AUTODESK

2026 Benefits Plan Comparison

Medical | Dental | Vision

UnitedHealthcare Medical Plans

Glossary of common terms

		UHC Choice Plus (PPO)	UHC Choice (EPO) Network coverage only	UHC Choice Plus High Deductible (HDHP) Health Savings Account (HSA) compatible
Overview	**Payment level**	After calendar-year deductible, Plan generally pays 90% for network, 70% for non-network	Plan generally pays 100% of network services with applicable copay	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.	None	[3] Network: $1,700 Individual/Employee/Single, $3,400 Family Non-network: $3,400 Individual/Employee/Single, $6,800 Family Deductible applies to all network and non-network services other than preventive care services.
	Coinsurance	Network: 90%; Non-network: 70%	100%	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	[2] $2,000 Individual, $4,000 Family Includes copays and prescription coinsurance	[4] Network: $3,400 Individual/Employee/Single, $6,800 Family Non-network: $6,800 Individual/Employee/Single, $13,600 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 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%	$20 copay	Network: 80%; non-network: 60%
	Specialist	Network: $35 copay; non-network:70%	$30 copay	Network: 80%; non-network: 60%
	Routine physicals (PCP)	100% including associated x-ray and lab services	No charge	100% including associated X-ray and lab services
	Well-baby/child care	100% including associated x-ray and lab services	No charge	100% including associated X-ray and lab services
	X-ray and lab services	Network: 90%; non-network: 70%	No charge	Network: 80%; non-network: 60%
Urgent care clinic	**Physician fees may apply**	Network: 90%; non-network:70%	$35 copay	Network: 80%; non-network: 60%
Hospitalization	**Semiprivate room/board**	Network: 90%; non-network:70%	$150 copay	Network: 80%; non-network: 60%
	X-Ray and lab services	Network: 90%; non-network:70%	No charge	Network: 80%; non-network: 60%
	Surgery	Network: 90%; non-network: 70%	No charge	Network: 80%; non-network: 60%
	Emergency room	90% after meeting Network deductible	$50 copay (waived if admitted)	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 & EPO :** 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).

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UnitedHealthcare Medical Plans (continued)

Glossary of common terms

		UHC Choice Plus (PPO)	UHC Choice (EPO) Network coverage only	UHC Choice Plus High Deductible (HDHP) Health Savings Account (HSA) compatible
Maternity	**Including prenatal care, delivery, and routine nursery charges (non-specialists). Does not include hospitalization.**	Network: 90% - $25 copay for initial PPO doctor's office visit (waived after initial visit) Non-network: 70%	100% - $20 copay for initial PCP doctor's office visit (waived after initial visit)	Network: 80% Non-network: 60%
Prescriptions	**Network pharmacy** - **Tier 1** - **Tier 2** - **Tier 3** - **Specialty**	[1]90% - member pays 10%, up to the maximum listed below - $20 - $50 - $80 - $100	[1]90% - member pays 10%, up to the maximum listed below - $20 - $50 - $80 - $100	80%
	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	[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%	$20 copay	Network: 80%; non-network: 60%
	Outpatient-other services (including ABA therapy)	Network: 90%; non-network: 70%	$20 copay	Network: 80%; non-network: 60%
	Inpatient	Network: 90%; non-network: 70%	100% after $150 inpatient copay	Network: 80%; non-network: 60%
Other services	**Acupuncture**	Network: $35 copay; non-network: 70%; 26 visits per calendar year maximum	$30 copay; 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	$30 copay; 26 visits per calendar year maximum	Network: 80%; non-network: 60%; 26 visits per calendar year maximum
	Doula support	Up to $2,500 reimbursement per pregnancy	Up to $2,500 reimbursement per pregnancy	Up to $2,500 reimbursement per pregnancy
	Infertility and fertility treatment	Network: 90%; non-network: not covered To receive additional information, contact the Fertility Solutions Program Nurse Team at 888-936-7246	Network: 100%; non-network: not covered To receive additional information, contact the Fertility Solutions Program Nurse Team at 888-936-724	Network: 80%; non-network: not covered To receive additional information, contact the Fertility Solutions Program Nurse Team at 888-936-724

[1] Up to 31-day supply

[2] Up to 90-day supply

Preventive care under all UHC medical plans includes the Galleri multi-cancer early-detection test for eligible members.

