NXP 2024

Summary Plan Description

NXP Benefits: Health, Wellness, Life and More

U.S. Benefits

Effective January 1, 2024

Introduction

A Rewards Package to Fit Your Lifestyle

As an employee of NXP USA, Inc. (NXP), you drive the innovation that sets our company apart – and fuels our success in the market. To reward your dedication and commitment, we offer a competitive and comprehensive rewards program – including benefits to protect your health and enhance your life.

About this SPD

While at NXP, you will make many important decisions regarding you, your family, wellness and health care. This Summary Plan Description (SPD) provides you with useful information to help you make your choices along with tips on taking full advantage of your NXP reward programs.

In addition, this document is your official SPD for the NXP Employee Health Benefit Plan, as described in and required under the Employee Retirement Income Security Act (ERISA).

This SPD is divided into the following sections:

- **Participation** includes information about who is eligible for the benefits described in this SPD, how to enroll, when coverage begins, when you can make changes and when coverage ends. You will also find information about continuing some coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA);
- **Health and Wellness** includes:
  - **Medical coverage**, including behavioral health and prescription drug for the following medical options:

UnitedHealthcare Medical Plan 1 (-HSA eligible);

- UnitedHealthcare Medical Plan 2 (PPO);
- UnitedHealthcare Medical Plan 3 (EPO);

UnitedHealthcare Out--of--Area (OOA) Plan; and

- Kaiser Permanente HMO;

  - **Dental coverage**;
  - **Vision coverage**;
  - **Wellness programs**; and
  - **Flexible spending accounts**, describing how you can save on taxes when you pay certain health care and dependent care expenses;

Disability Income Benefits, including short- and long--term disability;

- **Life, Accidental Death and Dismemberment and Business Travel Accident Benefits**, addressing life insurance plans for you and your dependents, as well as accidental death and dismemberment and business travel accident coverage;
- **Work/Life Programs and Life Events**, which include information on programs (such as legal services, identity theft protection and more) that assist with daily needs and describe what to do when you experience various life events, such as marriage, divorce or birth of a child;
- A **claims and appeals** section, including information about how benefits are coordinated, your privacy rights;
- A **plan information** section with other important information and your ERISA rights under the Employee Health Benefit Plan;
- A **definitions** section with explanations of terms and phrases commonly used throughout this SPD;
- An **index** to help you put your finger on the exact information you need; and
- A **contact information** reference, conveniently located at the back of the SPD, of telephone numbers, websites and other resources available for additional benefit claims and appeals information.

Each section includes, as applicable:

- Explanations of the benefit plans, with helpful charts and tables;
- Tips on getting the most from your benefits; and
- Important facts, resources, dates and deadlines.

Throughout the SPD, you will see references to where you can find additional information through various websites, toll--free numbers, addresses and other helpful sources. These are great tools to get the latest rewards news.

Keep this SPD handy and refer to it often as your resource for information on the many benefits of NXP's Rewards package.

UPDATES TO THE SUMMARY PLAN DESCRIPTION FOR THE NXP USA, INC. EMPLOYEE HEALTH AND WELFARE PLAN

Issued July 2024

The NXP USA, Inc. Employee Health and Welfare Benefit Plan (the "Plan") has recently been amended and changes outlined here are consistent with that amendment. The changes to the Summary Plan Description (the "SPD") for the Plan dated January 1, 2024 are set forth below:

Effective January 1, 2025, NXP is discontinuing the annual carryover allowance that was previously available under the Flexible Spending Account ("FSA") Plan (**see here**). You will be able to continue fully participating in the FSA Plan after this change becomes effective, but you will no longer be able to carry over a portion of your unused Health Care/Limited Use Health Care FSA account balance to fund reimbursements incurred in subsequent Plan Years. Any amounts held in your Health Care/Limited Use Health Care FSA after December 31, 2024 will be available to fund reimbursement claims for eligible health care expenses incurred in 2024 by you and your eligible family members through December 31, 2024 but may not be carried forward to reimburse claims incurred in 2025 or later Plan Years. You have until March 31, 2025 to submit claims for reimbursement for expenses you incurred in 2024. After March 31, 2025, any remaining balance in your Health Care/Limited Use Health Care FSA that was contributed during 2024 or an earlier year will be forfeited and used to fund the Plan's administrative expenses or for other permissible purposes as described in the Plan.

The applicable contribution limit, the health care expenses that are eligible for reimbursement under your Health Care/Limited Use Health Care FSA, the reimbursement process, and the other key terms outlined in the SPD will not be affected by the discontinuation of the annual carryover allowance.

These changes will not impact the Dependent Care Flexible Spending Account or Health Savings Account program nor will they change the existing rules for making pre-tax salary reductions to cover your share of the cost of coverage for medical, dental, vision, and other benefits available under the Plan.

NXP Benefits

An "X" in the column indicates that the benefit or program described in this SPD applies to you.

Benefit or Program	Domestic Employees *	Interns	U.S. Expatriates on U.S. Payroll	U.S. Inpatriates on U.S. Payroll
Activity Centers	X	X	X	X
Adoption Assistance Program	X	X	X	X
Behavioral Health Program	X	X	Eligible through global medical plan	Eligible through global medical plan
COBRA Continuation Coverage (Medical, Dental, Vision, Health Care Flexible Spending Account (FSA))	X	X	Limited eligibility through global medical plan	Limited eligibility through global medical plan
Dental Plan	X	X	Eligible through global medical plan	Eligible through global medical plan
Dependent Care Flexible Spending Account (DCFSA)	X	X	X	X
Disability Income Benefits	X	X	X	X
EAP, Live and Work Well Program	X	X	X	X
Health Care/Limited Use Health Care Flexible Spending Account (FSA)	X	X	X	X
Health Savings Account (HSA)	X	X		
Life Insurance Plans	X	X	X	X
Medical Plan	X	X	Eligible through global medical plan	Eligible through global medical plan
Prescription Drug Program	X	X	Eligible through global medical plan	Eligible through global medical plan

Benefit or Program	Domestic Employees *	Interns	U.S. Expatriates on U.S. Payroll	U.S. Inpatriates on U.S. Payroll
Vision Plan	X	X	Eligible through global medical plan	Eligible through global medical plan
Wellbeing@NXP	X	X	X	X
Work/Life Programs (Adoption Assistance, Backup Care, Identity Theft Protection, Legal Services Plan, Pet Insurance, Travel Assistance, Tutoring)	X	X	X	X

* *Assumes you are working 20 or more hours per week.*

U.S. Expatriates and U.S. Inpatriates

A U.S. Expatriate or U.S. Inpatriate is defined as an NXP employee on the payroll of an NXP entity based in the United States, regardless of where the employee actually performs work.

U.S. Expatriates are employees of NXP or a participating entity that are on assignment outside the U.S. as determined by NXP Global Mobility. The benefits described in this SPD are available to you as outlined if you are a U.S. Expatriate on U.S. payroll.

U.S. Inpatriates are employees of NXP or a participating entity that are transferred from their home country to the U.S. for an assignment as determined by NXP Global Mobility. The benefits described in this SPD are available to you as outlined if you are a U.S. Inpatriate on U.S. payroll.

See NXP Benefits chart above for a summary of your benefits and watch for the outlined, shaded boxes like this one that contain important information specifically for you. This information will help you identify which programs apply and assist you in taking full advantage of all the benefits available to you.

NXP 2024 Summary Plan Description

This SPD represents general information regarding provisions of the NXP Rewards Plans. You should not rely on this information other than as a summary of the features of the Plans.

Your rights are governed by the terms of the respective Plan documents. Refer to the Plan documents for complete information on your Plan rights and responsibilities. Also, any questions concerning the Plans are determined according to the terms of the Plan documents and not this SPD. You may get a copy of any Plan document governed by ERISA upon written request to the NXP Benefits Service Center.

In the event of any difference between the terms of this SPD and the Plan documents, the Plan documents' terms control.

No person has the authority to make any oral or written statement or representation of any kind that is legally binding upon NXP or that alters the Plan documents, or any contracts or other documents maintained in conjunction with the Plans.

NXP, the sponsor of the Plans, has reserved the sole right at any time to amend, modify or terminate one or more of the Plans described in the SPD. You will be notified of any changes.

This SPD describes the Plans, as each has been amended to date. Summaries of Material Modifications (SMMs) or new SPDs will be provided to advise you of changes in the Employee Health Benefit Plan, as required by ERISA.

Table of Contents

Participation

This section includes information about:

Eligibility

Employee Eligibility

Health and Wellness

You are eligible for NXP's Health, Wellness, Life, Disability, Accidental Death and Dismemberment, Disability, Legal Plan and Work Life Program benefits if:

- You are a U.S. domestic employee of NXP or a participating subsidiary on the U.S. payroll or you are a U.S. Expatriate or U.S. Inpatriate on the U.S. payroll;
- You are regularly scheduled to work at least 20 hours per week; and
- You have reported to work for your first day of employment on the day your coverage becomes effective*.

* *The last requirement does not apply if you are not actively at work on that date because of illness or other medical condition. However, in no event will your coverage begin until you have reported to work on your first day of employment.*

You are not eligible to participate if you provide services to NXP or a participating subsidiary under an independent contractor, consultant or employee leasing agreement, or if you are classified as contract labor. If you are a collective bargaining employee, you are eligible to participate only if your union agreement requires that you be eligible.

If you are a member of a group of employees who become employees of NXP or one of its participating subsidiaries as a result of a merger, an acquisition or the ending of a joint venture in which NXP or the subsidiary took part, you are eligible only if and to the extent that NXP expressly extends coverage to your group.

