

Your 2025 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: \$1,650 Individual + 1: \$3,300 Family: \$3,350	Individual: \$1,650 Individual + 1: \$3,300 Family: \$3,350	Individual: \$750 Maximum per family: \$1,500	Individual: \$1,500 Maximum per family: \$3,000	\$0	Individual: \$1,650 Maximum per family: \$3,300 (\$3,300 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: \$3,300 Family: \$6,600 (\$3,300 for any single family member)
Deductible / OOP Maximum	Embedded*		Non-Embedded**		Embedded*		Embedded*	Non-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		\$20 copay	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 cycles)	50% after deductible (covered up to 3 cycles)

* 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 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)								
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Retail	Generic Preventive: 0%	Generic Preventive: 0%	Generic Preventive: 0%	Generic Preventive: 0%	Generic: \$10 copay for a 30-day supply	30% R&C* fees	Generic: \$10 copay for a 30-day supply	Generic: \$10 copay for a 30-day supply after deductible
	Generic: 10% after deductible for a 30-day supply	Preferred brand-name and Non-preferred brand-name Preventive: 30% R&C* fees after deductible	Generic: 10% after deductible for a 30-day supply	Preferred brand-name and Non-preferred brand-name Preventive: 30% R&C* fees after deductible	Preferred brand-name: \$40 copay for a 30-day supply		Brand-name: \$30 copay for a 30-day supply	Brand-name: \$30 copay for a 30-day supply after deductible
	Preferred brand-name: 10% after deductible for a 30-day supply		Preferred brand-name: 10% after deductible for a 30-day supply	Non-preferred brand-name: \$80 copay for a 30-day supply				
	Non-preferred brand-name: 10% after deductible		Non-preferred brand-name: 10% after deductible					
Mail Order	Generic Preventive: 0%	Not covered	Generic Preventive: 0%	Not covered	Generic: \$20 copay for a 90-day supply	Not covered	Generic: \$20 copay for up to a 100-day supply	Generic: \$20 copay for up to a 100-day supply after deductible
	Generic: 10% after deductible for a 90-day supply		Generic: 10% after deductible for a 90-day supply		Preferred brand-name: \$80 copay for a 90-day supply		Brand-name: \$60 copay for up to a 100-day supply	Brand-name: \$60 copay for up to a 100-day supply after deductible
	Preferred brand-name: 10% after deductible for a 90-day supply		Preferred brand-name: 10% after deductible for a 90-day supply		Non-preferred brand-name: \$160 copay for a 90-day supply			
	Non-preferred brand-name: 10% after deductible		Non-preferred brand-name: 10% after deductible					

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