



FY'23 plan snapshot

This is a snapshot of how the medical, dental, and vision plans work. For a complete list of covered services, see the summary plan descriptions (SPDs).

Learn more at intuitbenefits.com.

Summary of medical benefits

	Cigna Choice Fund with HSA Plan	Cigna Managed Network Plan	UHC Network Plan	Kaiser (CA & GA)		
Full-Time Employee Biweekly Paycheck Deduction						
Employee only	\$14.50	\$15.00	\$16.00	CA North \$15.50	CA South \$12.00	GA \$13.50
Employee + spouse/DP	\$79.50	\$83.00	\$93.00	\$95.50	\$74.00	\$84.50
Employee + children	\$58.50	\$61.00	\$67.00	\$79.00	\$61.00	\$69.50
Employee + family	\$101.00	\$105.50	\$118.00	\$122.50	\$95.00	\$108.00
Plan Features						
Provider Network	Cigna Open Access Plus network; use any in-network or out-of-network provider	Use any provider in the Open Access Plus network, but pay less when you use Tier 1 specialists; out-of-network services not covered unless specified	UnitedHealthcare Choice network; out-of-network services not covered unless specified	Kaiser Permanente doctors and facilities only; out-of-network services not covered unless specified		
Plan-Year Deductible (August 1-July 31)	<i>In-Network:</i> Individual: \$1,400 Family: \$2,800 <i>Out-of-Network:</i> Individual: \$2,500 Family: \$5,000 Includes prescription drugs	No deductible	No deductible	No deductible		
Intuit's HSA Contribution (if applicable)	Salary less than \$80,000 Individual: \$1,000 Family: \$2,000 Salary \$80,000 or more Individual: \$750 Family: \$1,500	N/A	N/A	N/A		
Coinsurance	After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Plan pays 100%	Plan pays 100%	Plan pays 100%		
Plan-Year Out-of-Pocket Maximum (“Family” refers to two or more people)	<i>In-Network:</i> Individual: \$2,600 Family: \$5,200 <i>Out-of-Network:</i> Individual: \$2,600 Family: \$5,200 Includes deductibles, coinsurance, and prescription drugs	Individual: \$2,000 Family: \$6,000 Includes your medical copays, but does not include non-compliance penalties	Individual: \$2,000 Family: \$6,000 Includes your medical copays	Individual: \$1,500 Family: \$3,000 Includes your medical and pharmacy copays		
Physician Services						
Preventive Exams (such as routine physicals, immunizations, annual ob-gyn exams, and one mammogram per year for women starting at age 40)	<i>In-Network:</i> Plan pays 100% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹ after deductible; guidelines apply; call Cigna for details	Plan pays 100%; guidelines apply; call Cigna for details	Plan pays 100%; guidelines apply; call UHC for details	Plan pays 100%; guidelines apply; call Kaiser for details		
Well-Baby/Well-Child Care (includes immunizations)	<i>In-Network:</i> Plan pays 100% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹ after deductible	Plan pays 100%	Plan pays 100%	Plan pays 100%		
Telemedicine	Teladoc board-certified doctors are available 24/7 by phone or secure video to diagnose conditions and prescribe medicine. Use Teladoc for allergies, asthma, bronchitis, cold and flu, pinkeye, back pain, nutrition services, smoking cessation, and dermatology issues.					
	No cost to you after deductible	No cost to you	No cost to you	No cost to you through Kaiser providers		
Teladoc 360 Virtual Primary Care (employees and dependents age 18 and older)	Preventive exams: Plan pays 100% PCP visits (non-preventive): Plan pays 90% after deductible	Preventive exams: Plan pays 100% PCP visits (non-preventive): \$20 copay	Preventive exams: Plan pays 100% PCP visits (non-preventive): \$15 copay	N/A		
Doctor's Office Visit	After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	PCP: \$20 copay Tier 1 ² specialist: \$30 copay Non-Tier 1 ² specialist: \$40 copay	PCP: \$15 copay Specialist: \$30 copay	PCP: \$20 copay Specialist: \$20 copay		
Non-Hospital X-Ray & Lab Services	After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Plan pays 100%; copays apply for services rendered in a physician's office	Plan pays 100%; copays apply for services rendered in a physician's office	Plan pays 100%		