Pre-Existing Conditions

The NXP Medical Plan does not have any "pre-existing condition" restrictions.

However, the -Long-term Disability Plan does include pre-existing condition restrictions;

Flexible Spending Account (FSA)

You are eligible for NXP's Flexible Spending Account Plan if:

- You are a U.S. domestic employee of NXP or a participating subsidiary on the U.S. payroll or you are a U.S. Expatriate or U.S. Inpatriate on the U.S. payroll;
- You are regularly scheduled to work at least 20 hours per week; and
- You have reported to work for your first day of employment on the day your coverage becomes effective*.

* *The last requirement does not apply if you are not actively at work on that date because of illness or other medical condition. However, in no event will your coverage begin until you have reported to work on your first day of employment.*

You are not eligible to participate if you provide services to NXP or a participating subsidiary under an independent contractor, consultant or employee leasing agreement or if you are classified as contract labor. If you are a collective bargaining employee, you are eligible to participate only if your union agreement requires you to be eligible.

If you are a member of a group of employees who become employees of NXP or one of its participating subsidiaries due to a merger, an acquisition or the ending of a joint venture in which NXP or the subsidiary took part, you are only eligible if, and to the extent that, NXP expressly extends coverage to your group.

While health, limited use health care and dependent care accounts in the FSA Plan reimburse expenses for your eligible or qualified dependents (as defined for purposes of each account), you do not enroll family members in the FSA Plan.

Dependent Eligibility

For information on enrolling dependents and changing coverage, see Enrolling Your Eligible Spouse/Domestic Partner and Dependents 13

For information on dependents for which you are eligible for reimbursement under a flexible spending account, see Health Care/Limited Use Health Care Flexible Spending Account (FSA) 219 and Dependent Care Flexible Spending Account (DCFSA) 226. For information on dependents for which you are eligible for reimbursement under a health savings account, see Health Savings Account (HSA) 154

When you enroll in or are covered by the NXP Medical, Dental, Vision or Life Insurance Plans, you may also enroll your "eligible dependents." The NXP Benefits Service Center may require documentation to verify your dependents' relationship or eligibility, both when you enroll them and/or at any time they are covered.

You may enroll for individual or family coverage under the Identity Theft Protection program.

Your eligible dependents are covered under the Legal Services Plan when you enroll; you do not need to enroll your dependents.

Your eligible dependents include:

- Your legally recognized spouse* claimed as your federal tax dependent; or

Your -same-sex or opposite -sex domestic partner, meaning a person who has lived with you for at least six months, is not a blood relative of yours, is not legally married or in another domestic partner relationship and is at least 18 years old; and

- Your married and unmarried children** through the end of the month in which they reach age 26, except for child life insurance. For child life insurance, your unmarried children* through the end of the month in which they reach age 26; married children are not eligible for child life insurance regardless of age; and
- A child who is over age 25 who is:

– Incapable of working because of a mental or physical disability that began before age 26; and

– Financially supported by you.

* *For tax purposes, the Plans use federal tax laws to determine who is your spouse. If you are legally married, including a common -law marriage, in a state or country that recognizes same -sex spouses, your same -sex spouse is eligible for coverage as your spouse.*

** *Your children include your children by birth, adoption or pending adoption or legal guardianship, stepchildren or children of your domestic partner who live with you, foster children legally placed by a licensed agency, grandchildren you legally adopt or for whom you are the court -appointed guardian and children you must cover under a Qualified Medical Child Support Order (QMCSO).*

Your grandchild is not considered your eligible dependent for Plan coverage unless you have legally adopted the grandchild, or you have been appointed legal guardian through the courts.

You may not enroll your siblings, parents, -in-laws, ex--spouses, grandparents or grandchildren as your dependents, nor a dependent who is already covered by an NXP Plan.

Incapacitated Dependent Requirements

- If a dependent child becomes incapable of sustaining employment because of mental or physical disability, such individual may remain an eligible dependent under the Plan until such incapacity ends.
- You must provide proof of incapacity and dependency to UnitedHealthcare within 60 days after the child's coverage would otherwise end. You may also be asked to provide this proof from time to time to continue the child's coverage.
- For life insurance, proof of any handicap must be sent to MetLife no later than 31 days after the child reaches the age limit. To initiate the process, contact the NXP Benefits Service Center who will work with MetLife to complete the process.

Call the NXP Benefits Service Center at 888-375-2367 if you need assistance submitting your documentation or have any questions about the incapacitated dependent requirements.

Domestic Partner Eligibility Rules

Your eligible dependents under the NXP benefit plans include your domestic partner as well as the domestic partner's natural children, adopted children and children for whom your domestic partner is a legal guardian, provided you or your domestic partner may (but are not required to) properly claim the children as dependents on your (or domestic partner's, if applicable) tax return.

> If you and your same-sex spouse are legally married under the laws where the marriage was performed, your same-sex spouse is considered a spouse under the Plan rather than a domestic partner. In addition, legally wed same-sex couples will be treated as married for federal tax purposes, regardless of whether or not you live in a jurisdiction/state that recognizes same sex marriage.

To be eligible for domestic partner coverage under the NXP benefit plans, the following eligibility requirements must be met:

- You and your domestic partner are registered as domestic partners according to applicable city, county or state laws; or
- In the absence of domestic partner registration, all of the following requirements must be met (the NXP Benefits Service Center may request documentation and/or an **affidavit**):
  - You and your domestic partner are at least 18 years of age and have lived together for at least six months;
  - You and your domestic partner are not related to one another to a degree that would prevent marriage under the law of the state in which you reside; and
  - Neither you nor your domestic partner are married to another person under statutory or common law and neither of you are in another domestic partnership.

An affidavit can be requested from the NXP Customer Service Center or downloaded from **nxp.com/docs/en/brochure/COMMONLAW_AFFIDAVIT.pdf**.

Tax Implications and Information

While your eligible dependents may include your domestic partner and your domestic partner's eligible children (i.e., children whom you or your domestic partner can, but is not required to, properly claim as dependents on your or your domestic partner's tax return), most domestic partners and their children **do not qualify** under Internal Revenue Code Section 152 as your dependents.

Generally, to be a Section 152 dependent for health and welfare benefits under the Plan, your domestic partner and/or children of your domestic partner must:

- Live in your home;
- Be in a relationship with you that does not violate local law;
- Be a citizen of the U.S. or a resident of the U.S. or a country contiguous to the U.S.; and
- For your taxable year, be over 50% supported by you.

See **Section 152 Dependent** 427 for more information.

For domestic partners and their children who do not qualify as your Section 152 dependents. NXP includes in your reportable income the value of any medical, dental, vision and spouse/domestic partner and/or child(ren) life insurance coverage that NXP provides for them.

Therefore, before enrolling for domestic partner benefits, you should check with your tax adviser for assistance in determining the precise manner in which these additional benefits affect your personal income tax situations.

Different rules may apply for state income tax purposes.

Protection Against Use of Genetic Information

The Medical, Dental and Vision Plans will not deny, limit or cancel health care coverage for you or your eligible dependents based on genetic information.

Rescission of Coverage

Once you or a dependent are covered under a group health plan, a retroactive termination (that is, a rescission) is prohibited unless you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact, as prohibited by Plan terms. In this case, the Plan will provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded. If it is determined (for example, through a dependent eligibility audit) that you have enrolled an ineligible dependent or do not timely certify a dependent, that could constitute an intentional misrepresentation of a material fact and result in a retroactive termination of the ineligible dependent's coverage. A retroactive termination is not a rescission to the extent it is attributable to a failure to timely pay required premiums or contributions for the cost of coverage.

Spouse/Domestic Partner and Child(ren) Life Insurance Eligibility

> Eligibility rules for Child(ren) Life Insurance are different from those for Health and Wellness plans.

Your spouse/domestic partner is eligible for Spouse/Domestic Partner Life Insurance. Your unmarried children and your domestic partner's unmarried children from live birth up to age 26 are eligible for Child(ren) Life Insurance. Children older than age 26 may continue coverage if they are incapacitated; see **Incapacitated Dependent Requirements** 5 for details.

Your child must be your natural child, adopted child or stepchild (including the child of a domestic partner); or foster child who resides with you and who is supported by you; and who, in each case, is under age 26 and unmarried. Also eligible is your grandchild who is under age 26, unmarried and who was able to be claimed by you as a dependent for federal tax purposes at the time you applied for Life Insurance.

A child will be considered your adopted child during the period you are party to a suit in which you are seeking the adoption of the child.

Your dependent is not eligible if on the date the life insurance coverage is scheduled to take effect, your dependent is:

- On active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard;
- Insured under the group policy as an employee;
- Confined at home under a physician's care;
- Receiving or applying to receive disability benefits from any source;
- Hospitalized; or
- Married.

Dependent Identity Theft Protection and Legal Services Plan Eligibility

Once you enroll yourself, your eligible dependents, as outlined in **Dependent Eligibility** 4, are also eligible for Identity Theft Protection and the Legal Services Plan, as applicable depending on your enrollment.

If Your Spouse/Domestic Partner or Child Works at NXP

No one may be covered by any NXP Rewards plan as both an employee and a dependent, and no eligible dependent may be enrolled by more than one eligible employee. If you are an eligible employee and your spouse/domestic partner is an eligible employee, retiree or Terminated Disabled Participant (TDP), you have these enrollment options for NXP medical, dental, vision and life insurance coverage:

- One of you may enroll as an employee and the other enrolls as a dependent; or

You may each enroll as an employee.

