Real benefits begin here.

Benefits At-A-Glance

2010-11 Plan Year

Benefit plan: CA

How to Benefit from Your Benefits

We know how hard it is to make sense of health care plans. Which is why we put together this comparison summary for the benefit year October 1, 2010 to September 30, 2011.

Everything here is also available online at www.hrpassport.com.

Questions? Comments?

Call us toll-free any time at 800-638-0461.

TriNet's benefits give your company a competitive advantage by helping you attract and retain employees. They are designed to cover employees and their families at every stage of life; they provide greater security, tax saving opportunities, and important financial protection.

TriNet's benefits are comparable to the benefits the largest US employers offer — and, they package the right products, management tools, and support to help you make the most of every benefits dollar.

TriNet's health plans are different because we offer guaranteed issues with no pre existing limitations and same-day coverage. Included in the offering is a broad range of plans, from affordable higher-deductible plans to more costly low-deductible plans. TriNet also offers regional plans and HMOs in select states to provide a greater level of choice to many employees.

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TriNet's health plans are different because we offer guaranteed issue with no pre existing condition limitations, no medical underwriting, and same-day coverage. Included in the offering is a broad range of plans, from affordable higher-deductible plans to more costly low-deductible plans. TriNet also offers regional plans and HMOs in select states to provide a greater level of choice to many employees.

Medical

	Blue Shield PPO 1500	Blue Shield PPO 1000	Blue Shield PPO 600	Blue Shield PPO 300	Blue Shield CDHP 2500
Regional Plan Names	Blue Shield PPO 1500	Blue Shield PPO 1000	Blue Shield PPO 600	Blue Shield PPO 300	Blue Shield CDHP 2500
Plan Locations	CA	CA	CA	CA	CA
Carrier Network	Blue Shield of California PPO	Blue Shield of California PPO	Blue Shield of California PPO	Blue Shield of California PPO	Blue Shield of California PPO
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	$1,500/person; $3,000/family	$1,000/person; $2,000/family	$600/person; $1,200/family	**In-Network:** $300/person; $600/family **Out-of-Network:** $600/person; $1,200/family	**In-Network:** $2,500/person; $5,000/family **Out-of-Network:** $5,000/person; $10,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $8,000person; $16,000/family	**In-Network:** $3,000/person; $6,000/family **Out-of-Network:** $6,000/person; $12,000/family	**In-Network:** $2,500/person; $5,000/family **Out-of-Network:** $5,000/person; $10,000family	**In-Network:** $2,000/person; $4,000/family **Out-of-Network:** $4,000/person; $8,000/family	**In-Network:** $5,000/person; $10,000/family **Out-of-Network:** $10,000/person; $20,000/family
Lifetime Benefits Maximum	$6 million	$6 million	$6 million	$6 million	$6 million
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	**In-Network:** $35/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered **Out-of-Network:** 60% covered after deductible
Vision Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable coinsurance
Hearing Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable coinsurance
Physician & Hospital Services					

Physician Office Visit	**In-Network:** $35/visit Specialist: $45/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit Specialist: $45/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit Specialist: $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit Specialist: $35/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Surgery Outpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $350/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $350/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $350/day	**In-Network:** 90% 70% covered after deductible, up to $350/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $350/day
Hospital Inpatient **Room and Board** **Surgery** **Anesthesia** **Drugs/Supplies**	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day
Emergency Room **(Copay waived if admitted)**	**In-Network:** 70% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 80% covered after deductible
Urgent Care	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	**In-Network:** $35 for initial visit, then 90% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient **(Applicable deductibles and copays apply)**	**In-Network:** $35/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Chiropractic **(Subject to visit limits)**	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Physical Therapy and Speech Therapy **(Subject to visit limits)**	**In-Network:** Physical therapy: $35/visit Speech therapy: $20/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** Physical therapy: $45/visit Speech therapy: $20/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** Physical therapy: $40/visit Speech therapy: $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** Physical therapy: $35/visit Speech therapy: $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 20% covered after deductible **Out-of-Network:** 60% covered after deductible
Mental Health					