**Cigna Choice Fund
with HSA Plan**

**Cigna Managed
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UHC Network Plan

Kaiser (CA & GA)

Urgent Care & Emergency Room

Urgent Care	After Deductible: <i>In- and Out-of-Network:</i> Plan pays 90%	You pay \$40 copay	You pay \$40 copay	You pay \$20 copay
Emergency Room	After Deductible: <i>In- and Out-of-Network:</i> Plan pays 90%; only covered for true emergencies	You pay \$250 copay (waived if admitted); only covered for true emergencies	You pay \$250 copay (waived if admitted); only covered for true emergencies	You pay \$100 copay (waived if admitted)
Ambulance	After Deductible: <i>In- and Out-of-Network:</i> Plan pays 90%; only covered for true emergencies	Plan pays 100%; only covered for true emergencies	Plan pays 100%; only covered for true emergencies	You pay \$50 per trip

Surgery

Inpatient Surgery	After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Plan pays 100% after you pay \$200 facility copay per admission	Plan pays 100% after you pay \$150 hospital copay per admission	Plan pays 100% after you pay \$100 hospital copay per admission
Outpatient Surgery	After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Plan pays 100% after you pay \$100 facility copay per visit	Plan pays 100% after you pay \$30 facility copay per visit	Plan pays 100% after you pay \$20 copay per procedure

Mental Health & Substance Use Disorder Therapy

Employee Assistance Program (EAP)	You, your spouse, and your dependents age 2 and older have access to 12 coaching or therapy sessions per plan year, at no cost to you.			
Telemedicine	Teladoc licensed therapists and psychiatrists available 24/7 by phone or secure video for counseling related to stress, anxiety, depression, addiction, and abuse. Available to employees and covered family members age 13 and older.			
	After Deductible: Plan pays 100%	Plan pays 100%	Plan pays 100%	No cost to you through Kaiser providers
Inpatient Care	After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹ ; you pay less when you use a Cigna Substance Use Center of Excellence	Plan pays 100% after you pay \$200 copay per admission; you pay less when you use a Cigna Substance Use Center of Excellence	Plan pays 100% after you pay \$150 copay per admission	Plan pays 100% after you pay \$100 copay per admission
Office Visit/Outpatient Care	After Deductible: <i>In-Network:</i> Plan pays 100% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹ ; you pay less when you use a Cigna Substance Use Center of Excellence	Plan pays 100%	Plan pays 100%	Mental Health: Individual session: You pay \$20 copay Group session: You pay \$10 copay Substance Abuse: Individual session: You pay \$20 copay Group session: You pay \$5 copay in CA; \$10 copay in GA

Other Services

Infertility <i>Including elective egg freezing, cryopreservation, storage and thawing</i>	Testing and treatment for underlying conditions, testing to determine cause of infertility, procedures to restore fertility; includes artificial insemination, in vitro, GIFT and ZIFT, elective egg freezing (cryopreservation, storage, and thawing)	Testing and treatment for underlying conditions, testing to determine cause of infertility, procedures to restore fertility; includes artificial insemination, in vitro, GIFT and ZIFT, elective egg freezing (cryopreservation, storage, and thawing)	Testing and treatment for underlying conditions, testing to determine cause of infertility, procedures to restore fertility; includes artificial insemination (6-visit limit), in vitro, GIFT and ZIFT, elective egg freezing (cryopreservation, storage, and thawing)	Testing and treatment for underlying conditions, testing to determine cause of infertility, procedures to restore fertility; includes artificial insemination, in vitro, GIFT and ZIFT. Elective egg freezing (cryopreservation, storage, and thawing) not covered.
	After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹ ; limited to \$30,000 lifetime maximum for medical and \$10,000 for prescriptions (through CVS Caremark)	You pay \$30 for Tier 1 ² specialist or \$40 for non-Tier 1 ² specialist per visit; limited to \$30,000 lifetime maximum for medical and \$10,000 for prescriptions (through CVS Caremark)	You pay \$30 specialist copay; limited to \$30,000 lifetime maximum for medical and \$10,000 for prescriptions (through CVS Caremark)	You pay \$20 copay per visit for outpatient services; \$100 copay per admission for inpatient services; limitations apply; check with Kaiser for more details on covered services
Physical, Speech, & Occupational Therapy	After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Up to 60 visits per year ³ ; you pay \$40 for specialist per visit	Up to 60 visits per year ⁴ ; you pay \$30 copay per visit. For mental health-related visits, plan pays 100% (unlimited visits).	You pay \$20 copay per visit; physical therapy and speech therapy require authorization by your doctor