Only one of you may enroll your children as dependents. For life insurance, neither of you may enroll in spouse/domestic partner coverage. Duplicate coverage is allowed under the NXP's Flexible Spending Account Plans, but IRS regulations limit benefits under those Plans.

Working Beyond Age 64

If you intend to continue working at NXP past age 64, although you may be entitled to Medicare beginning on your 65th birthday, NXP will continue to be the primary source of coverage for you and possibly for any eligible dependents. Social Security may allow you to defer your Medicare coverage beyond your 65th birthday without penalty until you retire. For information about Medicare, including when and how to enroll, see **When You Reach Age 65** 340 for details.

If you need help completing any Social Security Administration (SSA) Form, contact the NXP Benefits Service Center at 888-375-2367.

At Retirement

When you retire, you may be eligible for medical (including behavioral health and prescription drug), dental and vision coverage under the NXP U.S. Post-Employment Benefits Plan (Post-Employment Benefits Plan), but only if you met the age and service requirements below on or before December 2, 2007. Your dependents' medical, dental and vision coverage may continue if your dependents remain qualified for coverage under the Post-Employment Benefits Plan. You must make the required contributions and continue to meet all of the other requirements of the Post-Employment Benefits Plan.

Check with the NXP Benefits Service Center if you have any questions about your eligibility for coverage after your retirement.

After December 2, 2007, no employee may become eligible for the Post-Employment Benefits Plan. Please see the Post-Employment Benefits Summary Plan Document (SPD) for further information.

Important Note: Those who did not meet the age and service requirements on or before December 2, 2007, are not eligible for the Post-Employment Benefits Plan, but may be eligible to continue health care coverage at retirement under COBRA. Check with the NXP Benefits Service Center for complete details.

Enrolling in NXP Rewards

Most NXP Rewards require your enrollment, but some cover you automatically if you are eligible.

Social Security Numbers Required

When you enroll, you need to provide Social Security Numbers (SSN) and/or Taxpayer Identification Number (TIN) for yourself and all eligible family members you enroll. Medicare Secondary Payer rules require group health plan insurers, third-party administrators and Plan Administrators or fiduciaries to report specific information regarding all covered members to the **Centers for Medicare and Medicaid Services (CMS)**. The statute and regulations are designed to benefit employer groups by making it easier to pay claims correctly the first time, thus increasing the accuracy of coordination of benefits with Medicare.

Automatic Enrollment for Medical Plan

If you do not complete your benefits enrollment within 30 days of becoming eligible, you will be automatically enrolled in the NXP Medical Plan 1 coverage option with employee-only coverage:

- If you live in an area served by an NXP provider network, you will be enrolled in the Medical Plan 1 coverage option; or
- If you live "out-of-area," you will be enrolled in the Out-of-Area Plan.

If You Are a U.S. Expatriate or U.S. Inpatriate

Medical (including behavioral health and prescription drug), dental and vision coverage for U.S. Expatriates and U.S. Inpatriates are provided by separate Global plans that are not described in this SPD.

U.S. Expatriates

Enrollment into the Global plans is automatic as long as you were enrolled in a U.S. medical plan before your assignment. Your Global plan enrollment will automatically include the same covered dependents as you were covering under the U.S. medical plan before your assignment. If you need to update your covered dependents and/or initiate enrollment into the Global plans call the NXP Benefits Service Center at 888-375-2367 within 30 days of your assignment begin date.

U.S. Inpatriates

Enrollment into the Global plans is not automatic. To enroll and add eligible dependents into the Global plans, call the NXP Benefits Service Center at 888-375-2367 within 30 days of your assignment begin date.

Opt Out of Medical Coverage

You may opt out of medical coverage within 30 days of the day you begin work, during annual enrollment or when you have a qualified status change (also commonly referred to as a life event change) that allows you to change your coverage election mid-year. If you opt out, you will not have any before-tax contributions automatically deducted from your paycheck.

To opt out, simply go online to **NXP.com/benefits** or call the NXP Benefits Service Center at 888-375-2367 within 30 days of the day you begin work.

FSA Enrollment

You are eligible to enroll in a Health Care Flexible Spending Account (or Limited Use Health Care Flexible Spending Account) and the Dependent Care Flexible Spending Account as of the day you begin work. If you enroll within 30 days of becoming eligible, your participation in that account begins on your first day of eligibility.

If You Are a U.S. Expatriate or U.S. Inpatriate

If you are a U.S. Expatriate who participated before assignment in either account, you will continue to participate as a U.S. Expatriate. Otherwise, you may establish an account within 30 days of your U.S. Expatriate or U.S. Inpatriate assignment begins date.

Short-Term Disability Buy-Up Enrollment

You may only elect Short-Term Disability Buy-Up coverage when you are first eligible (such as when you join NXP) or during any annual enrollment. You may not elect this coverage due to a qualified status change.

If you do not enroll within 30 days of your hire date, you may not elect coverage until the next annual enrollment.

Identity Theft Protection and Legal Services Plan Enrollment

You may only elect Identity Theft Protection and/or Legal Services Plan coverage when you are first eligible (such as when you join NXP) or during any annual enrollment. You may not elect or withdraw from this coverage due to a qualified status change.

If you do not enroll within 30 days of your hire date, you may not elect coverage until the next annual enrollment.

Enrolling Your Eligible Spouse/Domestic Partner and Dependents

Your eligible spouse/domestic partner and dependents are **not** automatically covered under the Plans offering dependent coverage. You must elect coverage for them under your medical (including behavioral health and prescription drug), dental, vision and/or life insurance coverage choices and then enroll each as follows:

- **Medical, dental, vision and life insurance coverage**: You may enroll your eligible spouse/domestic partner and dependents:
  - Within 30 days of when you initially meet the eligibility requirements;
  - During annual enrollment;
  - When you have a qualified status change or other applicable life event change (see **When You May Change Your Coverage** 24; or
  - When special enrollment rights are triggered (see **HIPAA Special Enrollment** 29.

Contacting your UnitedHealthcare Advocate, requesting prior authorization and participation in the Maternity Support Program does not automatically enroll your newborn child in the Plans. You must call UnitedHealthcare at 844-210-5428 or call the NXP Benefits Service Center at 888-375-2367 within 30 days of the date of birth to enroll your newborn.

If You Are a U.S. Expatriate or U.S. Inpatriate

Medical (including behavioral health and prescription drug), dental and vision coverage for U.S. Expatriates and U.S. Inpatriates on U.S. payroll are provided by separate Global plans that are not described in this SPD.

U.S. Expatriates

Enrollment into the Global plans is automatic as long as you were enrolled in a U.S. medical plan before your assignment. Your Global plan enrollment will automatically include the same covered dependents as you were covering under the U.S. medical plan before your assignment. If you need to update your covered dependents and/or initiate enrollment into the Global plans call the NXP Benefits Service Center at 888-375-2367 within 30 days of your assignment begin date.

U.S. Inpatriates

Enrollment into the Global plans is not automatic. To enroll and add eligible dependents into the Global plans call the NXP Benefits Service Center at 888-375-2367 within 30 days of your assignment begin date.

Your Responsibilities – Enrolling and Certifying Your Spouse/Domestic Partner and Dependents

It is your responsibility to ensure that you, your spouse/domestic partner and the dependents you enroll are eligible for coverage according to Plan terms and conditions. When you enroll your spouse/domestic partner and/or dependents or change your benefit elections, you represent that these individuals meet the definition of an eligible spouse or dependent under the applicable Plan. NXP or the Dependent Verification Center may require you to provide documentation verifying any person's eligibility. *You agree to notify the NXP Benefits Service Center within 30 days* of any event that causes any of your covered spouse/domestic partner or dependents to no longer meet the definition of an eligible spouse or dependent.

If you provide information that is untrue or incomplete, you do not promptly comply with NXP's request for verifying documentation or you do not timely notify the NXP Benefits Service Center of an event that causes your covered spouse/domestic partner or dependent to no longer be eligible, NXP may, in its sole and absolute discretion:

- Subject you to discipline up to and including termination of employment;
- Obligate you to reimburse the appropriate NXP Reward plan for any medical (including behavioral health and prescription drug), dental and vision expenses paid by the Plan, as far back as administratively possible, for the ineligible dependent;

- Terminate your spouse's/domestic partner's and/or dependent's coverage prospectively or retroactively or refuse to cover your spouse/domestic partner and/or dependents; and/or
- Take other action as it may determine is appropriate.

You will not be reimbursed for any contributions you paid to provide coverage to your ineligible spouse/domestic partner or dependent.

Paying for Coverage

You and NXP share the cost of your Medical and Dental Plan coverage.

NXP pays the full cost of the Employee Assistance Program, Short-Term, Long-Term Disability, Basic Employee Life Insurance, AD&D Insurance and Business Travel Accident Insurance.

You pay the full cost of Vision Plan, Short-Term Buy-Up Plan, Supplemental, Spouse/Domestic Partner and Child(ren) Life Insurance, Identity Theft Protection and Legal Services Plan coverage.

As a participant, generally, you pay contributions with each paycheck (26 contributions per year) on a before-tax basis, unless noted below. The cost of coverage may be adjusted from time to time. You may call the NXP Benefits Service Center to review current coverage rates before enrolling. In addition, you are notified of the contribution amounts during annual enrollment.