Mental Health – Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day
Mental Health – Outpatient	**In-Network:** $35 – $45/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30 – $45/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $25 – $40/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $20 – $35/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Substance Abuse					
Substance Abuse – Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day
Substance Abuse – Outpatient	**In-Network:** $35 – $45/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30 – $45/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $25 – $40/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $20 – $35/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$35/$50	$10/$35/$50	$10/$30/$50	$10/$35/$50	$10/$35/$55
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$70/$100	$20/$70/$100	$20/$60/$100	$20/$70/$100	$30/$70/$110
Self-Injectables	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization

Medical

	Blue Shield HMO 30	Blue Shield HMO 20	Kaiser HMO 30 CA	Kaiser HMO 20 CA
Regional Plan Names	Blue Shield HMO 30	Blue Shield HMO 20	Kaiser CA HMO 30	Kaiser CA HMO 20
Plan Locations	CA	CA	CA	CA
Carrier Network	Access+ HMO	Access+ HMO	Kaiser HMO	Kaiser HMO
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	None	None	$1,000/person; $2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	$2,000/person; $4,000/family	$2,000/person; $4,000/family	$1,500/person; $3,000/family
Lifetime Benefits Maximum	None	None	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	$30/visit	$20/visit	100% covered	100% covered
Vision Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	100% covered	100% covered
Hearing Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	100% covered	100% covered
Physician & Hospital Services				
Physician Office Visit	PCP: $30/visit Specialist: $45/visit	PCP: $20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit
Surgery Outpatient	Hospital: 100% covered after $300/surgery Ambulatory center: 100% covered after $150/surgery	Hospital: 100% covered after $150/surgery Ambulatory center: 100% covered after $100/surgery	80% covered after deductible	$35/procedure
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	100% covered after $500/admission	100% covered after $350/admission	80% covered after deductible	100% covered after $250/admission
Emergency Room (Copay waived if admitted)	$150/visit	$100/visit	80% covered after deductible	$100/visit
Urgent Care	Within service area: $30/visit Outside of service area: $50/visit	Within service area: $20/visit Outside of service area: $50/visit	$30/visit	$20/visit
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	Prenatal: 100% covered Inpatient: 100% covered after $500/admission	Prenatal: 100% covered Inpatient: 100% covered after $350/admission	80% covered after deductible	100% covered after $250/admission
Other Medical Services (Including Alternative Care)				

X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	100% covered	100% covered	$10/encounter after deductible	
Chiropractic (Subject to visit limits)	**In-Network:** $10/visit **Out-of-Network:** Not covered (Up to 30 visits/year)	**In-Network:** $10/visit **Out-of-Network:** Not covered (Up to 30 visits/year)	$15/visit (up to 20 visits/calendar year)	$15/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$30/visit	$20/visit	$30/visit after deductible	$20/visit
Mental Health				
Mental Health – Inpatient	100% covered after $500/admission	100% covered after $350/admission	80% covered after deductible	100% covered after $250/admission
Mental Health – Outpatient	$30 – $45/visit	$20 – $35/visit	Individual session: $30/visit Group session: $15/visit	Individual session: $20/visit Group session: $10/visit
Substance Abuse				
Substance Abuse – Inpatient	100% covered after $500/admission	100% covered after $350/admission	80% covered after deductible	100% covered after $250/admission
Substance Abuse – Outpatient	$30 – $45/visit	$20 – $35/visit	Individual session: $30/visit Group session: $5/visit	Individual session: $20/visit Group session: $5/visit
Prescription Drugs				
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$35/$50	$10/$35/$50	Up to 30-day supply: $10/$35/full retail 31- to 60-day supply: $20/ $70/full retail 61- to 100-day supply: $30/$105/full retail	$10/$35/full retail
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$70/$100	$20/$70/$100	31- to 60-day supply: $10/$20/full retail 61- to 100-day supply: $35/$70/full retail	$20/$70/full retail (Up to 100-day supply)
Self-Injectables	20% of prescription cost, up to $150/prescription, with prior authorization	20% of prescription cost, up to $150/prescription, with prior authorization	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Kaiser for more details

