NVIDIA PRESCRIPTION DRUG SUMMARY PLAN DESCRIPTION

Prescription Drug Coverage for You and Your Dependents

Effective January 1, 2021

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IMPORTANT NOTICE REGARDING CERTAIN EXTENDED PLAN DEADLINES DUE TO THE COVID-19 PANDEMIC

In accordance with Department of Labor guidance, jointly issued with the Department of the Treasury and Internal Revenue Service (the "Joint Notice"), the Plan will disregard any days within the "Outbreak Period"[1] when determining certain Plan periods and deadlines, for all ERISA participants, COBRA qualified beneficiaries, and claimants. Specifically, the following Plan deadlines have been temporarily extended due to the COVID-19 pandemic:

1. The deadline to request HIPAA special enrollment (e.g., birth, adoption, etc.);
2. The deadline to elect COBRA continuation coverage;
3. The deadline to make COBRA continuation of coverage premium payments;
4. The deadline to notify the COBRA Administrator of a COBRA Qualifying Event;
5. The deadline for the Plan Administrator to provide a COBRA election notice to qualified beneficiaries; and
6. The deadlines to submit ERISA benefit claims, appeals, and requests for external review.

Accordingly, if you experience one of the following ERISA deadlines, you will have until the earlier of:

- One year from the date of the original deadline, or
- The end of the Outbreak Period[1].

These temporarily extended Plan deadlines will prevail in case of any conflict with the Plan terms. Unless otherwise specified herein, all other provisions of the Plan continue to apply.

[1] The Outbreak Period is the period from March 1, 2020 until 60 days after the end of the National Emergency period (or other date announced by the Department of Labor, Department of the Treasury, the Internal Revenue Service, or Plan Administrator in the future). As of the time of the restatement of this SPD, the federal government has not yet announced the end of the National Emergency period.

OVERVIEW

This Summary Plan Description or SPD summarizes the Prescription Drug benefit component of the NVIDIA Welfare Plan as in effect on January 1, 2021. NVIDIA has chosen to partner with CVS/Caremark to administer your Prescription Drug benefits by processing your claims and allowing you to utilize CVS/Caremark's Pharmacy Network.

It is important to understand that your Prescription Drug coverage is a component of the medical plan you have chosen for yourself and your Dependents (if any). The cost of your Prescription Drug coverage is included in the cost of your medical plan – you do not pay a separate additional amount for Prescription Drug coverage. Although Cigna administers your medical plan, CVS/Caremark administers your Prescription Drug benefits. You are eligible to participate in this Prescription Drug Benefit Plan (the "Plan") if you are enrolled in one of the following medical plans offered by NVIDIA:

- NVIDIA PPO Plan
- NVIDIA HSA Plus Plan
- NVIDIA HSA Plan

NVIDIA reserves the right to change or terminate this Prescription Drug component of the NVIDIA Welfare Plan in any way and at any time.

IMPORTANT INFORMATION

Explanation of Terms

You will find terms starting with capital letters throughout this document. To help you understand your benefits, most of these are defined in the Definitions section at the end of this SPD. This SPD describes the benefits offered under the Prescription Drug component of the NVIDIA Welfare Plan and is either referred to as the "Prescription Drug Plan" or the "Plan" in this SPD.

Prescription Drug Coverage and Your Medical Plan

If you have elected one of the medical plans administered by Cigna, this SPD applies to your Prescription Drug coverage. With CVS/Caremark, you can:

- Purchase a 90-day supply in person, at the mail-order rate when you use a CVS pharmacy.
- Access a vast network of Participating Pharmacies, including Walmart and Walgreens.
- Sign up for home delivery and the ReadyFill service to manage your mail-order Prescriptions. The service automatically refills your medications and contacts your doctor before your Prescription runs out.
- Use CVS/Caremark's mobile app to easily manage Prescription fills and refills. You can download it from the iTunes store or Google Play.

The Schedules

The Schedules on pages 9 through 15 of this SPD summarize the Prescription Drug benefits payable under each medical plan option. For more detail on different aspects of your Prescription Drug benefit coverage, refer to the appropriate section listed in the Table of Contents.

Importance of Participating Pharmacies

When you select a Participating Pharmacy, this Plan pays a greater share of the cost than if you select a non-Participating Pharmacy because Participating Pharmacies have agreed to contract with CVS/Caremark to lower costs. Consult your Pharmacy Guide at www.caremark.com for a list of Participating Pharmacies in your area. Participating Pharmacies are committed to providing you and your Dependents appropriate care while lowering costs.

Prior Authorization

Some medications are not covered unless you first receive approval through a coverage review (also known as a prior authorization). This review used plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective.

There are other medications that may be covered, but with limits (for example, only a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, CVS/Caremark asks your doctor for more information than what is on the prescription before the medication may be covered under your plan.

Step Therapy

When you are prescribed a Prescription Drug, this Plan may require that you begin with the most cost-effective and safest drug therapy before progressing to a more costly or riskier drug therapy as determined by the CVS/Caremark team of pharmacists. This generally means that you will be required to try a generic medication first (if one is available) before you are able to try a preferred brand or a non-preferred brand. The Step Therapy program only applies to new Prescriptions.