Contributions for coverage for your **domestic partner** must be paid on an after-tax basis unless he or she qualifies as your dependent under Internal Revenue Code Section 152; see **Section 152 Dependent** 427 for details.

For **Short-Term Disability Buy-Up coverage**, if you are disabled and receiving benefits, your after-tax contributions are waived. When you return to work, your contributions will resume through payroll deduction at the rate in effect when you return.

If elected, you pay the full cost of Supplemental, Spouse/Domestic Partner and Child(ren) Life Insurance coverage, but on an after-tax basis.

To be covered by **Supplemental Life Insurance**, you must make after-tax contributions for the coverage. The cost of Supplemental Life Insurance is based on the coverage option you choose, tobacco use status and your age.

Your Medical Plan, Supplemental Life Insurance and Spouse Life Insurance Plan contributions are also based on your tobacco use status. When you enroll each year, you complete a certification of tobacco use. The Plan offers discounted rates when you certify you:

- Have not used tobacco products for the past 6 months; or
- Are enrolled in a smoking cessation program.

If you or your spouse/domestic partner are a tobacco user, we offer a tobacco cessation program at no cost to you. The Quit For Life® program lets you work with a certified coach. If you complete the program, you can avoid the tobacco surcharge. To get started, contact UHC at (844)210-5428.

For Supplemental Life Insurance and Spouse Life Insurance, tobacco use status cannot change during the calendar year, even if you have a qualified status change (see **Qualified Status Change and Special Enrollment** 26.

To be covered by Identity Theft Protection and/or the Legal Services Plan, you must make -after-tax contributions for the coverage.

Government Assistance for Children's Coverage

If your eligible child qualifies for health coverage under the federal Children's Health Insurance Program (CHIP), you may qualify for a government subsidy of the cost of covering the child under the NXP Medical and Dental Plans.

If this applies to you, please contact the NXP Benefits Service Center at 888-375-2367.

Proof of Coverage – IRS Form 1095

Form 1095 is a tax form that is required to be provided under the Affordable Care Act (ACA) as proof to the IRS that you had coverage. You can expect to receive a Form 1095 in January 2024 to use when filing your 2023 taxes. This form shows the months of the year that you and/or your dependents were offered or enrolled in medical coverage. (This form will not replace any state forms you may receive providing proof of medical insurance.)

You will receive Form 1095 if, for at least one day in 2023, you were any of the following:

- A full-time employee;
- A part-time employee who was enrolled in medical coverage;
- An individual with COBRA coverage; or
- A retiree or dependent of a retiree under age 65 who was enrolled in coverage.

You may need this form when filing your taxes to prove that you are adequately insured, which is why it is important to keep this form with other important tax documents.

Forms for the 2023 tax year will be mailed no later than January 31, 2024. Please allow 7 to 10 business days for delivery. Or, if you would like to receive your Form 1095 earlier, you can sign up for electronic notifications.

When you consent to electronic notification, you agree to be notified by email or text when Form 1095 is available online. Once you are notified, you can log on to your account to view and print the form. Form 1095 will not be sent to you by email or text; the only electronic communication you receive is the notice informing you that you can access the form online.

There are three versions of Form 1095:

- Form 1095-A, Health Insurance Marketplace Statement;
- Form 1095-B, Health Coverage; and
- Form 1095-C, Employer-Provided Health Insurance Offer and Coverage.

Form 1095 Questions

This information is only a summary to help you understand the Form 1095, why it is important and how it affects you. If you have questions about these forms or see something on Form 1095 that you believe is incorrect, call the phone number listed in the top right corner of the tax form. You can also learn more at **IRS.gov** and/or by speaking with your legal or tax advisor.

Form 1095 Reprints

If you need a copy of your Form 1095, contact the NXP Benefits Service Center at 888-375-2367.

Benefits Value on W-2 Statement

The ACA also requires NXP to report the cost of coverage under its group health plans on an employee's Form W-2. Reporting the cost of health care coverage on a Form W-2 does not mean that the coverage is taxable to the employee. The value of an employer's excludable contribution to health coverage continues to be excludable from an employee's income, and it is not taxable. This reporting is for informational purposes only and is intended to provide employees useful and comparable consumer information on the cost of health care coverage.

The value of the NXP medical coverage will be reported in Box 12 of Form W-2, with Code DD to identify the amount. Visit the **IRS.gov Frequently Asked Questions** for more information.

Before-Tax Contributions and Social Security

Your before-tax contributions reduce the amount of pay on which your federal income taxes and most state and local income taxes are calculated. Your before-tax contributions also reduce the amount of pay on which your FICA (Social Security and Medicare) taxes are figured. Because these taxes are calculated on a lower taxable income amount, you pay less tax. This has the effect of reducing the cost of your NXP coverage.

When you reduce the amount of your pay that is subject to Social Security taxes, you may also reduce your Social Security benefit. Any benefit reduction, however, should be only slight, and it will likely be more than offset by your reduced taxes.

Health and Wellness Coverage

Your coverage under the Health and Wellness Plans begins on the day you actually start work. If you are off work for any reason other than illness when your coverage is supposed to start, coverage begins on the date you actually start work. However, in no event will your coverage begin until you have reported to work on your first day of employment.

Earliest Date Coverage Can Begin		
Plan	**You**	**Your Dependents**
U.S. Domestic Employees		
NXP Medical Plan	The day you begin work if you enroll within 30 days of that date.	The day you begin work if you enroll your dependents within 30 days of that date.
NXP Dental Plan	The day you begin work if you enroll within 30 days of that date.	The day you begin work if you enroll your dependents within 30 days of that date.
NXP Vision Plan	The day you begin work if you enroll within 30 days of that date.	The day you begin work if you enroll your dependents within 30 days of that date.
NXP Health Care/Limited Use Health Care and Dependent Care Flexible Spending Account Plans	The day you begin work if you enroll within 30 days of that date.	Not applicable
U.S. Expatriates and U.S. Inpatriates		
NXP Global Medical Plans (not described in this SPD)	The day you begin work if you enroll within 30 days of that date.	The day you begin work if you enroll your dependents within 30 days of that date.

Disability Income Benefits

Generally, both short-term and long-term disability coverages begin on the first day of the month following the date you have been continuously at work for 90 days as an employee regularly scheduled to work at least 20 hours per week.

If your employment terminates and you are rehired within six months, your new coverage will begin on your new date of hire; your prior employment counts toward any pre-existing condition period.

For Short-Term Disability Buy-Up coverage, when you enroll determines when your coverage begins and when you begin paying contributions. If you enroll within 30 days after your hire date, the coverage and your contributions will begin on the first of the month following 90 days of continuous service. If you are not actively at work on that date, your coverage will be delayed until you return to active work.

Supplemental Life Insurance Coverage

When you are initially eligible, if you complete the enrollment process within 30 days of becoming eligible for coverage, your coverage will begin as follows:

- If you are **not required** to provide evidence of insurability, coverage will begin on the date you become eligible, if you are actively at work on that date; or
- If you are **required** to provide evidence of insurability and MetLife determines that you are insurable, coverage will begin on the date MetLife states in writing, if you are actively at work on that date.

If you are not actively at work on the date coverage would otherwise begin, coverage will begin on the day you resume active work. In addition, you must have been actively at work for at least 20 hours during the seven calendar days before that date.

When Spouse/Domestic Partner and Child(ren) Life Insurance Coverage Begins

When your spouse/domestic partner and/or children are initially eligible, if you complete the enrollment process within 30 days of your spouse/domestic partner and/or children becoming eligible for coverage, the coverage will begin as follows:

- If the eligible individual is **not required** to provide evidence of insurability, coverage will begin on the date the eligible individual becomes eligible, if you are actively at work on that date and your dependent meets the additional requirements stated below; or
- If the eligible individual is **required** to provide evidence of insurability and MetLife determines that the eligible individual is insurable, coverage will begin on the date MetLife states in writing, if you are actively at work on that date and the eligible individual meets the additional requirements stated below.

If you are not actively at work on the date the eligible individual's coverage would otherwise begin, coverage will begin on the day you resume active work.

Additional Requirements

On the date the eligible individual's coverage is to begin, the eligible individual must not be:

- Confined at home under a physician's care;
- Receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If the eligible individual does not meet this requirement on that date, the eligible individual's coverage will begin when the eligible individual is no longer confined, receiving or applying to receive disability benefits from any source or hospitalized.

> An NXP employee may not be considered a dependent of another NXP employee for Spouse/Domestic Partner or Child(ren) Life Insurance; further, the same person cannot be a dependent of two NXP employees.

When Business Travel Accident (BTA) Insurance Begins

Your coverage for BTA Insurance begins on your first day of work or on the day you first meet the eligibility requirements for plan participation (see **Employee Eligibility** 2

Identity Theft Protection and Legal Services Plan

When you are first eligible, if you enroll within 30 days of your hire date, coverage is effective on the first day of the month after you submit your enrollment.

If you enroll or change/update your benefit elections during the annual enrollment period, coverage and/or changes becoming effective as of January 1.

Work/Life Programs

Your coverage for Work/Life programs begins the day you begin work, unless otherwise noted.

When You May Change Your Coverage

When you elect your coverage initially or when you want to change your coverage because you experience a qualified status change or life event, you must go online to **NXP.com/benefits** or call the NXP Benefits Service Center at 888-375-2367. Please read the following sections for information on when elections become effective under the Medical Plan, Dental Plan, Vision Plan, Flexible Spending Account Plan, Life Insurance Plan and Disability Income Plan.