Dental

	Aetna Dental 50	Delta Dental 50	MetLife Dental 50	Aetna Dental 100
Regional Plan Names	• Aetna Dental 50 Group • Aetna Dental 50 Optional	• Delta Dental 50 Group • Delta Dental 50 Optional	• MetLife Dental 50 Group • MetLife Dental 50 Optional	• Aetna Dental 100 Group • Aetna Dental 100 Optional
Plan Locations	Nationwide*	Nationwide, except FL*	CA	Nationwide*
Carrier Network	Dental PPO/PDN with PPO II Network	Delta Dental PPO Network	MetLife Preferred Dentist Program (PDP) Network	Dental PPO/PDN with PPO IINetwork
Plan Features				
Notes on Availability Service areas may not be available in all ZIP codes for DMO/PPO plans	You can use any licensed dentist – you receive adiscount when you use a dentist who participatesin the PPO network	You can use any licensed dentist – you receive adiscount when you use a dentist who participatesin the PPO network	You can use any licensed dentist – you receive adiscount when you use a dentist who participatesin the PPO network	You can use any licensed dentist – you receive adiscount when you use a dentist who participatesin the PPO network
Calendar-Year Deductible (Required before plan pays benefits)	**In-Network:** $50/person; $150/family **Out-of-Network:** $100/person; $300/family	**In-Network:** $50/person; $150/family **Out-of-Network:** $100/person; $300/family	**In-Network:** $50/person; $150/family **Out-of-Network:** $100/person; $300/family	**In-Network:** $100/person; $300/family **Out-of-Network:** $150/person; $450/family
Calendar-Year Benefit Maximum	$1,500/person	$1,500/person	$1,500/person	$1,000/person
Diagnostic & Preventive				
Routine Checkups, Cleanings, X-rays, and Diagnostic Visits	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered
Basic Services				
Fillings and Oral Surgery	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible
Periodontics	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible
Endodontics	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible
Crowns & Cast Restorations				
Crowns, Inlays, Onlays, and Bridges	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible
Prosthodontics				
Dentures	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible
Orthodontics				
Orthodontics	**In-Network:** 50% covered after $50 orthodontia deductible **Out-of-Network:** 50% covered after $50 orthodontia deductible (Up to $1,500/person/lifetime)	**In-Network:** 50% covered after $50 orthodontia deductible **Out-of-Network:** 50% covered after $50 orthodontia deductible (Up to $1,500/person/lifetime)	**In-Network:** 50% covered after $50 orthodontia deductible **Out-of-Network:** 50% covered after $50 orthodontia deductible (Up to $1,500/person/lifetime)	Not available

* In Texas, the coverage level for out-of-network benefits is the same as for in-network benefits for the Aetna and MetLife dental plans due to state regulations.
** Includes initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The treatment phase includes the initial construction, placement, and adjustments to retainers and office visits for a maximum of 24 months. Eligible children are dependent, unmarried children up to age 19, or 25 if full-time students. Some state rules may differ.