Retail Pharmacy Limits

It is important to know that you must use the Maintenance Choice program (described on page 14 of this SPD) to fill your maintenance medications as a 90-day supply, through either a CVS retail pharmacy or CVS Mail Service pharmacy. Over-the-counter preventive medications are covered with a Prescription.

Dispense as Written

If you choose a preferred/non-preferred brand name drug when an exact FDA approved generic equivalent is available, you are responsible for the applicable copay/coinsurance for the brand name drug in addition to the difference in cost between the selected drug and the generic equivalent of that drug (unless the Doctor designates on the Prescription Drug "dispense as written" or otherwise indicates that generic substitution is not permissible).

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU AND YOUR DEPENDENT(S)

Eligible Employees

Eligible Employees are full-time or part-time employees or interns scheduled to work at least 20 hours per week and enrolled in one of the following medical plan options under the NVIDIA Welfare Plan:

- NVIDIA PPO Plan
- NVIDIA HSA Plus Plan
- NVIDIA HSA Plan

The following employees are excluded from coverage under the Plan:

- any leased employee;
- any individual employed by NVIDIA pursuant to a written agreement between NVIDIA and an agency or other third party with respect to a specific job assignment or project, whether or not such individual is a leased employee;
- any individual who is specifically described in NVIDIA's payroll systems as a temporary employee;
- any individual not on NVIDIA's United States payroll;
- any individual whose employment is governed by a collective bargaining agreement; and
- any non-resident alien.

Furthermore, it is expressly intended that individuals not treated as common law employees by NVIDIA or a member of its controlled group, as identified by a specific job code or work status code, are to be excluded from Plan participation even if a court or administrative agency subsequently determines that such individuals are common law employees of NVIDIA and not independent contractors.

No person may be covered as a Dependent of more than one Eligible Employee. You will only be eligible to cover your Dependent(s) if you are also covered.

Enrollment Process

The Prescription Drug coverage described in this SPD is provided automatically if you enroll yourself and your Dependent(s) in one of the medical plan options administered by CIGNA. You may enroll for medical/Prescription Drug coverage for yourself and your Dependents by completing the required online benefits enrollment process. You must also give NVIDIA permission during the enrollment process to deduct contributions from your pay for medical coverage under the NVIDIA Cafeteria Plan. NVIDIA will determine the amount of your required contribution for medical coverage which also includes the cost of your Prescription Drug coverage.

Medical/Prescription Drug coverage is offered during NVIDIA's annual open enrollment period. Subject to the rules of this Plan, you may enroll yourself and your Dependents for medical/Prescription Drug coverage only when you are first eligible, during an annual open enrollment period or if you have a qualifying event or become eligible for special enrollment under HIPAA.

Coverage for a Dependent child may be continued past age 26 if the child is permanently disabled and incapable of self-sustaining employment because of a mental or physical disability. Disabled Dependents must be approved by Social Security and have been disabled prior to their 18th birthday, and proof of disabled status must be submitted upon request.

Coverage will continue while such child:

- remains incapable of self-sustaining employment because of a mental or physical disability; and
- continues to qualify as a child, except for the Plan's age limit.

Date When Coverage Takes Effect Enrollment When First Eligible

If you complete the enrollment process within 31 days of becoming eligible for medical/Prescription Drug coverage, your coverage will take effect on the date you become eligible. You and your Dependents, if any, will not be enrolled for coverage if you do not make an election within 31 days of the date you become eligible.

If You Do Not Enroll When First Eligible

If you do not complete the enrollment process within 31 days of becoming eligible, you will not be able to enroll yourself or your Dependents, if any, for coverage until the next open enrollment period, as determined by NVIDIA, following the date you first become eligible. At that time, you will be able to enroll for coverage for which you are then eligible.

Enrollment During NVIDIA's Annual Open Enrollment Period

NVIDIA has an annual open enrollment period which means that you will have the option to continue your prior year's election for medical/Prescription Drug coverage for yourself and your Dependents (if any) for another calendar year unless you choose a different medical plan option than the one for which you are currently enrolled. If you are not currently enrolled for medical/Prescription Drug coverage, you may enroll yourself and your Dependents (if any) during annual open enrollment, and your coverage will take effect on the following January 1st.

Enrollment Due to a Qualifying Event

You may change your coverage between annual open enrollment periods only if you have a qualifying event.

If you have a qualifying event, you will have 31 days from the date of that event change to request a coverage change. This request must be consistent with the nature of the qualifying event. The coverage you elect as a result of a qualifying event, will take effect as of the date of your qualifying event.

Qualifying Event Includes:

- marriage;
- the birth, adoption or placement for adoption of a Dependent child;
- divorce, legal separation or annulment;
- the death of a Dependent;
- gain or loss of other coverage;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires:
    - you to provide health coverage for your child or Dependent foster child; or
    - your spouse, former spouse or other individual to provide coverage for your child or foster child if that other person does in fact provide that coverage.

Proof Required

You will be required to submit proof to substantiate that you have experienced a qualifying event.

Proof Includes:

- Marriage Certificate / Affidavit of Marriage
- Birth Certificate / Birth Statements
- Divorce Decree
- Court Documents
- Notice of coverage under another plan
- Death Certificate
- Any other legal document or proof that substantiates loss of coverage

Date your Coverage Ends

Your coverage will end on the earliest of:

1. the date this Plan or the NVIDIA Welfare Plan terminates;
2. the last day of the calendar month in which you are no longer an Eligible Employee;
3. the last day through which contributions for coverage are paid;
4. the last day of the calendar month in which your employment ends.