New Employees: You should go online to **NXP.com/benefits** or call the NXP Benefits Service Center at 888-375-2367 promptly so your selected plan coverage can begin. You must do this within the new hire election period of 30 days from your date of hire. Once you submit your elections, you cannot make changes to your coverage unless you change your elections according to the provisions below.

Annual Enrollment

Each year, you have an opportunity to change your coverage elections under the Medical Plan, Dental Plan, Vision Plan, Health Care/Limited Use Health Care and Dependent Care Flexible Spending Account Plans, Health Savings Account, Life Insurance Plans, Disability Income Plans, Identity Theft Protection and Legal Services Plan for the following year. When you elect a coverage change during annual enrollment, your change is effective the following January 1, except for Life Insurance, as described below.

For Supplemental Life Insurance, when you elect a coverage change during annual enrollment, your change is effective as follows:

- If you are **not required** to provide evidence of insurability, coverage will take effect on the following January 1, if you are actively at work on that date; or
- If you are **required** to provide evidence of insurability and MetLife determines that you are insurable, coverage will take effect on the date MetLife states in writing, if you are actively at work on that date.

If you are not actively at work on the date coverage would otherwise take effect, coverage will take effect on the day you resume active work. In addition, you must have been actively at work for at least 20 hours during the seven calendar days before that date.

For Spouse/Domestic Partner and Child(ren) Life Insurance, when you elect a coverage change during annual enrollment, the change is effective as follows:

- If your eligible dependent is **not required** to provide evidence of insurability, coverage will take effect on the following January 1, if you are actively at work on that date and your dependent meets the additional requirements stated below; or
- If your eligible dependent is **required** to provide evidence of insurability and MetLife determines that the eligible individual is insurable, coverage will take effect on the date MetLife states in writing, if you are actively at work on that date and the eligible individual meets the additional requirements stated below.

If you are not actively at work on the date the eligible dependent coverage would otherwise take effect, coverage will take effect on the day you resume active work.

Additional Requirements

On the date the eligible individual's coverage is to take effect, the eligible individual must not be:

- Confined at home under a physician's care;
- Receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If your eligible dependent does not meet this requirement on that date, your eligible dependent's coverage will take effect when your eligible dependent is no longer confined, receiving or applying to receive disability benefits from any source or hospitalized.

Your annual coverage elections remain in force during the year unless you change your elections according to the provisions below.

Qualified Status Changes and Special Enrollment

If you experience a qualified status change that affects eligibility, you may be eligible to change **some or all** of your health and wellness, health care/limited use health care flexible spending account, dependent care flexible spending account, life insurance or disability income elections. The election you may make depends on the qualified status change and benefit; not all benefits may be changed due to a qualified status change (for example, you may not change your disability income election due to a change in the custody of a child); contact the NXP Benefits Service Center at 888-375-2367 for more information.

Qualified status changes include:

- Your marriage, establishment of an eligible **domestic partnership** 6, divorce, dissolution of a domestic partnership, legal separation or annulment;
- Death of your spouse/domestic partner;
- The birth, adoption, placement for adoption or death of a child (including the child of a domestic partner if the child is eligible under the plan);
- A change in custody of the child;
- A change in employment status by you or your spouse/domestic partner or dependent, including:
  - Beginning or ending employment;
  - A switch from part-time to full-time status (or vice versa);
  - A strike, lockout or layoff;
  - Beginning or returning from an unpaid or significantly reduced paid leave of absence;
  - A change in work site; and
  - Any other change in employment status that affects your or your spouse's/domestic partner's or dependent's health coverage;
- Beginning or ending a dependent's eligibility due to age, student status, incapacity or other similar circumstance;
- A change in the place of residence of you or your dependent that affects medical coverage (e.g., moving to or from a network location);
- You or your spouse/domestic partner or dependent enrolls in or lose coverage under Medicare (Part A or B) or Medicaid;

- You experience an unanticipated and significant change in cost of dependent care during the year, however, election changes are not allowed if the increase is imposed by a provider who is your relative;
- An unexpected and unforeseen event curtails your current dependent care arrangement or causes it to cease; or
- Any other event recognized under applicable law and regulations as a reason to change plan elections, such as becoming covered or losing coverage under the Health Insurance Marketplace.

A significant change in the cost of coverage may allow a change in some Plans 30

Your change in coverage is approved only if it qualifies as being consistent with the qualified status change as determined under the principles contained in the applicable Internal Revenue Service (IRS) regulations. The approved change in coverage is effective as of the date of the event, except for the life insurance coverage, as described below.

For Supplemental Life Insurance, when you elect a coverage change as a result of a qualified status change, your change is effective as follows:

- If you are **not required** to provide evidence of insurability, coverage will take effect on the date of the event, if you are actively at work on that date; or
- If you are **required** to provide evidence of insurability and MetLife determines that you are insurable, coverage will take effect on the date MetLife states in writing, if you are actively at work on that date.

If you are not actively at work on the date coverage would otherwise take effect, coverage will take effect on the day you resume active work. In addition, you must have been actively at work for at least 20 hours during the seven calendar days before that date.

For Spouse/Domestic Partner and Child(ren) Life Insurance, when you elect a coverage change as a result of a qualified status change, the change is effective as follows:

- If your eligible dependent is **not required** to provide evidence of insurability, coverage will take effect on the date of the event, if you are actively at work on that date and your dependent meets the additional requirements stated below; or
- If your eligible dependent is **required** to provide evidence of insurability and MetLife determines that the eligible individual is insurable, coverage will take effect on the date MetLife states in writing, if you are actively at work on that date and the eligible dependent meets the additional requirements stated below.

If you are not actively at work on the date the eligible dependent coverage would otherwise take effect, coverage will begin on the day you resume active work.

Additional Requirements

On the date your eligible dependent's coverage is to take effect, your eligible dependent must not be:

- Confined at home under a physician's care;
- Receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If your eligible dependent does not meet this requirement on that date, your eligible dependent's coverage will take effect when your eligible dependent is no longer confined, receiving or applying to receive disability benefits from any source or hospitalized.

Domestic Partners

The Internal Revenue Code limits benefit changes during the year for coverage paid for on a before-tax basis. To make a benefit change for elections paid on a before-tax basis, your domestic partner or child of your domestic partner must qualify as your **Section 152 dependent** 427), as defined under the Internal Revenue Code. For example, the establishment of a domestic partnership will not allow an election change for benefits to be paid on a before-tax basis unless your domestic partner qualifies as your dependent under the Internal Revenue Code. Any benefit changes during the year due to a domestic partner or child of a domestic partner who does not qualify as your dependent as defined under the Internal Revenue Code can only be made on an after-tax basis.

You may make the change in coverage by going online to **NXP.com/benefits** or by calling the NXP Benefits Service Center at 888-375-2367 within 30 days of a qualified status change.

HIPAA Special Enrollment

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to enroll yourself and your dependents under the Medical Plan and to enroll yourself in the Health Care/Limited Use Health Care Flexible Spending Account, even if you were not previously enrolled, when you acquire a new dependent or when you or your dependents lose coverage under another group health plan for any of the following reasons:

- You or your dependents exhaust COBRA coverage under another employer's group health plan (other than due to failure to pay contributions or for cause);
- Employer contributions toward the other group health plan coverage end; or
- You or your dependents lose eligibility under the other group health plan.

You must request a change in coverage within 30 days of the special enrollment event and your election is effective as of the date of the event. If you do not request the change within 30 days, you lose your special enrollment rights for that event.

You may enroll your eligible child for the Health and Welfare Plans within 60 days after your eligible child:

- Loses coverage under a Medicaid plan or state CHIP plan due to loss of eligibility; or
- Becomes eligible for a government subsidy of the cost of coverage for the NXP Medical and Dental Plans under a Medicaid plan or state CHIP plan.

If you do not request this change within 60 days, you lose your special enrollment rights for that event. For more information, contact the NXP Benefits Service Center at 888-375-2367.

Qualified Medical Child Support Order (QMCSO)

If you become subject to a Qualified Medical Child Support Order (QMCSO) that requires you to provide health coverage for a child, you may change your Medical Plan, Dental Plan, Vision Plan and/or Health Care/Limited Use Health Care Flexible Spending Account elections accordingly. The change is effective on the date the order is determined by the Plan to be qualified. The NXP Benefits Service Center will provide QMCSO procedures describing the process to follow in entering a QMCSO at your request. An order will not be approved for a child who does not otherwise meet the Plan's dependent eligibility conditions.

The NXP Benefits Service Center has established a special process for requesting information about QMCSOs. You may:

- **By Phone:** 888-375-2367

By Mail:
NXP Benefits Center
Attn: QMCSO Processing
P.O. Box 617907
Chicago, IL 60661

Significant Cost or Coverage Change/Change in Family Member's Plan

You may change your Medical, Dental or Vision Plan coverage election mid-year if:

- The cost of your current benefit option significantly increases or significantly decreases;
- An event occurs that significantly curtails coverage or causes you to lose coverage under your current benefit option;

- A benefit option is added or significantly improved under the Medical, Dental or Vision Plan during the year and you are eligible for it;
- You or your spouse/domestic partner or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution; or
- The change corresponds with a change made by you or your dependent (as defined above) under another employer plan in the following circumstances:

– If the annual enrollment period under the other plan occurs at a different time of year than annual enrollment under the NXP Medical, Dental and Vision Plans; or

– If the other employer plan allows you or your dependent to change elections due to the reasons described above (qualified status change, special enrollment, QMCSO, Medicare or Medicaid entitlement or significant cost or coverage changes).

