NUTANIX

How Our Medical Plans Stack Up

Take a time-out to review the key stats of our medical plans to see if your current plan is still the best fit. The chart below summarizes coverage for all options. Gain more insights on **nutanixbenefits.com**.

	UnitedHealthcare HDHP with HSA		UnitedHealthcare POS Plan		Kaiser Permanente HMO (California only)	
PAYCHECK DEDUCTIONS						
Employee **Employee + Spouse** **Employee + Children** **Employee + Family**	$0 Nutanix pays the full cost		$0 Nutanix pays the full cost		$0 Nutanix pays the full cost	
Imputed Income	If you cover a domestic partner and/or their children, the value of these benefits is considered imputed income due to IRS regulations. See **nutanixbenefits.com** and search "imputed income" for details.					
PLAN FEATURES	**Employee Pays**		**Employee Pays**		**Employee Pays**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Provider Network	UnitedHealthcare Choice Plus		UnitedHealthcare Select Plus (CA) Choice Plus (Outside CA)		Kaiser Permanente	
Health Savings & Reimbursement Accounts	**Nutanix** Contributions: $750 Individual & $1,500 Family (prorated for hires after 1/1/2023) **Employee** Contributions: Up to $3,850 Individual & $7,750 Family		N/A		**Nutanix** Contributions: $1,500 Individual & $3,000 Family **Employee** Contributions: N/A	
Annual Deductible	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family	$0 Individual $0 Family	$6,000 Individual $12,000 Family	$0 Individual $0 Family	N/A
What You Pay for Most Services *(coinsurance)*	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	Copays as noted below	Not covered
Annual Out-of-Pocket (OOP) Maximum *(includes deductibles, coinsurance, copays and pharmacy)*	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$0 Individual $0 Family	$10,000 Individual $12,000 Family	$1,500 Individual $3,000 Family *(use your HRA to cover your OOP expenses)*	Not covered
MEDICAL SERVICES	**Employee Pays**		**Employee Pays**		**Employee Pays**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive Care Services *(such as routine physicals, vaccinations, annual OB-GYN exams, mammograms, colonoscopies)*	$0	30% (after deductible)	$0	Not covered	$0	Not covered
Well-Baby / Well-Child Visit	$0	30% (after deductible)	$0	Not covered	$0	Not covered
Virtual Care *(available by phone or video visit)*	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$0	Not covered
Doctor or Specialist Visit	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$20 copay for most visits	Not covered
X-ray / Lab / Imaging	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	X-ray / Lab: $10 Imaging: $50	Not covered
Inpatient Hospital / Surgery	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$250 copay per admission	Not covered
Urgent Care	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$20 copay per visit	Not covered
Emergency Room	10% (after deductible)	10% (after deductible)	$0	$0	$50 copay per visit	Not covered
Ambulance	10% (after deductible)	$0 for emergency 30% (after deductible) for nonemergency	$0	$0 for emergency 40% (after deductible) for nonemergency	$100 per trip	Not covered

This represents a summary of the benefits available to you as an eligible employee of Nutanix. Every effort has been made to provide an accurate summary of the terms of the plans. However, if there is a conflict between this information and the official plan documents or insurance contracts, the official plan documents and insurance contracts will control. In addition, Nutanix reserves the right to change, amend, modify or terminate the plans in whole or in part at any time.

	UnitedHealthcare HDHP with HSA		UnitedHealthcare POS Plan		Kaiser Permanente HMO (California only)	
BEHAVIORAL HEALTH & SUBSTANCE ABUSE THERAPY	**Employee Pays**		**Employee Pays**		**Employee Pays**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Virtual Behavioral Health *(available by phone or video visit)*	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$20 copay for most visits	Not covered
Doctor or Specialist Visit	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$20 copay for most visits	Not covered
Outpatient Care	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$20 copay per visit	Not covered
Inpatient Care	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$250 copay per admission	Not covered
OTHER SERVICES	**Employee Pays**		**Employee Pays**		**Employee Pays**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical, Speech & Occupational Therapy	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$20 copay	Not covered
			Limit of 60 visits per year for each therapy type (combined in- and out-of-network)			
Applied Behavioral Analysis (ABA) Therapy	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$20 copay	Not covered
Chiropractic Care	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	$15 copay *Limit of 20 visits per year*	Not covered
	Limit of 24 visits per year		*Limit of 24 visits per year*			
Acupuncture	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)		
	Limit of 24 visits per year		*Limit of 24 visits per year*			
Fertility Treatment *(infertility diagnosis and treatment of underlying medical condition covered)*	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	50%	Not covered
Gender Affirmation Benefits	10% (after deductible)	30% (after deductible)	$0	40% (after deductible)	Copay varies—contact Kaiser Permanente for details	Not covered
Nutritionist Visit	10% (after deductible) *No visit limits*	30% (after deductible)	$0 *No visit limits for chronic conditions only*	40% (after deductible)	$0 *Referral may be required*	Not covered
PHARMACY	**Employee Pays***		**Employee Pays***		**Employee Pays**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Provider Network	Express Scripts		Express Scripts		Kaiser Permanente	
Tier 1 *(generics and some brand names)*	10% (after deductible)	30% (after deductible)	Retail: $0 Mail-order: $0	Retail: $10 (after deductible) Mail-order: Not covered	Retail: $10 per 30-day fill Mail-order: $20 per 100-day supply	Not covered
Tier 2 *(preferred brand names)*	10% (after deductible)	30% (after deductible)	Retail: $0 Mail-order: $0	Retail: $30 (after deductible) Mail-order: Not covered	Retail: $30 per 30-day fill Mail-order: $60 per 100-day supply	Not covered
Tier 3 *(higher-cost non-preferred brand names and select generics)*	10% (after deductible)	30% (after deductible)	Retail: $0 Mail-order: $0	Retail: $50 (after deductible) Mail-order: Not covered		Not covered

* Retail: Up to a 30-day supply. Mail-order: Up to a 90-day supply.

Important: For all medical plans, certain preventive medications are covered at 100% as mandated by the Affordable Care Act. You can find the UnitedHealthcare list of medications at **expressscripts.com** and the Kaiser list at **kp.org**.

Note: This is only a partial list of the covered benefits. For an expanded list of covered services, please refer to the medical plan benefit summaries available at **nutanixbenefits.com**.