Date Dependent Coverage Ends

A Dependent's coverage will end on the earliest of:

1. the date your coverage ends for any reason;
2. the last day of the calendar month in which the individual ceases to be a Dependent.

COBRA CONTINUATION COVERAGE

If medical/Prescription Drug coverage for you, or a Dependent, ends, you or your Dependent may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). If you or your Dependent(s) (if any) elect to continue medical coverage under COBRA, your Prescription Drug coverage will automatically continue under COBRA as well. You or your Dependent(s) are not permitted to elect Prescription Drug coverage as a stand-alone benefit under COBRA.

Please refer to the COBRA section of the Summary Plan Description for your medical plan for information regarding your rights and responsibilities under COBRA or contact the COBRA Administrator for information regarding continuation of coverage under COBRA.

CONTINUING COVERAGE DURING A LEAVE OF ABSENCE

For the first 12 months of an approved leave of absence, other than a personal leave of absence, you will be permitted to continue participating in this Plan at the same level and under the same conditions of coverage as if you had remained an active employee. NVIDIA will continue to pay its portion of the premium cost for your coverage for up to 12 months to the same extent such premiums are paid for active employees. Should your leave of absence extend beyond 12 months, NVIDIA will not pay any premiums on your behalf beyond the one-year anniversary of the day preceding the start of your leave of absence.

NVIDIA will deduct your portion of the premium as a regular payroll deduction during the first 30 days of your leave of absence in which you continue to receive salary continuation. After 12 months of leave, if you do not return to work, you will be offered COBRA continuation coverage and will be responsible for paying the entire cost of your COBRA premium (i.e., both the employer and employee portion).

If you take a personal leave of absence, your coverage will continue until the end of the month in which your leave began. You should check the Corporate Policies page on the NVIDIA Intranet to get information on your eligibility to continue medical/Prescription Drug coverage for yourself and your Dependent(s), if any, and your COBRA rights and obligations.

If you terminate employment, your coverage will continue until the end of the month in which you terminate employment.

PRESCRIPTION DRUG SCHEDULES

In General

The following Schedules briefly summarize the Prescription Drug coverage under each of the medical plans administered by CVS/Caremark. Each Schedule is different because your Prescription Drug coverage depends on the medical plan you select. Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment, or Coinsurance shown in the Schedule, after you have satisfied your combined Medical/Prescription Drug Deductible, if applicable. Please refer to the Schedule for your medical plan for any required Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums ("OOPM").

The NVIDIA HSA and HSA Plus Plans both have combined medical/Prescription Drug deductibles that you must satisfy before your coinsurance percentages for Prescription Drugs apply. A combined deductible means that the deductible applies to both medical charges, Prescription Drugs, and Related Supplies.

All of the medical plan options have OOPMs that are included in each Schedule. An OOPM is the maximum amount you will pay for all of your medical expenses, Prescription Drugs and Related Supplies in a calendar year. Any amounts you are charged for medical care, Prescription Drugs, and Related Supplies are counted towards satisfaction of the OOPM and once the OOPM is reached, you will not be responsible for any further charges in that calendar year (certain penalties may not count toward satisfaction of the OOPM, but may apply after the OOPM has been reached). In addition, if you incur Out-of-Network charges, they are applied to satisfy the In-Network OOPM and vice versa.

When a treatment regimen contains more than one type of Prescription Drug and are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug. In no event will the Copayment or Coinsurance for the Prescription Drug or Related Supply exceed the amount paid by the Plan to the Pharmacy, or the Pharmacy's Usual and Customary (U&C) charge. U&C means the established Pharmacy retail price, less all applicable customer discounts that Pharmacies usually apply to its customers regardless of the customer's payment source.

Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a Prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in connection with a covered dental procedure.

Coverage also includes Prescription Drugs and Related Supplies dispensed for a Prescription issued to you or your Dependents for the treatment of infertility, including egg freezing / cryopreservation. Diagnosis of infertility is not required for treatment.

When you or a Dependent are issued a Prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that Prescription cannot reasonably be filled by a Participating Pharmacy, the Prescription will be covered by CVS/Caremark, as if filled by a Participating Pharmacy.

NVIDIA PPO PLAN SCHEDULE OF BENEFITS

NVIDIA PPO PLAN SCHEDULE	**CVS/Caremark Network of Participating Pharmacies** Use for In-Network short-term medications 30-day supply (1-month fills)	**Maintenance Choice CVS/Caremark Mail Service or CVS Pharmacy** Use for In-Network long-term medications (up to a 90-day supply).
	To locate a CVS/Caremark Participating Pharmacy in your area, simply click on "Find a Pharmacy" at www.Caremark.com or call a Customer Care representative toll-free at 1-855-293-7946	With Maintenance Choice, your long-term medications can be filled as a 90-day (3 month) supply at a CVS retail pharmacy or CVS Mail Service Pharmacy for your mail order copay. To switch to a 90-day supply, call the Customer Care number on your Prescription ID card, or visit Caremark.com/90day, and your medications will be sent directly to your home, office, or a location of your choice.