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Other Services (continued)

Applied Behavioral Analysis (ABA) Therapy	After Deductible: <i>In-Network:</i> Plan pays 100% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Plan pays 100%	Plan pays 100%	You pay \$20 copay per visit (CA), \$0 copay (GA); requires authorization by your doctor
Music & Equine Therapy	After Deductible: <i>In-Network:</i> Plan pays 100% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Plan pays 100%	Plan pays 100%	Not covered
Acupuncture	Up to 30 visits per year, combined in-network and out-of-network After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Up to 20 visits per year; you pay \$20 copay for PCP or \$40 copay for specialist	Up to 30 visits per year; you pay \$30 copay per visit	You pay \$20 copay per visit; limitations apply—check with plan administrator
Chiropractic Care	Up to 30 visits per year, combined in-network and out-of-network After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Up to 20 visits per year; you pay \$20 copay for PCP or \$40 copay for specialist	Up to 30 visits per year; you pay \$30 copay per visit	Up to 20 visits per year; you pay \$15 copay per visit
Nutritionists <i>(If you have a chronic condition, all plans pay 100% for unlimited visits with a registered and licensed dietician or nutritionist.)</i>	Up to 5 visits per year with a registered and licensed dietician or nutritionist (covered in-network and out-of-network) After Deductible: <i>In-Network:</i> Plan pays 90% <i>Out-of-Network:</i> Plan pays 70% of UCR ¹	Up to 5 visits per year with a registered and licensed dietician or nutritionist You pay \$40 copay per visit (covered in-network and out-of-network)	Up to 5 visits per year with a registered and licensed dietician or nutritionist You pay \$30 copay per visit (covered in-network and out-of-network)	Not covered

Prescription Drugs

Provider	CVS Caremark: caremark.com 1-888-797-8890			Kaiser Pharmacy or Mail Order Only
Annual Out-of-Pocket Maximum	Prescription amounts count toward medical plan out-of-pocket maximum	Individual: \$4,100 Family: \$6,200	Individual: \$4,100 Family: \$6,200	Prescription copays count toward medical plan out-of-pocket maximum
Generic	After Deductible: <i>Retail:</i> You pay \$5 or less for 30-day supply ⁵ <i>Mail Order:</i> You pay \$10 for 90-day supply	<i>Retail:</i> You pay \$5 or less for 30-day supply ⁵ <i>Mail Order:</i> You pay \$10 for 90-day supply	<i>Retail:</i> You pay \$5 or less for 30-day supply ⁵ <i>Mail Order:</i> You pay \$10 for 90-day supply	<i>Retail:</i> You pay \$10 at Kaiser pharmacy for up to 30-day supply <i>Mail Order:</i> You pay \$20 for up to 100-day supply (CA), 90-day supply (GA)
Preferred Brand Name	After Deductible: <i>Retail:</i> You pay 10% (\$15 minimum) for 30-day supply ⁵ <i>Mail Order:</i> You pay 10% (\$30 minimum) for 90-day supply	<i>Retail:</i> You pay 30% (\$30 minimum/\$90 maximum) for 30-day supply ⁵ <i>Mail Order:</i> You pay 30% (\$60 minimum/\$180 maximum) for 90-day supply	<i>Retail:</i> You pay \$30 for 30-day supply ⁵ <i>Mail Order:</i> You pay \$60 for 90-day supply	<i>Retail:</i> You pay \$20 at Kaiser pharmacy for up to 30-day supply <i>Mail Order:</i> You pay \$40 for up to 100-day supply (CA), 90-day supply (GA)
Non-Preferred Brand Name	After Deductible: <i>Retail:</i> You pay 10% (\$30 minimum) for 30-day supply ⁵ <i>Mail Order:</i> You pay 10% (\$60 minimum) for 90-day supply	<i>Retail:</i> You pay 50% (\$50 minimum/\$150 maximum) for 30-day supply ⁵ <i>Mail Order:</i> You pay 50% (\$100 minimum/\$300 maximum) for 90-day supply	<i>Retail:</i> You pay \$60 for 30-day supply ⁵ <i>Mail Order:</i> You pay \$120 for up to 90-day supply	<i>Retail:</i> You pay \$20 (CA), \$30 (GA) at Kaiser pharmacy for up to 30-day supply <i>Mail Order:</i> You pay \$40 for up to 100-day supply (CA), \$60 for up to 90-day supply (GA)