You must request a change in coverage within 30 days of the change. Your election is effective the date the NXP Benefits Service Center approves your coverage change.

The Plan determines if a cost or coverage change is significant for these purposes.

Note: If you owe the Plan repayment of excess benefit payments, subrogated payments or amounts subject to reimbursement, you may not change any coverage in any respect until those amounts are repaid.

Marriage/Domestic Partnership

If you get married or establish an eligible domestic partnership, you may choose to enroll your spouse/domestic partner in the Plans in which he or she is eligible starting on the date of the marriage or establishment of the domestic partnership, if you apply for family coverage and enroll your spouse/domestic partner within 30 days after your marriage or establishment of domestic partnership.

If you marry abroad, you may enroll your spouse only if the marriage is valid in the country in which you marry and in the state of your primary residence while in the U.S.

Your child's marital status does not influence their eligibility for medical, dental or vision coverage.

Domestic Partner

You may enroll your domestic partner for medical, dental, vision and spouse/domestic partner life insurance coverage within 30 days of a qualified status change or during annual enrollment, provided you meet specific eligibility requirements. For more information, see **Domestic Partner Eligibility Rules** 6.

Divorce/End of Domestic Partnership

Your ex-spouse/domestic partner is not eligible to remain on your Plans as outlined in the **Dependent Eligibility** section above after your marriage or domestic partnership ends. You must notify the NXP Benefits Service Center within 30 days of the date of your divorce or the date your domestic partnership ends. Your ex-spouse/domestic partner may be eligible for COBRA coverage (see **COBRA Continuation Coverage**44.

If you get divorced, your dependents' eligibility for coverage can be affected. To inquire about your dependent's continuing eligibility for coverage, you should contact the NXP Benefits Service Center before the date of divorce.

Even if your children meet the eligibility requirements for eligible dependent children, you may not cover your children for medical, dental or vision benefits if your divorce decree states that your former spouse/domestic partner is responsible for the children's health coverage. You may, however, cover your eligible dependent children if required by your divorce decree or by the terms of a **Qualified Medical Child Support Order** 425.

> If you have a Health Savings Account (HSA), money in your HSA may be considered part of your assets when going through divorce proceedings. Therefore, these accounts may be subject to division under the terms of the divorce or a Qualified Domestic Relations Order (QDRO).

Enrollment at Any Time Other than Annual Enrollment, a Qualified Status Change or Special Enrollment

You may enroll in the Life Insurance Plans or elect to change your life insurance coverage at any time by contacting the NXP Benefits Service Center at 888-375-2367.

For Supplemental Life Insurance, if you request to enroll or elect to a change to your current coverage, your change is effective as follows:

- If you are **not required** to provide evidence of insurability, coverage will take effect on the date of your request, if you are actively at work on that date; or
- If you are **required** to provide evidence of insurability and MetLife determines that you are insurable, coverage will take effect on the date MetLife states in writing, if you are actively at work on that date.

If you are not actively at work on the date coverage would otherwise take effect, coverage will take effect on the day you resume active work. In addition, you must have been actively at work for at least 20 hours during the seven calendar days before that date.

For Spouse/Domestic Partner and Child(ren) Life Insurance, if you request to enroll or elect a change to current coverage, the change is effective as follows:

- If your eligible dependent is **not required** to provide evidence of insurability, coverage will take effect on the date of the request, if you are actively at work on that date and your dependent meets the additional requirements stated below; or
- If your eligible dependent is **required** to provide evidence of insurability and MetLife determines that the eligible individual is insurable, coverage will take effect on the date MetLife states in writing, if you are actively at work on that date and the eligible dependent meets the additional requirements stated below.

If you are not actively at work on the date the eligible dependent coverage would otherwise take effect, coverage will begin on the day you resume active work.

Additional Requirements

On the date your eligible dependent's coverage is to take effect, your eligible dependent must not be:

- Confined at home under a physician's care;
- Receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If your eligible dependent does not meet this requirement on that date, your eligible dependent's coverage will take effect when your eligible dependent is no longer confined, receiving or applying to receive disability benefits from any source or hospitalized.

FSA Participation

If you elect to participate in a Flexible Spending Account (FSA), your election remains in effect for the remainder of the calendar year, unless you have a qualified status change or another event that allows you to make an election change (see **When You May Change Your Coverage** beginning **here.**). Your request for a change must be consistent with the qualified status change circumstance. You may change your FSA election and how much you contribute to both accounts for the following year during each annual enrollment.

Special Participation Rules – Health Care and Limited Use Health Care Flexible Spending Accounts (FSAs) Only

Because the IRS considers Health Care FSAs health plans, these health plan enrollment rules apply (these do not apply to the Dependent Care FSA):

- HIPAA Special Enrollment; and
- Qualified Medical Child Support Order (QMCSO).

Identity Theft Protection and Legal Services Plan Participation

Identity Theft Protection and the Legal Services Plan requires that you maintain the coverage for the entire plan year.

Health and Wellness

If you are enrolled in the Medical Plan 1 coverage option and have a Health Savings Account (HSA), you "own" the HSA account. So, if you leave, you take the HSA with you.

Your coverage under the Medical, Dental, Vision and Health Care/Limited Use Health Care and Dependent Care FSA Plans ends on the earliest of the following dates:

- The last day of the month in which your employment with NXP (or a participating subsidiary) ends or in which you die;
- The last day of the month in which you begin a leave of absence (other than a military leave under the NXP Military Service Pay Policy or a disability leave of absence) if you have less than six months of service;
- The last day of the sixth month following the month you begin a leave of absence (other than military leave under the NXP Military Service Pay Policy or a disability leave of absence) if you have more than six months of service;
- The last day of the month for which you paid a contribution, if you have discontinued payments for any reason;
- The last day of the month in which you fail to meet the Plans' eligibility requirements, other than due to a leave of absence;
- The last day you receive military service pay under the NXP Military Service Pay Policy;
- If you are on a disability leave of absence, the earliest of:

– The last day of the month you are no longer disabled, unless you return to active employment with NXP or a participating subsidiary;
– The last day of the month for which you paid a contribution, if you have discontinued payments for any reason;
– The day you become eligible for coverage under the Post-Employment Benefits Plan (if you are on a disability leave of absence and your disability continues until your termination of employment under NXP's Medical Leave Policy or you become eligible to retire);
– The last day of the month your employment ends.

- 90 days after the Plan Administrator requires repayment from you or your covered dependent of amounts subject to reimbursement under any NXP welfare plan, overpayments or mistaken payments, if you fail to repay or set up an acceptable repayment schedule;
- For the Health Care/Limited Use Health Care and Dependent Care FSA Plans:

– The last day of the month in which you have a qualified status change that allows you to discontinue your participation; or

– 90 days after the Plan Administrator requests repayment from you or your covered dependent of amounts subject to reimbursement, overpayments or mistaken payments from any NXP welfare plan, if you do not repay or set up an acceptable repayment schedule; or

- The date the Plans end or the effective date of an amendment eliminating the coverage.

If you have any questions about coverage or eligibility, call the NXP Benefits Service Center at 888-375-2367.

When Dependent Coverage Ends

Coverage for a dependent under the NXP Medical, Dental and Vision Plans ends automatically on the earliest of the following dates:

- The last day of the month in which he or she ceases to be an eligible dependent;
- The last day of the month in which your coverage ends for any reason, including your death;
- The last day of the period for which you have paid for dependent coverage if you stop making your contributions;
- The last day of the month in which the dependent child enters the military service of any country (unless otherwise required by law);
- The last day of the month in which the dependent spouse/domestic partner enters the military service of any country other than the U.S.;
- 90 days after the Plan Administrator requires repayment from you or your covered dependent of amounts subject to reimbursement, overpayments or mistaken payments from any NXP welfare plan, if you fail to repay or set up an acceptable repayment schedule;
- The last day of the month in which your employment with NXP ends for a reason other than death;

- The date after your death on which your dependent child becomes covered by another group health plan that does not contain applicable pre-existing condition limitations;
- The date of your dependent's death; or
- The date the Plans end or the effective date of an amendment eliminating the coverage.

Continued Protection for Survivors

If you die while employed by NXP, your covered dependents may continue certain coverage (such as medical, dental, vision) for up to 36 months under COBRA (see **COBRA Continuation Coverage**) for more information. NXP subsidizes the cost of the first six months' COBRA coverage for your survivors. Your survivors will pay active employee contributions for the first six months of medical, dental and vision COBRA coverage (if enrolled before your death).

> If you have a Health Savings Account (HSA) when you die, the account may be transferred to your designated beneficiary. The account will continue to be considered an HSA for your spouse. However, if you designate another beneficiary (other than your spouse), it will no longer be considered an HSA and your beneficiary will be required to pay taxes on the account.

If you are eligible for retiree coverage when you die, your dependents who were covered *or eligible* for coverage under the Medical, Dental and Vision Plans will be eligible to enroll in the Post-Employment Benefits Plan. When they enroll, they must make the required contributions and continue to meet all of the other requirements of that Plan. See **At Retirement** to see if you are eligible for the Post-Employment Benefits Plan. Then call the NXP Benefits Service Center at 888-375-2367 to review your enrollment options.

Coverage History Notice (Formerly Known as Certificate of Creditable Coverage)

When you leave NXP or otherwise lose health plan coverage, you may request a coverage history notice that shows how long you have had coverage under the Plan. This coverage history notice confirms the length and type of coverage you had under the Plan. Using this notice, you will be able to reduce or eliminate any pre-existing condition exclusion a new employer's plan or insurance policy imposes. The certificate of creditable coverage is no longer legally required and a coverage history notice will only be provided by calling the NXP Benefits Service Center at 888-375-2367.