	Participating Pharmacy	**Mail Order or Pickup at a CVS Pharmacy**
Generic Medication	You pay $10 for a 30-day supply	You pay $20 for up to a 90-day supply
Preferred Brand-Name Medications	You pay $40 for a 30-day supply	You pay $80 for up to a 90-day supply
Non-Preferred Brand-Name Medications	You pay $80 for a 30-day supply	You pay $160 for up to a 90-day supply

Your Maximum Out-of-Pocket Cost for Medical Charges and Prescription Drugs – Embedded	**In-Network** $3,000 individual $6,000 family	**Out-of-Network** $5,000 individual $10,000 family

Use of Out-of-Network pharmacy	If you use an Out-of-Network pharmacy, you will pay 30% of the retail cost of your Prescription Drugs or Related Supplies up to a 30-day supply.
Maintenance Choice	It is recommended that you use Maintenance Choice and obtain a 90-day Prescription Order from your Physician — you may use mail order or pick up your prescription at a CVS pharmacy and be charged the mail order copayment.
Preventive Drugs under Health Care Reform	You pay nothing for this type of Prescription Drug or Related Supply

NVIDIA HSA PLUS PLAN SCHEDULE OF BENEFITS

<table>
<tr><td>NVIDIA HSA PLUS PLAN SCHEDULE</td><td>CVS/Caremark Network of Participating Pharmacies

Use for In-Network short-term Medications, 30-day supply (1-month fills)</td><td colspan="2">Maintenance Choice CVS/Caremark Mail Service or CVS Pharmacy

Use for In-Network long-term medications (up to a 90-day supply).</td></tr>
<tr><td></td><td>To locate a CVS/Caremark Participating Pharmacy in your area, simply click on “Find a Pharmacy” at www.Caremark.com or call a Customer Care representative toll-free at 1-855-293-7946.</td><td colspan="2">With Maintenance Choice, your long-term medications can be filled as a 90-day (3 month) supply at a CVS retail pharmacy or CVS Mail Service Pharmacy for your mail order copay. To switch to a 90-day supply, call the Customer Care number on your Prescription ID card, or visit Caremark.com/90day, and your medications will be sent directly to your home, office, or a location of your choice.</td></tr>
<tr><td rowspan="2">Generic Medication</td><td>Participating Pharmacy</td><td colspan="2">Mail Order or Pick Up at a CVS Pharmacy</td></tr>
<tr><td>You pay 10% for a 30-day supply after deductible</td><td colspan="2">You pay 10% after deductible for up to a 90-day supply</td></tr>
<tr><td>Preferred Brand-Name and Generic Medications - Preventive</td><td colspan="3">You pay 10% for a 30-day supply of expanded “preventive” brand-name medications, and 0% ($0) for “preventive” generic medications, without having to reach your deductible</td></tr>
<tr><td>Non-Preferred Brand-Name Medications</td><td>You pay 10% for a 30-day supply after deductible</td><td colspan="2">You pay 10% after deductible for up to a 90-day supply</td></tr>
</table>

Your Maximum Out-of-Pocket Cost for Medical Charges and Prescription Drugs - Non-embedded		**In-Network** $2,500 individual $3,750 Individual +1 $5,000 family	**Out-of-Network** $5,000 individual $7,500 Individual +1 $10,000 family
Use of Out- of-Network Pharmacy	If you use an Out-of-Network pharmacy, you will pay 30% of the retail cost of your Prescription Drugs or Related supplies after you meet your deductible for a 30-day supply.		
Annual Deductible for Medical and Prescription Drug Coverage - Non-embedded		**In-Network** $1,400 individual $2,800 Individual +1 $3,350 family	**Out-of-Network** $1,800 individual $2,800 Individual +1 $3,600 family
Maintenance Choice	It is recommended that you use Maintenance Choice and obtain a 90-day Prescription Order from your Physician — you may use mail order or pick up your prescription at a CVS pharmacy and be charged the mail order copayment.		
Preventive Drugs under Health Care Reform	You pay nothing for this type of Prescription Drug or Related Supply		

NVIDIA HSA PLAN SCHEDULE OF BENEFITS

NVIDIA HSA PLAN SCHEDULE	CVS/Caremark Network of Participating Pharmacies Use for In-Network short-term Medications, 30-day supply (1-month fills)	Maintenance Choice CVS/Caremark Mail Service or CVS Pharmacy Use for In-Network long-term medications (up to a 90-day supply).
	To locate a CVS/Caremark Participating Pharmacy in your area, simply click on "Find a Pharmacy" at www.Caremark.com or call a Customer Care representative toll-free at 1-855-293-7946.	With Maintenance Choice, your long-term medications can be filled as a 90-day (3 month) supply at a CVS retail pharmacy or CVS Mail Service Pharmacy for your mail order copay. To switch to a 90-day supply, call the Customer Care number on your Prescription ID card, or visit Caremark.com/90day, and your medications will be sent directly to your home, office, or a location of your choice.
Generic Medication	**Participating Pharmacy** You pay 10% for a 30-day supply after deductible	**Mail Order or Pick Up at a CVS Pharmacy** You pay 10% after deductible for up to a 90-day supply
Preferred Brand-Name Medications	You pay 10% for a 30-day supply after deductible	You pay 10% after satisfaction of your deductible for up to a 90-day supply
Preferred Brand-Name and Generic Medications - Preventive	You pay 10% for a 30-day supply of expanded "preventive" brand- name medications, and 0% ($0) for "preventive" generic medications, without having to reach your deductible.	
Non-Preferred Brand-Name Medications	You pay 10% for a 30-day supply after your deductible	You pay 10% after satisfaction of your deductible for up to a 90-day supply

