Your 2027 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 CA HMO Plan	Kaiser CA 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: $1,750 Individual + 1: $3,500 Family: $3,750	Individual: $1,750 Individual + 1: $3,500 Family: $3,750	Individual: $750 Maximum per family: $1,500	Individual: $1,500 Maximum per family: $3,000	$0	Individual: $1,750 Maximum per family: $3,500 ($3,500 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: $4,250 Family: $5,000	Individual: $5,000 Individual + 1: $8,500 Family: $10,000	Individual: $3,000 Family: $6,000	Individual: $5,000 Family: $10,000	Individual: $1,500 Family: $3,000	Individual: $3,500 Family: $7,000 ($3,500 for any single family member)
Deductible / OOP Maximum	Embedded*		Non-Embedded**		Embedded*		Embedded*	Embedded*
Preventive Care	$0	$0	$0	$0	$0	$0	$0	$0

More Ways To Get Care

	Crossover—Health Center < 1 Mile From Santa Clara Campus	
	What You Pay	
	NVIDIA HSA Plus and NVIDIA HSA	**NVIDIA PPO**
Annual Physical	$0	
Illness/Injury	$90	$20
Annual Flu Vaccine	$0	

* **Embedded:** If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The same applies to the out-of-pocket limits.

** **Non-Embedded:** If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The same applies to the out-of-pocket-limits.

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	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**
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	10% after deductible	Not covered	10% after deductible	Not covered	Urgent Virtual Care: $5 copay Primary Care: $20 copay Specialty Care: $50 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 per visit		$20 copay per visit	10% after deductible
Emergency Room	10% coinsurance after deductible		10% coinsurance after deductible		$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 lifetime maximum 30% R&C* fees after deductible	10% after deductible Unlimited; no infertility diagnosis required; egg freezing also covered as well as medically necessary storage	$50,000 covered out-of-network lifetime maximum 30% R&C* fees after deductible	10% after deductible Unlimited; no infertility diagnosis required; egg freezing also covered as well as medically necessary storage	$50,000 covered out-of-network lifetime maximum 30% R&C* fees after deductible	$20 copay (covered up to 3 egg retrievals) Oocyte retrieval or procurement of donor materials is limited to three attempts per lifetime. Procurement of donor oocytes is limited to one cohort per active course of fertility treatment.	10% after deductible (covered up to 3 egg retrievals) Oocyte retrieval or procurement of donor materials is limited to three attempts per lifetime. Procurement of donor oocytes is limited to one cohort per active course of fertility treatment.

* Reasonable and customary

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	NVIDIA HSA Plan		NVIDIA HSA Plus		NVIDIA PPO		Kaiser CA HMO Plan	Kaiser CA 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**
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
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 20 visits.		A maximum of 100 visits per service per year. Therapy must be medically necessary, and review is required after 20 visits.		A maximum of 100 visits per service per year. Therapy must be medically necessary, and review is required after 20 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 **Combined Acupuncture and Chiropractic:** Maximum of 30 visits per calendar year	**Chiropractic:** $10 after deductible **Chiropractic:** Maximum of 20 visits per calendar year
	You get a maximum of 30 visits per calendar year. Medical necessity required after 20 visits.		You get a maximum of 30 visits per calendar year. Medical necessity required after 20 visits.		You get a maximum of 30 visits per calendar year. Medical necessity required after 20 visits.			
Outpatient Mental Health Or Substance Use Disorder	10% after deductible	**Professional fees:** 10% R&C* fees after deductible; **all other services:** 10% R&C* fees after deductible	10% after deductible	**Professional fees:** 10% R&C* fees after deductible; **all other services:** 10% R&C* fees after deductible	$20 copay	**Professional fees:** 10% R&C* fees after deductible; **all other services:** 10% R&C* fees after deductible	$20 copay per individual visit $10 copay per group visit $5 copay per group substance use visit	10% coinsurance after deductible
Inpatient Mental Health Or Substance Use Disorder	10% after deductible	10% R&C* fees after deductible	10% after deductible	10% R&C* fees after deductible	10% after deductible	10% 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)								
	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**
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	Not covered	**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	Not covered	**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	Not covered	**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

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