A note about non-network payment levels—applies to UHC Choice Plus (PPO) and UHC Choice Plus High Deductible (HDHP) plans: Non-network claims may be adjusted based upon a reference-based methodology that is geographically adjusted, and based on what providers generally charge for the same or similar service

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Kaiser Medical Plans

Glossary of common terms

		Kaiser HMO (California)	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
	Calendar year deductible	None	None
	Out-of-pocket maximum for the year	$1,500 Individual/$3,000 Family; includes copays	$600 Individual/$1,200 Family
	Preauthorization	N/A	N/A
At the doctor's office	**Primary care**	$25 copay	$25 copay
	Specialist	$35 copay	$35 copay
	Routine physicals (PCP)	No charge	No charge
	Well-baby/child care	No charge	No charge
	X-ray and lab services	No charge	$15 copay
Urgent care clinic	**Physician fees may apply**	$25 copay/visit	$35 copay
Hospitalization	**Semiprivate room/board**	$150 copay per admission	$50 copay per day to $250 maximum per admission
	X-ray and lab services	Included in inpatient hospital copay	Included in inpatient hospital copay
	Surgery	Included in inpatient hospital copay /$30 copay for outpatient surgery	Included in inpatient hospital copay/$20 copay for outpatient
Emergency room (not covered for non- emergencies)	**Emergency room**	$75 copay (waived if admitted)	Kaiser facility: $75 copay (waived if admitted); Qualifying care non-Kaiser facility: $75 copay (waived if admitted)
Prescriptions	**Network pharmacy**	$10 copay (generic)/$20 copay (brand) up to a 30-day supply (50% drugs for the treatment of sexual dysfunction)	$10 (generic)/$20 (formulary brand)/$40 (non-formulary)/$150 (specialty) (up to 30-day supply)
	Non-network pharmacy	Not covered	Not covered—unless qualifying emergency
	Mail order	$20 copay (generic)/$40 copay (brand) up to 100-day supply	$20 (generic)/$40 (formulary brand)/$80 non-formulary 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	No charge for prenatal and postnatal visits
Mental health/ Substance use	**Outpatient**	Mental health: $20 copay individual/$10 copay group visit; Substance use disorder: $25 copay individual/$5 copay group visit	$25 copay
	Inpatient	Mental health: $150 hospital admission copay; Substance use disorder: $150 hospital admission copay (detox only); $100 copay Transitional residential recovery services	$50 copay per day to a $250 maximum per admission
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	50% Coinsurance Includes IVF, GIFT & ZIFT and Infertility Rx; up to $30,000 per lifetime
	Acupuncture	Coverage limited to treatment of nausea and chronic pain management	$25 copay 12 visits per accumulation period
	Chiropractic care	$15 copay per visit 30 visit limit per accumulation period	$25 copay 20 visits per accumulation period

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Aetna dental plans

Glossary of common terms

Overview	Preferred Provider Organization (PPO)	Dental Maintenance Organization (DMO)
Summary	Enrollees may use any provider Participating PPO dentists provide dental services at a reduced fee schedule	All services (except for certain emergency care) must be provided or prescribed by your selected DMO network primary care dentist. DMO network is limited and differs from PPO network. You can switch DMO dentists by calling Aetna any time before the 15th of the month and the change will become effective the first day of the following month.
Benefit basis	Reasonable and customary (maximum paid based on the most common costs for services or procedures in a specific geographic area)	Negotiated in advance between Aetna and network providers
Calendar year maximum benefit	$2,500 per covered member Preventive services are not applied to the calendar year maximum benefit	None
Calendar year deductible **Per person** **Per family**	Individual deductible waived for preventive care and orthodontia $50 $150	 None None
Preventive care	100%; exams, cleaning, fluoride for children, bitewing x-rays Prophylaxis limited to four (4) times per calendar year for adults and two (2) times per calendar year for children	100%; exams, cleaning, fluoride for children, x-rays Prophylaxis limited to four (4) times per calendar year
Basic care	80%; extractions, fillings, periodontics, endodontics, minor restorations, space maintainers, other x-rays	100%; extractions, fillings, most periodontics and endodontics, minor restorations
Major care	60%; inlays, onlays, crowns, bridgework, dentures, implants	60%; inlays, onlays, crowns, bridgework, dentures, space maintainers
Orthodontia, adults and children	50% $2,500 lifetime maximum benefit per covered member	50% Limited to 24 months of active and 24 months of post treatment. If enrolling for the first time and you or dependent have already started an orthodontic treatment program, the DMO option will not cover your orthodontia expenses.

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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 other calendar year (Every calendar year if prescription changes)	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 every calendar year Lenses & frame every other calendar year $80 Allowance for frame Anti-glare coating	$10 copay for services Exam every calendar year Lenses & frame 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.

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VSP vision plans (continued)

Glossary of common terms

	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 this chart, VSP members are eligible for discounts, including the Laser VisionCare℠ program.

An important note about this document:
This document is only a summary.
It is not intended to be a complete list of all plan details, exclusions, or limitations.
Please refer to the governing plan documents for full details.