Refill Limit	One initial fill plus two (2) refills	One initial fill plus two (2) refills	N/A
Your Maximum Out-of-Pocket Cost for Medical Charges and Prescription Drugs — Embedded		**In-Network** $6,450 individual $9,700 Individual +1 $12,900 family	**Out-of-Network** $6,450 individual $9,700 Individual +1 $12,900 family
Use of Out- of-Network Pharmacy	If you use an Out-of-Network pharmacy, you will pay 30% of the retail cost of your Prescription Drugs or Related Supplies up to a 30-day supply.		
Annual Deductible for Medical and Prescription Drug Coverage - Embedded		**In-Network** $5,000 individual $7,500 Individual +1 $10,000 family	**Out-of-Network** $5,000 individual $7,500 Indiv3idual +1 $10,000 family
Maintenance Choice	It is recommended that you use Maintenance Choice and obtain a 90-day Prescription Order from your Physician — you may use mail order or pick up your prescription at a CVS pharmacy and be charged the mail order copayment.		
Preventive Drugs under Health Care Reform	You pay nothing for this type of Prescription Drug or Related Supply		

LIMITATIONS AND EXCLUSIONS

Each Prescription and refills of that Prescription shall be limited as follows:

- Up to a consecutive 30-day supply, at a retail pharmacy, unless limited by the drug manufacturer's packaging; or
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- Up to a consecutive 90-day supply at a CVS Pharmacy or CVS/Caremark Mail Service Pharmacy unless limited by the drug manufacturer's packaging; or
- To a dosage and/or dispensing limit as determined by CVS/Caremark pharmacy therapeutic team.

Using Maintenance Choice to Fill Your Maintenance Drugs

You may either pick up your Maintenance Drugs at your local CVS Pharmacy or use mail order.

IF YOU WOULD LIKE TO	THEN
Continue with mail service	**You don't have to do anything.** We'll continue to send your medications to your location of choice.
Pick up a prescription at your local retail CVS/pharmacy	**Please let us know.** You can do so quickly and easily. Choose the option that works best for you: • Register or log into www.caremark.com to select a CVS/pharmacy location for pick up • Visit your local CVS/pharmacy and talk to the pharmacist Call us toll-free using the number on the back of your Prescription Card, and we'll handle the rest.
Sign up for mail service for the first time	**You can do so easily online or by phone.** • Register or log into www.caremark.com, select "Start a New Prescription," then click on "Fast Start" • Call FastStart toll-free at 1-800-875-0867. We'll handle the rest.
More information	**Give us a call.** Use the phone number on the back of your Prescription Card to call us toll-free.
Web Services	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefits. To register, have your Prescription Card ready.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a Step Therapy determination which requires the progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Caremark to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the Prescription Order.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the Prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drug or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on your ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-preferred or non-prescription Drug List based on CVS/Caremark's P&T Committee review. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee after FDA approval. **Exclusions**

This Plan does not cover the following:

- drugs available over the counter that do not require a Prescription by federal or state law unless state or federal law requires coverage of such drugs;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- FDA-approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in the standard reference compendia—The American Hospital Formulary Service Drug Information (AHFS)—or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- Prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- diet pills or appetite suppressants (anorectics);

- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, as well as drugs used to control perspiration and face cream products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medication used for travel prophylaxis;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed hospital, skilled nursing facility, rest home, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational;
- Prescription Drugs for health conditions that are required by state or local law to be dispensed in a public facility;
- Prescription Drugs required by state or federal law to be supplied by a public school system or school district;
- Prescription Drugs for military disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available;
- Prescription Drugs for treatment of an injury or sickness which is due to war, declared, or undeclared, riot or insurrection;
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that you were covered under this Plan;
- for or in connection with experimental, investigational or unproven drugs;
  - Experimental, investigational and unproven drugs are drug therapies, supplies, or devices that are determined by the P&T Committee to be:
    - not demonstrated through existing peer reviewed, evidence-based scientific literature to be safe and effective for treating the condition or sickness for which use is proposed;
    - not approved by the FDA or other regulatory agency to be lawfully marketed for the proposed use; and
    - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trial" section(s) of your enrolled medical plan.
- Prescription Drugs in connection with cosmetic surgery or therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomology or psychosocial complaints related to one's appearance;
- All injectable Prescription Drugs that do not require Physician supervision and are typically considered self-administered drugs except as provided by this Plan;
- cost of biologicals that are medications for the purpose of travel or to protect against occupational hazards and risks;
- cosmetics, dietary supplements, and health and beauty aids;
- all nutritional supplements and formula except for infant formula needed for the treatment of metabolism dysfunction;
- payment for those covered under Medicare when payment is denied by Medicare plan because prescription drugs were received from a nonparticipating pharmacy;
- charges made by a hospital owned or operated by or which provides care or preforms services for the United States Government, if such charges are directly related to military-service-connected injury or sickness;

- charges to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- charges to the extent that payment is unlawful where the person resides when the expenses are incurred;
- charges in excess of the maximum reimbursable charge; and
- charges made by any covered provider who is a member of your or your Dependent's family.