Coverage History Notice for Dependents

The coverage history notice provides the information for you and your dependents if the information is identical. The notice specifies the dependents covered by the Plan based on information you have previously provided. The NXP Benefits Service Center makes reasonable efforts to collect information applicable to any dependent and to include that information on the notice.

A separate coverage history notice is not sent to a dependent who lives with you. If a dependent's last known address is different from yours, a separate coverage history notice will be provided to your dependent at his or her last known address. A notice is not sent automatically to any dependent unless the NXP Benefits Service Center knows that the dependent's coverage has ended under the Plan.

Health Savings Account Participation

If you enroll in the Medical Plan 1 coverage option and have a Health Savings Account (HSA), you own the HSA, if you leave NXP, change/lose medical coverage or go on a leave of absence, the account remains yours. You have the flexibility to use your account when you want, now or in the future for eligible health-related costs. Once your enrollment in Medical Plan 1 ends, you will not receive any contributions to your HSA from NXP.

Health Care/Limited Use Health Care FSA Participation

When your Health Care/Limited Use Health Care FSA coverage ends, although contributions are not allowed after your coverage ends, you may submit claims for reimbursement (for expenses incurred before your contributions ended) until March 31 of the year following the earliest of the above dates. Expenses incurred after you ceased contributions are not eligible for reimbursement unless you elected continuation coverage under COBRA.

Rehire

If your employment with NXP ends mid-year and NXP rehires you in the same year, you are eligible to re-establish a Health Care/Limited Use Health Care FSA on a pro rata basis for the remainder of the calendar year in which you are rehired.

Leave of Absence

If you go on a leave of absence, contributions to your Health Care or Limited Use FSA account will automatically stop during the time that you are direct billed for your premiums. When you return to work, your contributions to your Health Care/Limited Use FSA account will automatically resume as deductions from your paycheck. This applies even if your leave of absence is paid. Note that this will reduce the amount of funds available for you to spend out of your Health Care/Limited Use FSA account. You will only be able to spend up to the amount that you contributed out of your paycheck while you were actively at work.

When you return from a leave of absence, you may choose to participate in the Health Care/Limited Use Health Care FSA for the remainder of the plan year on a pro rata basis, using your election that was in effect immediately before your leave. If your leave of absence was covered by the Federal Family and Medical Leave Act of 1993, then you may alternatively elect to participate in the Health Care/Limited Use Health Care FSA for the remainder of the plan year at the level of coverage in effect before the leave of absence and make up the unpaid contributions for the period of the leave of absence.

Dependent Care Flexible Spending Account Participation

Rules for using the Dependent Care FSA after your coverage ends are different from those for the Health Care/Limited Use Health Care FSA.

When your Dependent Care FSA coverage ends, these rules apply:

- Your contributions to the Dependent Care FSA end when your coverage ends;
- Only expenses you incur before your Dependent Care FSA coverage ends may be submitted for reimbursement; reimbursement is limited to the amount remaining in your Dependent Care FSA; and
- You have until March 31 of the following year to submit your claims for reimbursement.

> While you have until March 31 of the following year to submit expenses, eligible expenses must be incurred while you are actively employed with NXP.

Rehire

If your employment with NXP ends mid-year and NXP rehires you in the same year or if you go on an unpaid or significantly reduced paid leave of absence and you return to employment with NXP during the same year, you are eligible to re-establish a Dependent Care FSA on a pro rata basis for the rest of the calendar year in which you are rehired or went on leave.

Leave of Absence

You cannot participate in the Dependent Care FSA while on leave of absence. Your participation and contributions will automatically be stopped as of the first day of your leave of absence. To begin participation again on pro rata basis when you return to active status, contact the NXP Benefits Service Center at 888-375-2367 within 30 days of your return to work. You may continue to submit claims for reimbursement through the end of the plan year, but only for services received during the dates of your participation.

Short-Term and Long-Term Disability Coverage

Your eligibility for Plan coverage ends on the earliest of the following dates:

- The date your employment with NXP ends (including, but not limited to, the date you elect to voluntarily terminate employment under an NXP individual or group voluntary separation program regardless of your actual termination date). However, this provision does not apply, as long as you do not reside abroad and you continue to meet the other Plan provisions, if:
  - You are receiving Disability Income Plan benefits and terminate employment under an NXP individual or group involuntary severance program; or
  - You are on a disability leave of absence and your disability continues until your termination of employment under NXP's Medical Leave Policy;
- The date on which your employment is terminated for cause and/or gross misconduct, regardless of whether you are disabled on such date;
- The last day you work before a family, parental or personal leave of absence that is not based on your medical condition, other than approved leave under the Family and Medical Leave Act;
- The last day of the month in which you receive military service pay under the NXP Military Service Pay Policy, provided that your coverage as a participant who returns to active employment within 31 days of ending military service as described in the Uniformed Services Employment and Reemployment Rights Act is not terminated due to the absence (does not apply to maternity leave);
- The last day you work before a "non-approved disability" medical leave of absence, unless NXP changes this within the first 180 days to a "disabled" leave of absence (does not apply to maternity leave);
- The date your NXP employment category changes to one in which you are not eligible for coverage other than due to a disability leave of absence;
- The day your disability ends or the last day NXP considers you to be in a job-finding period (up to a maximum of 30 days after your disability ends);
- The day you commit or attempt to commit fraudulent activity against the Plan, NXP or related company;
- The date of your death; or
- The day the Plan terminates or the effective date of an amendment eliminating such coverage.

Basic Life Insurance, Supplemental Life Insurance and Accidental Death and Dismemberment Insurance Coverage

Your Basic Life Insurance, Supplemental Life Insurance and Accidental Death and Dismemberment Insurance coverage end on the earliest of the following dates:

- The date all life insurance is discontinued under the Plan;
- The date the Plan or group insurance policy ends;
- The end of the period for which your last premium was paid to the carrier;
- The last day of the calendar month in which you retire (according to NXP's retirement rules); or
- The last day of the calendar month in which you are no longer eligible.

When Spouse/Domestic Partner and Child(ren) Life Insurance Ends

Both Spouse/Domestic Partner and Child(ren) Life Insurance coverage end on the earliest of the following dates:

- The date all life insurance is discontinued under the Plan;
- The date you die;
- The date this Plan or group insurance policy ends;
- The date coverage for spouses/domestic partners and/or dependents, as applicable, ends or is no longer offered under the Plan;
- The last day of the calendar month in which your spouse/domestic partner and/or dependent is no longer considered eligible;
- The end of the period for which the last premium was paid for your spouse's/domestic partner's and/or dependent's coverage;
- The last day of the calendar month in which you retire (according to NXP's retirement rules); or
- The last day of the calendar month in which you are no longer eligible.

When Business Travel Accident Insurance Plan Insurance Coverage Ends

Coverage under BTA ends on the earliest of the following dates:

- Your last day of employment;
- The day you no longer meet the Plan's eligibility requirements;

- The day you begin a leave of absence, including disability leave of absence; or
- The date the Plan terminates or the effective date of a Plan amendment that eliminates your coverage.

Identity Theft Protection and Legal Services Plan

Your coverage under Identity Theft Protection and/or the Legal Services Plan ends when you are no longer an eligible employee or you choose not to enroll during a future annual enrollment period.

For the Legal Services Plan, when you are no longer eligible to participate in the Plan or your employment ends, the Plan covers the legal fees for covered services that were opened and pending when you were enrolled. No new matters may be started after you become ineligible.

Work/Life Programs

Your coverage for Work/Life programs ends on the day your employment with NXP ends, unless otherwise noted.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you to continue your health care coverage in certain situations when coverage would otherwise end. Upon a qualifying event (described below), you and your covered dependents may be able to continue coverage for the NXP Medical Plan, Dental Plan, Vision Plan, Employee Assistance Program (EAP) and Health Care/Limited Use Health Care Flexible Spending Account (FSA).

There may be other coverage options for you and your family. Under the Affordable Care Act, you can buy coverage through the Health Insurance Marketplace (Marketplace). In the Marketplace, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and --out-of-pocket costs will be before you decide to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible, such as a spouse's plan, even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Domestic Partners

Continuation health coverage under the NXP Medical Plan, Dental Plan and Vision Plan may also be provided to domestic partners under certain situations. Although domestic partners are not entitled to rights under COBRA, NXP applies the rules that would provide spouses coverage under COBRA in determining whether a domestic partner will be provided continuation coverage under the NXP Medical Plan, Dental Plan and Vision Plan. For ease of reference, when referring to COBRA continuation coverage the coverage includes continuation coverage for domestic spouses. However, NXP wants to make clear that any continuation coverage provided to domestic partners is not to be considered as continuation coverage intended to meet the requirements of COBRA.

Qualifying Events and Maximum COBRA Periods

The following chart lists the medical, dental, vision, EAP and Health Care/Limited Use Health Care FSA continuation choices available to you and your covered dependents under COBRA, based on specific qualifying events that would otherwise result in a loss of your medical, dental, vision, EAP and/or Health Care/Limited Use Health Care FSA coverage. You and your eligible dependents must be covered by the particular plan at the time of the COBRA event to be eligible for continuation of coverage. You may also elect COBRA coverage for a child who becomes an eligible child while your COBRA coverage is in effect.

