

YOUR 2017 MEDICAL PLANS

2017 MEDICAL PLAN COMPARISON

| | NVIDIA HSA PLAN | | NVIDIA HSA PLUS | | NVIDIA PPO | | KAISER PERMANENTE HMO PLAN (CA) | KAISER PERMANENTE HSA PLAN |
|---------------------------------------|--|--|---|--|--|--|--|--|
| | WHAT YOU PAY in-network | WHAT YOU PAY out-of-network | WHAT YOU PAY in-network | WHAT YOU PAY out-of-network | WHAT YOU PAY in-network | WHAT YOU PAY out-of-network | WHAT YOU PAY in-network only | WHAT YOU PAY in-network only |
| Annual Deductible | Individual: \$5,000 Individual + 1: \$7,500 Family: \$10,000 | Individual: \$5,000 Individual + 1: \$7,500 Family: \$10,000 | Individual: \$1,300 Individual + 1: \$2,600 Family: \$3,350 | Individual: \$1,800 Individual + 1: \$2,700 Family: \$3,600 | Individual: \$500 Maximum per family: \$1,000 | Individual: \$1,000 Maximum per family: \$1,000 | \$0 | Individual: \$1,500 Maximum per family: \$3,000 |
| NVIDIA Annual HSA Contribution | \$2,000/\$2,500/\$3,000 (paid quarterly) | | \$1,000/\$1,250/\$1,500 (paid quarterly) | | \$0 | | \$0 | \$1,000/\$1,250/ \$1,500 (paid quarterly) |
| Annual Out-Of-Pocket Maximum | Individual: \$6,450 Individual + 1: \$9,700 Family: \$12,900 | Individual: \$6,450 Individual + 1: \$9,700 Family: \$12,900 | Individual: \$2,500 Individual + 1: \$3,750 Family: \$5,000 | Individual: \$5,000 Individual + 1: \$7,500 Family: \$10,000 | Individual: \$2,500 Family: \$5,000 | Individual: \$4,000 Family: \$8,000 | Individual: \$1,500 Family: \$3,000 | Individual: \$3,000 Family: \$6,000 |
| Preventive Care | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Office Visit | 10% after deductible | 30% of R&C* fees after deductible | 10% after deductible | 30% of R&C fees after deductible | Doctor: \$20 copay per visit Specialist: \$25 copay per visit | 30% of R&C fees after deductible | \$10 copay per visit | 10% after deductible |

More Ways to Get Care

| | HEAL—HOME DOCTOR VISITS BAY AREA ONLY | | | CROSSOVER—HEALTH CENTER < 1 MILE FROM SANTA CLARA CAMPUS | |
|---------------------------|--|------------|------------------------------------|--|---------------------------------|
| | WHAT YOU PAY | | | WHAT YOU PAY | |
| | NVIDIA HSA Plus & NVIDIA HSA | NVIDIA PPO | Kaiser HMO and HSA Or No Insurance | NVIDIA HSA Plus & NVIDIA HSA | NVIDIA PPO |
| Annual Physical | \$0 | | | \$99 per person/per visit | \$0 (includes routine eye exam) |
| Illness/Injury | \$99 per visit until deductible is met 10% after deductible | \$20 copay | \$99 per person/per visit | \$90 | \$20 |
| Annual Flu Vaccine | \$0 | | | \$30 per shot/per person | \$25 |

* Reasonable and customary

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| Emergency Room | 10% coinsurance after deductible | | 10% coinsurance after deductible | | \$125 copay per visit (copay waived if admitted) | \$125 copay per visit (copay waived if admitted) | \$100 copay per visit (copay waived if admitted) | 10% coinsurance after deductible |
| Inpatient Hospital Stay Or Surgery | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | \$0 | 10% after deductible |
| Maternity | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | No charge-prenatal care exams (\$0 copay with hospital admission) | 10% after deductible |
| Speech, Hearing, Occupational, Or Physical Therapy | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | \$0 after doctor or specialist office visit copay | 30% R&C fees after deductible | \$10 copay per visit (\$0 copay with hospital admission) | 10% after deductible |
| | You get 30 visits per service per year for physical/occupational/speech therapies (hearing aids covered, 2 per 24 months, no maximum) | | You get 30 visits per service per year for physical/occupational/speech therapies (hearing aids covered, 2 per 24 months, no maximum) | | You get 30 visits per service per year for physical/occupational/speech therapies (hearing aids covered, 2 per 24 months, no maximum) | | | |
| Acupuncture And Chiropractic Services | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | \$0 after doctor or specialist office visit copay | 30% R&C fees after deductible | Acupuncture: \$10 copay Chiropractic: \$10 copay per visit | Chiropractic: 10% after deductible |
| | You get a maximum of 30 visits per calendar year. Medical necessity required. | | You get a maximum of 30 visits per calendar year. Medical necessity required. | | You get a maximum of 30 visits per calendar year. Medical necessity required. | | Combined Acupuncture & Chiropractic: Maximum of 30 visits per calendar year | Chiropractic: Maximum of 20 visits per calendar year |
| Outpatient Mental Health Or Substance Use Disorder | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | \$20 copay | 30% R&C fees after deductible | \$10 copay per individual visit \$5 copay per group visit | 10% coinsurance after deductible |
| Inpatient Mental Health Or Substance Use Disorder | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | 10% after deductible | 30% R&C fees after deductible | \$0 | 10% after deductible |

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| PRESCRIPTION DRUG BENEFITS (prescriptions apply to the out-of-pocket maximum) | | | | | | | | |
| Retail | Generic Preventive: 0% Generic: 10% after deductible for a 30-day supply Preferred brand-name: 10% after deductible for a 30-day supply Non-preferred brand-name: 10% after deductible | Generic Preventive: 0% Preferred brand-name, & Non-preferred brand-name Preventive: 30% R&C fees after deductible | Generic Preventive: 0% Generic: 10% after deductible for a 30-day supply Preferred brand-name: 10% after deductible for a 30-day supply Non-preferred brand-name: 10% after deductible | Generic Preventive: 0% Preferred brand-name, & Non-preferred brand-name Preventive: 30% R&C fees after deductible | Generic: \$10 copay for a 30-day supply Preferred brand-name: \$25 copay for a 30-day supply Non-preferred brand-name: \$50 copay for a 30-day supply | 30% R&C fees | Generic: \$10 copay for a 30-day supply Brand-name: \$20 copay for a 30-day supply | Generic: \$10 copay for a 30-day supply after deductible Brand-name: \$30 copay for a 30-day supply after deductible |
| Mail Order | Generic Preventive: 0% Generic: 10% after deductible for a 90-day supply Preferred brand-name: 10% after deductible for a 90-day supply Non-preferred brand-name: 10% after deductible | Generic Preventive: 0% Preferred brand-name, & Non-preferred brand-name Preventive: 30% R&C fees after deductible | Generic Preventive: 0% Generic: 10% after deductible for a 90-day supply Preferred brand-name: 10% after deductible for a 90-day supply Non-preferred brand-name: 10% after deductible | Generic Preventive: 0% Preferred brand-name, & Non-preferred brand-name Preventive: 30% R&C fees after deductible | Generic: \$20 copay for a 90-day supply Preferred brand-name: \$50 copay for a 90-day supply Non-preferred brand-name: \$100 copay for a 90-day supply | 30% R&C fees | Generic: \$20 copay for a 100-day supply Brand-name: \$40 copay for a 100-day supply | Generic: \$20 copay for a 100-day supply after deductible Brand-name: \$60 copay for a 100-day supply after deductible |