Coordination of Benefits

This section applies if you or any one of your Dependents are covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. In that case, this Plan may reduce what it pays based on what the other Plans pay. In other words, this Plan will coordinate with any other Plans you may have that reimburse you for the same Prescription Drugs or Related Supplies. If you have more than one Prescription Drug Plan, refer to Appendix I for details on how this Plan will pay benefits. You should file all claims with each Plan.

Recovery of Overpayment

When an overpayment has been made by CVS/Caremark, CVS/Caremark will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

FEDERAL REQUIREMENTS

Notice of Provider Directory/Networks

A list of Participating Providers who are employed by or contract with CVS/Caremark is available to you without charge by visiting www.caremark.com; or by calling the toll-free telephone number on your ID card.

How To File Your Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy (In-Network), you pay any applicable Copayment, Coinsurance, or Deductible at the time of purchase. You do not need to file a claim form; just show your identification card and pay your share of the cost, if any.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy (Out-of-Network), you pay the full cost at the time of purchase. You must submit a claim form and itemized bills to the claims address listed on the claim form in order to receive reimbursement. You can find this claim form online at www.caremark.com or by calling Member Services using the toll-free number on your identification card.

Out-of-Network claims can be submitted on your behalf by the pharmacy as well.

Claims Reminder

- **BE SURE TO USE YOUR CVS/Caremark MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU VISIT THE PHARMACY OR FILE A PAPER CLAIM.**
- **YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD. YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.**
- **BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE CLAIM FORM CAREFULLY WHEN SUBMITTING A PAPER CLAIM.**

Timely Filing of Out-of-Network Claims

CVS/Caremark will consider Out-of-Network claims if submitted within 365 days after services are rendered. If Out-of-Network claims are not submitted within 365 days, the claim will not be considered valid and will be denied.

Filing Fraudulent Claims

Any person who knowingly and with intent to defraud any person files a claim containing any materially false information commits a fraudulent act against the Plan and NVIDIA.

Procedures Regarding Claims Determinations

In general, Prescription Drug benefits must be Medically Necessary to be covered under this Plan. The procedures for determining Medical Necessity vary, according to the underlying type of service or benefit requested, and the medical plan option you have chosen. Claim determinations are made based on the type of claim: urgent care, pre-service, concurrent, or post-service, as described below.

1. Urgent Care Claims: A claim for benefits under the Plan where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Pre-service Claims: A claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Further, if the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." You simply follow the Plan's procedures with respect to any notice that may be required after receipt of treatment, and file the claim as a Post-service Claim.

3. Concurrent Claims: A “concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or for a specified number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) you request an extension of the course of treatment beyond that which the Plan has approved.

4. Post-service Claims: A claim for a benefit under the Plan that does not require prior approval under the terms of the Plan.

CVS/Caremark will notify you of its determination of your claim within the following time periods:

1. Pre-service Urgent Care Claims: If you have provided CVS/Caremark all of the necessary information, CVS/Caremark will notify you of its initial decision within 72 hours from the time of receipt of your initial claim.

   If you have not provided all of the information needed to process the claim, then you will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. You will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded you to provide the information.

2. Pre-service Non-Urgent Care Claims: If you have provided all of the information needed to process the claim, CVS/Caremark will notify you of its initial decision within 15 days of receipt of your initial claim, unless an extension, of up to 15 days, is necessary due to matters beyond the control of the Plan. If CVS/Caremark determines that such an extension is necessary, you will be notified, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which CVS/Caremark expects to render a decision.

   If you have not provided all of the information needed to process the claim, then you will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. You will be given at least 45 days from receipt of this notice within which to provide the specified information.

3. Concurrent Claims:

Plan Notice of Reduction or Termination. If CVS/Caremark is notifying you of a reduction or termination of a course of treatment, before the end of such period of time or number of treatments, you will be notified sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. For urgent care claims involving an extension of an ongoing treatment or a course of treatment over a period of time (i.e., a concurrent claim that is also an urgent care claim), CVS/Caremark will provide you with a notice of its decision within 24 hours of the receipt of the claim, so long as the claim was made at least 24 hours prior to the expiration of the previously approved prescribed period of time or number of treatments.

4. Post-service Claims: If you have provided all of the information needed to process the claim, CVS/Caremark will notify you within 30 days of receipt of the initial claim unless an extension of up to 15 days is necessary due to matters beyond the control of the Plan. If CVS/Caremark determines that such an extension is necessary, you will be notified, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which CVS/Caremark expects to render a decision.

   If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

Notice of Claim Determination

When prescription drug benefits are determined not to be covered, you or your representative will receive a written description of the adverse determination will include the following information: the specific reason for the denial; specific references to the Plan provisions on which the denial is based; a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary; an explanation of the Plan's review procedures; your right to bring a civil action under ERISA Section 502(a) after completion of all required levels of review; if your claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or a notice of where and how you can obtain a copy; if your claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request; and for purposes of urgent care, a description of the expedited review process.

