, including the Laser VisionCare℠ program.