Dental

	Delta Dental 100	MetLife Dental 100	Aetna DMO
Regional Plan Names	• Delta Dental 100 Group • Delta Dental 100 Optional	• MetLife Dental 100 Group • MetLife Dental 100 Optional	• Aetna DMO Group • Aetna DMO Optional
Plan Locations	Nationwide, except FL*	CA	Nationwide, except AL, AK, AR, LA, ME, MS, MT, ND, NH, SC, SD, VT, WY
Carrier Network	Delta Dental PPO Network	MetLife Preferred Dentist Program(PDP) Network	Dental Maintenance Organization
Plan Features			
Notes on Availability **Service areas may not be available in all ZIP codes for DMO/PPO plans**	You can use any licensed dentist – you receive adiscount when you use a dentist who participatesin the PPO network	You can use any licensed dentist – you receive adiscount when you use a dentist who participatesin the PPO network	No benefits are available outside the DMO network of providers
Calendar-Year Deductible (Required before plan pays benefits)	**In-Network:** $100/person; $300/family **Out-of-Network:** $150/person; $450/family	**In-Network:** $100/person; $300/family **Out-of-Network:** $150/person; $450/family	None
Calendar-Year Benefit Maximum	$1,000/person	$1,000/person	None
Diagnostic & Preventive			
Routine Checkups, Cleanings, X-rays, and Diagnostic Visits	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered (Limitations may apply – refer to the EOC booklet for details)
Basic Services			
Fillings and Oral Surgery	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	$0 – $75/visit depending on the services rendered
Periodontics	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	$10 – $140/visit depending on the services rendered
Endodontics	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	$0 – $246/visit depending on the services rendered
Crowns & Cast Restorations			
Crowns, Inlays, Onlays, and Bridges	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible	$0 – $220/visit depending on the services rendered
Prosthodontics			
Dentures	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible	$10 – $240/visit depending on the services rendered
Orthodontics			
Orthodontics	Not available	Not available	$30 – $1,545 for 24-month treatment plan**

* In Texas, the coverage level for out-of-network benefits is the same as for in-network benefits for the Aetna and MetLife dental plans due to state regulations.
** Includes initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The treatment phase includes the initial construction, placement, and adjustments to retainers and office visits for a maximum of 24 months. Eligible children are dependent, unmarried children up to age 19, or 25 if full-

time students. Some state rules may differ.

Vision

	Aetna Vision Preferred Powered by EyeMed High Plan	Aetna Vision Preferred Powered by EyeMed Low Plan	Vision Service Plan High Plan	Vision Service Plan Low Plan
Regional Plan Names	• **Aetna Vision Preferred Powered by EyeMed High Plan**	• **Aetna Vision Preferred Powered by EyeMed Low Plan**	• **Vision Service Plan High Plan**	• **Vision Service Plan Low Plan**
Plan Locations	Nationwide	Nationwide	Nationwide	Nationwide
Carrier Network	Aetna through EyeMed	Aetna through EyeMed	VSP Network	VSP Network
Plan Features				
Notes on Availability	None	None		
Copay Schedule	**In-Network:** Exam: $10 Materials: $25 **Out-of-Network:** Exam: $10 Materials: $25	**In-Network:** Exam: $10 Materials: $25 **Out-of-Network:** Exam: $10 Materials: $25	**In-Network:** Exam: $10 Materials: $25 **Out-of-Network:** Exam: $10 Materials: $25	**In-Network:** Exam: $10 Materials: $25 **Out-of-Network:** Exam: $10 Materials: $25
Frequency of Services				
Eye Examinations	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Replacement Lenses	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Frames	Every 12 months	Every 24 months	Every 12 months	Every 24 months
Exam				
Diagnostic Eye Exam	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $50 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $45 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $50 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $45 covered after copay
Lenses				
Single Vision Lenses (Depends on prescription and add-ons)	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $50 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $45 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $50 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $45 covered after copay
Bifocal Lenses (Depends on prescription and add-ons)	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $75 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $65 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $75 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $65 covered after copay
Trifocal Lenses (Depends on prescription and add-ons)	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $100 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $85 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $100 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $85 covered after copay
Frames				
Moderate Frames (Depends on style and brand)	**In-Network:** Up to $150 covered after copay, then 20% discount **Out-of-Network:** Up to $75 covered after copay	**In-Network:** Up to $130 covered after copay, then 20% discount **Out-of-Network:** Up to $47 covered after copay	**In-Network:** Up to $150 covered after copay, then 20% discount **Out-of-Network:** Up to $75 covered after copay Costco: Up to $100 covered after copay	**In-Network:** Up to $130 covered after copay, then 20% discount **Out-of-Network:** Up to $47 covered after copay
Contact Lenses				