Notices will be provided in a culturally and linguistically appropriate manner and will also include the following information, as appropriate:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), notice of the opportunity to request diagnosis codes and treatment codes (and their corresponding meanings);
- For an adverse benefit determination or final internal adverse benefit determination, the denial code and its corresponding meaning, as a well as a description of the Plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

Internal Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to CVS/Caremark within 180 days of receipt of a denial notice (note: appeal requests involving urgent care claims may be submitted orally or in writing). You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CVS/Caremark to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will notify you of our appeal determination within the following timeframes:

1. Pre-service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal. If you request that your appeal be expedited, you may also ask for an expedited external review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.
2. Pre-service Non-Urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims. Within an appropriate time period based upon the type of claim: pre-service urgent, pre-service non-urgent or post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

In the event any new or additional information (evidence) is considered, relied upon or generated by CVS/Caremark in connection with the appeal, CVS/Caremark will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by CVS/Caremark, CVS/Caremark will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific Plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review.

External Review Procedure

If you are not fully satisfied with the decision of CVS/Caremark's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be

referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by CVS/Caremark, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the Plan.

There is no charge for you to initiate an external review. The IRO will review any timely-received additional information you (or your representative) provide and the documents and information that CVS/Caremark reviewed in connection with its denial (for example, medical records, attending health care professional's recommendation, the terms of the plan, appropriate practice guidelines, any applicable clinical review criteria developed and used by the Plan, the opinion of the IRO's clinical reviewer(s), etc.). CVS/Caremark and this Plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator within four months of your receipt of CVS/Caremark's appeal review denial. CVS/Caremark will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days of receipt of the request for external review.

You can request expedited review of urgent care claims. When requested, and if a delay would be detrimental to your medical condition, as determined by CVS/Caremark's Physician Reviewer, the external review shall be completed within 72 hours.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied Prescription Drug benefit, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

You have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against CVS/Caremark until you have completed the Plan's internal appeal processes. However, no action may be brought unless done so within three years after proof of claim is provided.

ERISA REQUIRED INFORMATION

Name and Address of Plan Administrator

NVIDIA Corporation
2788 San Tomas Expressway
Santa Clara, CA 95051
408-486-2000
Nvidia-benefits@nvidia.com

Employer ID Number: 94-3177549

Plan Number	Type of Coverage	Plan Name
502	Prescription Drug Benefits	NVIDIA Welfare Plan

Type of Plan:

This Summary Plan Description describes the self-funded Prescription Drug component of the NVIDIA Welfare Plan. CVS/Caremark does not insure any of the Prescription Drug benefits described in this Summary Plan Description.

Name and address of Claims Administrator:

CVS/Caremark
www.caremark.com
Mail Claims to the address on the Claim Form

Type of Administration:

CVS/Caremark is the Claims Administrator pursuant to the terms of an administrative service agreement with NVIDIA and acts as a fiduciary under ERISA as to self-insured Prescription Drug claims and appeals.

Agent for Service of Legal Process:

For disputes arising under this Plan, service of legal process may be made upon NVIDIA at the following address:

Corporate General Counsel
NVIDIA Corporation
2788 San Tomas Expressway
Santa Clara, CA 95051

Contributions:

NVIDIA and Eligible Employees both make contributions towards the cost of Prescription Drug benefits.

Plan Year:

Calendar Year (the 12-month period beginning each January 1 and ending the following December 31).

Qualified Medical Child Support Orders

You and your beneficiaries can obtain, without charge from NVIDIA, a copy of any procedures governing Qualified Medical Child Support Orders (QMCSO).

Discretionary Authority

The Plan Administrator delegates to CVS/Caremark the discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of claims and appeals under the Plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the Plan, the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all Prescription Drug benefit payments. The Plan Administrator also delegates to CVS/Caremark the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative. CVS/Caremark is the "named fiduciary" under ERISA as to the determination of all self-insured Prescription Drug claims and appeals. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Plan Amendment or Termination

NVIDIA reserves the right to change or terminate this Plan and the NVIDIA Welfare Plan (of which this Plan is a Component Plan) in any way and at any time.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

(A) Receive Information About Your Plan and Benefits:

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration;

- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies; and

- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

(B) Continue Group Health Plan Coverage:

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your federal continuation coverage rights.

(C) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

(D) Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. For example, a suit for benefits under this Plan must be brought within three years after proof of claim is provided.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are

discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

Charges means the actual billed charges; except when the provider has contracted directly or indirectly with CVS/Caremark for a different amount.

Child(ren) means the following:

Your natural, legally adopted, step, foster, or those of a qualified domestic partner relationship. This includes children:

- Who are under age 26;
- Who are over age 26, permanently disabled and incapable of self-sustaining employment because of a mental or physical handicap. Disabled dependents must be approved by Social Security and have been disabled prior to their 26th birthday, and proof of disabled status must be submitted upon request;
- For whom you are a legal guardian (and became their guardian before their 18th birthday);
- For whom you are required to provide prescription drug coverage under a qualified medical support order (and who is a qualified IRS dependent); and
- An adopted child includes a child placed in your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from your custody, the child's status as an adopted child will end.

Claim Administrator means CVS/Caremark. The Claim Administrator is responsible for processing claims for Prescription Drug benefits in accordance with this SPD.

Dependent(s) means your Spouse/Domestic Partner and/or Child(ren)/Domestic Partner's Child(ren).

