

YOUR 2020 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: \$1,400 Individual + 1: \$2,800 Family: \$3,350	Individual: \$1,800 Individual + 1: \$2,800 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 (\$2,800 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 (\$3,000 for any single family member)
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 \$0 after deductible for scheduled telephone visits and video visits
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 copay per admission	10% after deductible
In Vitro Fertilization	10% after deductible Unlimited; no infertility diagnosis required; egg freezing also covered (but not storage)	Not covered	10% after deductible Unlimited; no infertility diagnosis required; egg freezing also covered (but not storage)	Not covered	10% after deductible Unlimited; no infertility diagnosis required; egg freezing also covered (but not storage)	Not covered	\$20 copay (covered up to 3 cycles)	50% after deductible (covered up to 3 cycles)
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 No charge for scheduled prenatal care exams

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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	Professional fees: 10% R&C* fees after deductible; all other services: 30% R&C* fees after deductible	10% after deductible	Professional fees: 10% R&C* fees after deductible; all other services: 30% R&C* fees after deductible	\$20 copay	Professional fees: 10% R&C* fees after deductible; all other services: 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 copay per admission	10% after deductible
PRESCRIPTION DRUG BENEFITS (prescriptions apply to the out-of-pocket maximum)								

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Retail	<p>Generic Preventive: 0%</p> <p>Generic: 10% after deductible for a 30-day supply</p> <p>Preferred brand-name: 10% after deductible for a 30-day supply</p> <p>Non-preferred brand-name: 10% after deductible</p>	<p>Generic Preventive: 0%</p> <p>Preferred brand-name and Non-preferred brand-name Preventive: 30% R&C* fees after deductible</p>	<p>Generic Preventive: 0%</p> <p>Generic: 10% after deductible for a 30-day supply</p> <p>Preferred brand-name: 10% after deductible for a 30-day supply</p> <p>Non-preferred brand-name: 10% after deductible</p>	<p>Generic Preventive: 0%</p> <p>Preferred brand-name and Non-preferred brand-name Preventive: 30% R&C* fees after deductible</p>	<p>Generic: \$10 copay for a 30-day supply</p> <p>Preferred brand-name: \$25 copay for a 30-day supply</p> <p>Non-preferred brand-name: \$50 copay for a 30-day supply</p>	<p>30% R&C* fees</p>	<p>Generic: \$10 copay for a 30-day supply</p> <p>Brand-name: \$30 copay for a 30-day supply</p>	<p>Generic: \$10 copay for a 30-day supply after deductible</p> <p>Brand-name: \$30 copay for a 30-day supply after deductible</p>
Mail Order	<p>Generic Preventive: 0%</p> <p>Generic: 10% after deductible for a 90-day supply</p> <p>Preferred brand-name: 10% after deductible for a 90-day supply</p> <p>Non-preferred brand-name: 10% after deductible</p>	<p>Generic Preventive: 0%</p> <p>Preferred brand-name and Non-preferred brand-name Preventive: 30% R&C* fees after deductible</p>	<p>Generic Preventive: 0%</p> <p>Generic: 10% after deductible for a 90-day supply</p> <p>Preferred brand-name: 10% after deductible for a 90-day supply</p> <p>Non-preferred brand-name: 10% after deductible</p>	<p>Generic Preventive: 0%</p> <p>Preferred brand-name and Non-preferred brand-name Preventive: 30% R&C* fees after deductible</p>	<p>Generic: \$20 copay for a 90-day supply</p> <p>Preferred brand-name: \$50 copay for a 90-day supply</p> <p>Non-preferred brand-name: \$100 copay for a 90-day supply</p>	<p>30% R&C* fees</p>	<p>Generic: \$20 copay for up to a 100-day supply</p> <p>Brand-name: \$60 copay for up to a 100-day supply</p>	<p>Generic: \$20 copay for up to a 100-day supply after deductible</p> <p>Brand-name: \$60 copay for up to a 100-day supply after deductible</p>

* Reasonable and customary