¹ A fee is considered to be usual, customary, and reasonable (UCR) if it falls within the parameters of the average or commonly charged fee for the particular service within a specific community.

² You pay less when you use Tier 1 specialists. Contact Cigna for details.

³ Visit limit will not apply to treatment of mental health and substance use disorder conditions.

⁴ Some services, such as outpatient detox, covered at 100% with no copay.

⁵ After two retail fills of maintenance medications, you must go through mail order or use a CVS pharmacy and fill a 90-day supply. Otherwise, a penalty copay is charged (\$15 for generic, \$20 for preferred brand name, and \$40 for non-preferred brand name). Specialty medications must be filled through CVS Specialty® pharmacy and have a 30-day limit.

Summary of dental benefits

	Aetna PPO Dental Plan	Aetna Dental Maintenance Organization (DMO) Plan	
Biweekly Paycheck Deduction for Full-Time Employees	Employee only: \$5.50 Employee + spouse/DP: \$14.00 Employee + children: \$11.00 Employee + family: \$16.50	Employee only: \$1.50 Employee + spouse/DP: \$4.00 Employee + children: \$3.00 Employee + family: \$5.00	
Plan Features	In-Network	Out-of-Network*	In-Network Only
Provider Network	Use any Aetna PPO network dentist, specialist, or orthodontist who has agreed to charge Aetna's negotiated rates for services.		You must see an Aetna DMO dentist. When you enroll, you will select and use a primary care dentist (PCD).
Plan-Year Deductible (August 1-July 31)	Individual: \$25 Family: \$50	Individual: \$50 Family: \$150	None
Plan-Year Maximum**	\$2,500	\$2,000	None
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Care	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 100%
Major Care	Plan pays 60% after deductible	Plan pays 50% after deductible	Plan pays 60%
Orthodontia	Plan pays 60%, up to \$3,000 lifetime maximum	Plan pays 50%, up to \$1,500 lifetime maximum	Plan pays 50%, up to 24-month lifetime maximum for comprehensive treatment and maintenance

* Out-of-network services are covered at usual, customary, and reasonable (UCR) rates.

** Comprehensive plan-year maximum applies only to basic and major care.

Summary of vision benefits

	VSP Provider	Non-VSP Provider
Biweekly Paycheck Deduction for Full-Time Employees	Employee only: \$2.00 Employee + spouse/DP: \$5.00 Employee + children: \$4.00 Employee + family: \$6.00	
Plan Features	Benefits are available on a rolling 12-month schedule, so you'll be eligible for a benefit 12 months after you last received it.	
Exam	\$10 copay \$20 copay for services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD); retinal screening for eligible members with diabetes	\$50 reimbursement*
Prescription Glasses	\$10 copay Frames: \$200 frame allowance (first pair) Lenses: Single vision, lined bifocal, lined trifocal	Frames: \$70 reimbursement* Lenses: \$50 single vision, \$75 lined bifocal, \$100 lined trifocal reimbursement*
Contact Lenses	Up to \$60 copay for contact lens exam (fitting and evaluation); \$300 allowance for contact lens materials	\$105 reimbursement*
Computer Glasses (for employees only)	\$10 copay; every 12 months; \$200 frame allowance	N/A
Laser Vision Care	\$0 copay; \$1,500 total allowance; once per lifetime	N/A

Note: The plan includes either frames and lenses **or** contact lenses once every 12 months.

* Copays apply.

This is intended to be a high-level summary of benefits. Please refer to the summary plan description (SPD) for detailed benefit information. If there is a discrepancy with any information herein provided, the provisions of the appropriate SPD will prevail.