YOUR 2022 MEDICAL PLAN COMPARISON

Did you know: We have a Medical Plan Cost Comparison Tool available for you to use.

	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: $750 Maximum per family: $1,500	Individual: $1,500 Maximum per family: $3,000	$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: $50 copay per visit	30% of R&C* fees after deductible	$20 copay per visit	10% after deductible
Virtual Care	$55 per visit; 10% ($5.50) after deductible	Not covered	$55 per visit; 10% ($5.50) after deductible	Not covered	$5 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		$20 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 as well as medically necessary storage	$50,000 covered out-of-network annually (LTM)	10% after deductible Unlimited; no infertility diagnosis required; egg freezing also covered as well as medically necessary storage	$50,000 covered out-of-network annually (LTM)	10% after deductible Unlimited; no infertility diagnosis required; egg freezing also covered as well as medically necessary storage	$50,000 covered out-of-network annually (LTM)	$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 $50 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	$50 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

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PRESCRIPTION DRUG BENEFITS (prescriptions apply to the out-of-pocket maximum)								
Retail	Generic Preventive: 0% Generic: 10% after deductible for a 30-day supply Preferred brand-name: 10% after deductible for a 30-day supply Non-preferred brand-name: 10% after deductible	Generic Preventive: 0% Preferred brand-name 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: $40 copay for a 30-day supply Non-preferred brand-name: $80 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: $80 copay for a 90-day supply Non-preferred brand-name: $160 copay for a 90-day supply	30% R&C* fees	Generic: $20 copay for up to a100-day supply Brand-name: $60 copay for up to a100-day supply	Generic: $20 copay for up to a 100-day supply after deductible Brand-name: $60 copay for up to a 100-day supply after deductible

* Reasonable and customary

This summary is not intended to provide a complete plan description. It is important for you to realize that additional terms, conditions, and limitations regarding benefit eligibility and entitlement are found in official Plan Documents. If there is an actual or apparent conflict between this benefit summary or your Summary Plan Description (SPD) booklet and the official Plan Documents, the provisions of the official Plan Document will prevail.