2024 Medical Plan Comparison Chart

All plans include preventive care at no cost to you. While all plans cover the same types of services, their costs differ. Use this chart and other **tools** on to understand your options and choose the plan that best fits your needs.

	UnitedHealthcare CDHP–HSA		UnitedHealthcare POS Plan		Kaiser Permanente HMO (California only)	
PAYCHECK DEDUCTIONS (PER BIWEEKLY PAY PERIOD)						
Employee	$0 (100% paid by Nutanix)		$0 (100% paid by Nutanix)		$0 (100% paid by Nutanix)	
Employee + Spouse **Employee + Children** **Employee + Family**	$55 $30 $80		$135 $75 $200		$95 $55 $140	
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 Account (HSA) and Health Reimbursement Account (HRA)	**Nutanix HSA contributions for 2024:** **Annual:** $800 Individual/$1,600 Family (prorated for hires after January 1, 2024) **One-time bonus:** $250 Individual/ $500 Family **Employee Contribution Maximums:** $4,150 Individual/$8,300 Family		N/A		**Nutanix HRA Contributions:** $1,500 Individual/$3,000 Family **Employee Contributions:** N/A	
Annual Deductible	$1,600 Individual $3,200 Family	$3,200 Individual $6,400 Family	$0 Individual $0 Family	$6,000 Individual $12,000 Family	$0 Individual $0 Family	N/A
Annual Out-of-Pocket (OOP) Maximum (includes deductibles, coinsurance, copays, and pharmacy)	$3,200 Individual $6,400 Family	$6,400 Individual $12,800 Family	$0 Individual $0 Family	$10,000 Individual $20,000 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%	$0	Not covered	$0	Not covered
Well-baby/Well-child Visit	$0	30%	$0	Not covered	$0	Not covered
Virtual Care (available by phone or video visit)	10%	30%	$0	40%	$0	Not covered
Doctor or Specialist Visit	10%	30%	$0	40%	$20 copay for most visits	Not covered
X-ray/Lab/Imaging	10%	30%	$0	40%	X-ray/Lab: $10 Imaging: $50	Not covered
Inpatient Hospital/Surgery	10%	30%	$0	40%	$250 copay per admission	Not covered
Urgent Care	10%	30%	$0	40%	$20 copay per visit	Not covered
Emergency Room	10%	10%	$0	$0	$50 copay per visit	$50 copay per visit
Ambulance	10%	10%	$0	$0	$100 per trip	$100 per trip

* After deductible

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 CDHP–HSA		UnitedHealthcare POS Plan		Kaiser Permanente HMO (California only)	
BEHAVIORAL HEALTH AND 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%	30%	$0	40%	$20 copay for most visits	Not covered
Doctor or Specialist Visit	10%	30%	$0	40%	$20 copay for most visits	Not covered
Outpatient Care	10%	30%	$0	40%	$20 copay per visit	Not covered
Inpatient Care	10%	30%	$0	40%	$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 and Occupational Therapy	10%	30%	$0	40%	$20 copay	Not covered
			60 visits per year for each therapy type (in- and out-of-network combined); limits do not apply for an autism diagnosis			
Applied Behavioral Analysis (ABA) Therapy	10%	30%	$0	40%	$20 copay	Not covered
Chiropractic Care	10%	30%	$0	40%	$15 copay *Limit of 20 visits per year*	Not covered
	Limit of 24 visits per year		*Limit of 24 visits per year*			
Acupuncture	10%	30%	$0	40%		
	Limit of 24 visits per year		*Limit of 24 visits per year*			
Fertility Treatment (infertility diagnosis and treatment of underlying medical condition covered)	10%	30%	$0	40%	50%	Not covered
Gender Affirmation Benefits	10%	30%	$0	40%	Copay varies—contact Kaiser Permanente for details	Not covered
Nutritionist Visit	10% *No visit limits*	30%	$0 *No visit limits*	40%	$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% for retail and mail-order**	Retail: 30%** Mail-order: Not covered	Retail: $0** Mail-order: $0**	Retail: $10** 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% for retail and mail-order**	Retail: 30%** Mail-order: Not covered	Retail: $0** Mail-order: $0**	Retail: $30** 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% for retail and mail-order**	Retail: 30%** Mail-order: Not covered	Retail: $0** Mail-order: $0**	Retail: $50** Mail-order: Not covered		Not covered

* After deductible

** 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. See the **UnitedHealthcare list of medications** and the **Kaiser list**

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**