Contact Lenses **(Depends on prescription and add-ons)**	**In-Network:** 100% covered after copay if medically necessary; up to $200 covered if elective **Out-of-Network:** Up to $210 coverd after copay if medically necessary; up to $200 covered if elective	**In-Network:** 100% covered after copay if medically necessary; up to $120 covered if elective **Out-of-Network:** Up to $150 covered after copay if medically necessary; up to $105 covered if elective	**In-Network:** 100% covered after copay if medically necessary; up to $200 covered if elective, then 15% discount **Out-of-Network:** Up to $210 covered after copay if medically necessary; up to $200 covered after copay if elective	**In-Network:** 100% covered after copay if medically necessary; up to $120 covered if elective, then 15% discount **Out-of-Network:** Up to $150 covered after copay if medically necessary; up to $105 covered after copay if elective

Expand Your Benefits Package With More Options

In addition to our high-caliber package of medical, dental, vision, and life insurance, TriNet also offers a wide range of optional benefits and services. Here are some of the programs that reward your employees and position your organization as a destination for top talent.

- **Voluntary Insurance and Legal Plans:** MetLife offers a suite of high-impact services such as Long-Term Care Insurance, Pet Insurance, Auto and Home Insurance, and Group Legal Services.
- **Retirement Assistance and Financial Services:** MetLife also provides customizable income annuities that guarantee retirement income for life in their Guaranteed Income program. The MetLife bank offers access to a full range of financial services including savings accounts, money market accounts, loans, and more.
- **Supplemental Insurance Plans:** One of the most respected insurance companies in the country, Aflac provides supplemental insurance on a pre-tax basis to cover out-of-pocket medical expenses, non-medical costs, and loss of income.
- **Credit Union:** Corporate America Family Credit Union (CAFCU) offers great money-saving and convenient services such as free checking with a VISA® credit card, loan-by-phone, online account access, loan payment protection, and more.
- **Flexible Spending Accounts (FSAs):** Participants contribute up to $5,000 each year to a Health Care and/or Dependent Day Care FSA, allowing them to pay for eligible health care and dependent day care expenses (such as medical co-payments or day care costs) on a pre-tax basis.
- **Employee Assistance Program:** FEI Behavioral Health provides employees with confidential counseling and referral services for alcohol and drug abuse, child and elder care resources, emotional and stress-related concerns, financial and credit consultation, family and relationship problems.
- **Commuter Benefits:** WageWorks allows employees to pay for commuting costs such as parking and public transit with pre-tax dollars, putting as much as 40% of routine commuting expenses back into their pocket.

MetLife®

Aflac™

CORPORATE AMERICA FAMILY CREDIT UNION

FEI BEHAVIORAL HEALTH

WageWorks®

CONTINUES ►

TriNet
Ambitions realized™

- **Recreational Discounts:** Offering promotions and discounts for over 25,000 merchants nationwide, TriNet Perks is a comprehensive employee discount purchasing plan that helps retain and motivate your employees.

- **Executive Supplemental Disability Program:** MetLife underwrites this plan to help maximize after-tax income in the event of an illness or injury. The program includes the following advantages: extra income protection benefit of up to $10,000 per month, income tax free benefit, and premiums paid via payroll deduction. And it is available to employees earning a minimum of $200,000 a year, and who participate in a Group or Optional Long Term Disability plan.

MetLife®

- **Medical Benefits Abroad (MBA):** This plan from CIGNA International protects traveling employees on approved international business trips (of less than 6 months' length) for injury or illness. The MBA coverage will pay medical or surgical expenses incurred and will end once the business trip is completed.

CIGNA International
Expatriate Benefits

To find out more about the voluntary benefits and services that can turn your company into destination for in-demand talent, contact your TriNet representative at 888-874-6388 or visit www.trinet.com.