YOUR 2019 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	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: $1,350 Individual + 1: $2,700 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: $2,000	$0	Individual: $1,500 Maximum per family: $3,000 ($2,700 for any single family member)
NVIDIA Annual HSA Contribution	$2,000/$2,500/$3,000		$1,000/$1,250/$1,500		$0		$0	$1,000/$1,250/ $1,500
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: $3,000 Family: $6,000	Individual: $5,000 Family: $10,000	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000
Preventive Care	$0	$0	$0	$0	$0	$0	$0	$0

More Ways To Get Care

	CROSSOVER—HEALTH CENTER < 1 MILE FROM SANTA CLARA CAMPUS		KAISER ONSITE MOBILE CLINIC	
	WHAT YOU PAY		WHAT YOU PAY	
	NVIDIA HSA Plus and NVIDIA HSA	NVIDIA PPO	Kaiser HMO	Kaiser HSA
Annual Physical	$0		$0	
Illness/Injury	$90	$20	$20	10% after deductible
Annual Flu Vaccine	$0		$0	

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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: $30 copay per visit	30% of R&C* fees after deductible	$20 copay per visit	10% after deductible
Virtual Care	$42 per visit; 10% ($4.20) after deductible	Not covered	$42 per visit; 10% ($4.20) after deductible	Not covered	$10 copay	Not covered	$0	$0 email, Nurse Advice Line, kp.org $20–$130 for scheduled phone and video visits before deductible; $0 after deductible
Urgent Care	10% after deductible		10% after deductible		$30 copay		$20 copay	10% after deductible
Emergency Room	10% coinsurance after deductible		10% coinsurance after deductible		$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)	$125 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	$200	10% after deductible
In Vitro Fertilization	Unlimited; no infertility diagnosis required; egg freezing also covered (but not storage)	Not covered	Unlimited; no infertility diagnosis required; egg freezing also covered (but not storage)	Not covered	Unlimited; no infertility diagnosis required; egg freezing also covered (but not storage)	Not covered	$20 copay (one cycle)	50% (one cycle)
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 for prenatal care exams ($200 copay with hospital admission)	10% after deductible

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Speech, Hearing, Occupational, Or Physical Therapy	10% after deductible	30% R&C* fees after deductible	10% after deductible	30% R&C* fees after deductible	$20 primary doctor or $30 specialist office visit copay	30% R&C* fees after deductible	$20 copay per visit	10% after deductible
	A maximum of 100 visits per service per year. Therapy must be medically necessary, and review is required after 12 visits.		A maximum of 100 visits per service per year. Therapy must be medically necessary, and review is required after 12 visits.		A maximum of 100 visits per service per year. Therapy must be medically necessary, and review is required after 12 visits.			
Acupuncture And Chiropractic Services	10% after deductible	30% R&C* fees after deductible	10% after deductible	30% R&C* fees after deductible	$30 specialist office visit copay	30% R&C* fees after deductible	Acupuncture: $15 copay Chiropractic: $15 copay	Chiropractic: $10 after deductible
	You get a maximum of 30 visits per calendar year. Medical necessity required after 12 visits.		You get a maximum of 30 visits per calendar year. Medical necessity required after 12 visits.		You get a maximum of 30 visits per calendar year. Medical necessity required after 12 visits.		Combined Acupuncture and 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	$20 copay per individual visit $10 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	$200	10% after deductible
PRESCRIPTION DRUG BENEFITS (prescriptions apply to the out-of-pocket maximum)								

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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 and 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 and 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: $30 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 and 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 and 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: $60 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

* Reasonable and customary