Domestic Partner means a person who meets and continues to meet all of the criteria detailed in the NVIDIA Affidavit of Domestic Partnership, provided that the domestic partnership has been internally registered with NVIDIA by the filing of a properly completed NVIDIA Affidavit of Domestic Partnership. The term Domestic Partner shall also include a person in a civil union or registered domestic partnership with an Eligible Employee, as defined under the laws of a state that recognizes such arrangements, provided that proof has been filed with NVIDIA.

Eligible Employee means a regular full-time or part-time U.S.-based employee or intern scheduled to work 20 or more hours per week.

Employer means NVIDIA Corporation or its successors.

Maintenance Drug is a Prescription Drug or Related Supply that is used on a routine or long-term continuing basis for the prevention or treatment of chronic or long-term health conditions and/or other medications as specified by CVS/Caremark.

Maximum Reimbursable Charge for Prescription Drugs, Related Supplies or other covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or

- a NVIDIA-selected percentile of charges made by providers of such Prescription Drugs, Related Supply or other covered service in the geographic area where it is received as compiled in a database selected by CVS/Caremark.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CVS/Caremark. Additional information about how CVS/Caremark determines the Maximum Reimbursable Charge or for help determining the Maximum Reimbursable Charge for a Prescription Drug, Related Supply or other covered services is available upon request by calling the toll-free number shown on your ID card.

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;

- in accordance with generally accepted standards of medical practice;

- clinically appropriate in terms of type, frequency, extent, site and duration;

- not primarily for the convenience of the patient, Physician or other health care provider; and

- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Necessary Services and Supplies include any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during hospital confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during hospital confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Participating Pharmacy means a hospital or an entity that has a direct or indirect contractual arrangement with CVS/Caremark to provide covered services with regard to a particular medical plan under which the participant is covered.

Pharmacy means a retail Pharmacy, or CVS/Caremark Mail Service Pharmacy.

Pharmacy & Therapeutics (P&T) Committee

A committee of CVS/Caremark Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this Plan when performed by a Physician.

Plan means the self-funded Prescription Drug component of the NVIDIA Welfare Plan described in this SPD. This SPD is a "Component Document" as that term is defined under the NVIDIA Welfare Plan and is incorporated by reference into the NVIDIA Welfare Plan and Summary Plan Description.

Prescription Drug means a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List means a list of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Note: Effective January 1, 2021, the prescription drug Hizentra will be a covered medication for patients diagnosed with Autoimmune Autonomic Small Fiber Polyneuropathy, a symptom of which is POTS (postural tachycardia syndrome).

Prescription Order or Prescription means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice and each authorized refill thereof.

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the Plan, and spacers for use with oral inhalers.

Spouse means the person who is recognized as the Eligible Employee's spouse in accordance with the laws of any state, the District of Columbia, a United States territory or a foreign jurisdiction. The term "Spouse" shall not include a domestic partner or a civil union partner.

APPENDIX I

Definitions

For the purpose of this section only, the following terms have the meanings as set forth below:

Plan

Any of the following that provide benefits or services for prescription drug benefits:

- Group Insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage;
- Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies; and
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Primary Plan

The plan that determines and provides or pays benefits without taking into consideration the existence of any other plan.

Secondary Plan

A plan that determines and may reduce benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expenses

A necessary reasonable and customary service or expense including deductibles, coinsurance and copayments that is covered in full or in part by any plan covering you. When a plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expenses and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense;
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense;
- If you are covered by one Plan that provide services or supplies on the basis of reasonable and customary fees and one Plan that provide services or supplies on the bases of negotiated fees the Primary Plan's fee arrangement shall be the Allowable Expense; and

- If your benefits are reduced under the Primary Plan (through the imposition of higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense.

Claims Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of pharmaceuticals Services and Related Supplies usually charge and which is within the range of fees usually charged for the same Services and Related Supplies by other licensed providers located within the immediate geographic area where the pharmaceutical Services and Related Supplies are purchased.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose Parents are not divorced or legally separated, the Primary Plan shall be the plan be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or an employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
    - first if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the court order, but only from the time of actual knowledge;
    - then, the Plan of the parent with custody of the child;
    - then, the Plan of the spouse of the parent with custody of the child;
    - then, the Plan of the parent not having custody of the child, and
    - finally, the Plan of the spouse of the parent not having custody of the child;
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid off or retired employee (or as the employee's Dependent shall be the secondary Plan. If the other plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply;
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply; and
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

Recovery of Excess Benefits

If CVS/Caremark pays charges for benefits that should have been paid by the Primary Plan, or if CVS/Caremark pays charges in excess of those for which we are obligated to provide under the Policy, CVS/Caremark will have the right to recover the actual payment made or the Reasonable Cash Value of any Services or Related Supplies.

CVS/Caremark will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such Services and Related Supplies were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CVS/Caremark without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the “other coverage” information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligible

The Pharmacy Expense Insurance for:

- a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
- the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months; and
- will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

- the amount payable under this plan will be reduced so that the total amount payable by Medicare and by CVS/Caremark will be no more than 100% of the expenses incurred.

CVS/Caremark will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied;
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled;
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract;
- A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him; and
- This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CVS/Caremark is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules explained above will apply.