Medical, Dental, Vision, EAP and Health Care/Limited Use Health Care FSA Continuation Coverage	
Qualifying Event	**Maximum COBRA Period**
• Termination of your employment (for reasons other than gross misconduct) • Reduction in your hours of employment • Retirement	You and your covered dependents have the right to continue medical, dental, vision and EAP coverage up to 18 months. You may continue Health Care/Limited Use Health Care FSA coverage until the last day of the calendar year in which the qualifying event occurs.
• Your death • Your child or the child of your domestic partner no longer meets the Plan's definition of a dependent • Divorce or legal separation between you and your spouse (unless a Qualified Medical Child Support Order provides otherwise) • Termination of your relationship with your domestic partner • You become entitled to Medicare	Your covered dependents have the right to continue medical, dental, vision and EAP coverage for up to 36 months.

Medical, Dental, Vision, EAP and Health Care/Limited Use Health Care FSA Continuation Coverage	
Qualifying Event	**Maximum COBRA Period**
• You or your covered dependents are determined to be disabled by the Social Security Administration	COBRA may be extended for medical, dental, vision and EAP coverage from 18 months up to 29 months if the Social Security Administration (SSA) determines that you were disabled at any time within 60 days of the qualifying event (i.e., the disability starts at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage). You must notify the NXP Benefits Service Center about the SSA's determination within 60 days of receiving it and before the end of the initial 18-month COBRA period*. This disability extension does not apply to Health Care/Limited Use Health Care FSA coverage.

* *Monthly contributions for continuation coverage increase to 150% (from 102%) of the monthly amount for each of the 11 additional months of continuation coverage.*

If you enroll in the Medical Plan 1 coverage option and have a Health Savings Account (HSA), you own the HSA, so if you leave NXP, change/lose medical coverage or go on a leave of absence, your account remains yours. You have the flexibility to use your account when you want, now or in the future for eligible health-related costs. The HSA is not subject to COBRA provisions. The medical and pharmacy component of Medical Plan 1 are eligible for COBRA continuation as described in the chart above.

Important Notes

If the Social Security Administration determines that the individual is no longer totally disabled, continuation coverage will cease. Thirty days after the Social Security Administration's findings, coverage will terminate on the first day of the following month. The individual must notify the NXP Benefits Service Center within 30 days of any such finding.

If a second qualifying event occurs within the 18- or 29-month period, the COBRA continuation period for medical, dental and vision (but not Health Care/Limited Use Health Care Flexible Spending Account) coverage may be extended for up to 36 months from the first qualifying event.

Reporting a Qualifying Event

You must notify the NXP Benefits Service Center either in writing or by phone within 30 days of the date on which any of the following events occurs, and to report the event and date of the event resulting in your and/or your dependents' loss of medical, dental and/or vision Plan coverage:

- You divorce or become legally separated or your domestic partnership ends;
- Your domestic partner no longer meets the Plan's definition of an eligible dependent (see the definition of **Domestic Partner**);
- Your child or the child of your domestic partner no longer meets the definition of an eligible dependent under the applicable plan (see **Dependent Eligibility** 4);
- You (or your covered dependent) are determined to have been disabled under the Social Security Act at any time during the first 60 days of receiving continuation coverage; or
- You become entitled to Medicare.

Your right to continue COBRA coverage is subject to all applicable federal laws and regulations. If you have any questions regarding COBRA, call UnitedHealthcare at 866-747-0048.

UnitedHealthcare is automatically notified within 30 days when any of the following qualifying events occurs and is entered into your employee record:

- Reduction in hours that makes you ineligible for coverage;
- Your termination; or
- Your death.

To report a qualifying event, please call UnitedHealthcare at 866-747-0048.

Deciding Whether to Continue Coverage

UnitedHealthcare should be notified within 30 days after the date you lose Plan coverage due to the qualifying event. UnitedHealthcare sends you a notice and election form within 14 days of receiving notification of the qualifying event. You have 60 days from the day coverage would otherwise end (or from the day the notice is sent to you, if later) to choose continuation coverage.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA on behalf of their spouses/domestic partners, and parents may elect COBRA on behalf of their children.

To continue your medical, dental, vision, EAP and Health Care/Limited Use Health Care FSA coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2% fee for administrative costs (or a 50% administrative fee in the case of, and during, an 11-month extension due to disability). **No benefits are payable under COBRA until the first premium payment is received.**

Your first payment (due within 45 days of your election) must include your COBRA contribution for the entire period from the date coverage ended through the month of the payment. Subsequent payments are due on the first of the month, whether or not you receive a bill. If UnitedHealthcare does not receive your monthly contribution within 30 days of the due date, coverage is permanently canceled as of the last day of the month in which you paid a contribution.

If you do not choose to continue coverage, you should make the appropriate election by calling UnitedHealthcare at 866-747-0048. In that case, your medical, dental, vision, EAP and Health Care/Limited Use Health Care FSA coverage ends on the last day of the month in which the qualifying event occurred.

Special COBRA rights may apply to you if you have been terminated or experienced a reduction of hours and you qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. If you qualify, you may be entitled to a second opportunity to elect COBRA coverage (if you did not already elect COBRA), but only within a limited period of 60 days (or less) and only during the six months immediately following the date your health plan coverage ended. You must contact UnitedHealthcare promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

COBRA may be extended for medical, dental and vision coverage for up to 24 months at the end of your unpaid military leave. These 24 months of COBRA are based on the Veteran's Benefits Improvement Act of 2004.

When Continuation Coverage Ends

Continuation coverage ends when any of the following events occurs:

- You die;
- You (or a covered qualified beneficiary) reach the end of the applicable maximum COBRA period for coverage;
- You (or a covered qualified beneficiary) do not pay a monthly contribution within 30 days of its due date;
- Upon your or your covered qualified beneficiary's written request to cancel coverage;
- You (or a covered qualified beneficiary) first become entitled to Medicare following your election for coverage;
- You (or a covered qualified beneficiary) first become covered under another group medical, dental or vision plan that does not contain a pre-existing condition rule following your election for coverage;
- NXP ceases to provide any group health plan coverage; or
- For Health Care/Limited Use Health Care Flexible Spending Account coverage only, the last day of the calendar year in which the qualifying event occurs.

Please inform UnitedHealthcare of any changes in address or in personal circumstances so that UnitedHealthcare can give you and your covered dependents the necessary information concerning your rights to continuation coverage rights.

Other Continuation Rights

You and your qualified beneficiaries may have additional medical, dental and vision coverage continuation rights if NXP is involved in a bankruptcy. You will be notified if these rules affect your coverage.

Health and Wellness Benefits

NXP's health and wellness plans include a comprehensive Medical Plan, Dental Plan, Vision Plan, Wellness Programs and Flexible Spending Accounts.

See Participation 1 for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

U.S. Expatriates and U.S. Inpatriates

Medical (including behavioral health and prescription drug), dental and vision coverage for U.S. Expatriates and U.S. Inpatriates on U.S. payroll are provided by separate Global plans that are not described in this SPD. All other benefits described below apply to U.S. Expatriates and U.S. Inpatriates as outlined in the NXP Benefits chart on page v.v

Health and Wellness Plans Summary

Plan/Program	What It Is	Who Is Eligible
Medical Plan	NXP health insurance benefits provided through the following coverage options: • UnitedHealthcare Medical Plan 1 (HSA-eligible); • UnitedHealthcare Medical Plan 2 (PPO); • UnitedHealthcare Medical Plan 3 (EPO); • UnitedHealthcare Out-of-Area (OOA) Plan; and • Kaiser Permanente HMO (if within the Kaiser service area). All coverage options include medical, behavioral health and prescription drug coverage.	You, your legal spouse/domestic partner and your eligible dependents, if you enroll yourself and them in medical coverage.
Prescription Drug Program	Program through which you purchase prescription drugs through approved retail and home delivery network pharmacies.	You, your legal spouse/domestic partner and your covered dependents if enrolled in medical coverage.
Health Savings Account (HSA)	A tax-favored savings account that is used with a High Deductible Health Plan (Medical Plan 1) to make healthcare more affordable and to save for retirement.	You, your legal spouse/domestic partner and your eligible dependents if you enroll yourself in Medical Plan 1, which is eligible for an HSA.
Behavioral Health	Access to quality behavioral health providers to help you remain healthy.	You, your legal spouse/domestic partner and your covered dependents if enrolled medical coverage.
Activity Centers	On-site Activity Centers are available at some locations for NXP employees to work out and help them in achieving a healthier lifestyle.	You

Plan/Program	What It Is	Who Is Eligible
Dental Plan	Plan provides coverage for preventive and diagnostic dental services, dental treatment, orthodontia and other covered treatment.	You, your legal spouse/domestic partner and your dependents, if you enroll yourself and them in dental coverage.
Vision Plan	Routine vision care services, including vision examinations, eyeglasses and contact lenses.	You, your legal spouse/domestic partner and your dependents, if you enroll yourself and them in vision coverage.
Flexible Spending Accounts	The Health Care/Limited Use Health Care Flexible Spending Account (FSA) and the Dependent Care Flexible Spending Account (DCFSA) allow you to set aside before-tax dollars into special accounts. When you incur an eligible expense, you file a claim for a tax-free reimbursement of that expense.	You, your spouse and your eligible dependents if you enroll. **Note:** Each spending account plan has a separate enrollment election.
Wellbeing @NXP	This free wellbeing hub provides all the guidance, resources and support you need to cheer you on as you work towards a healthier lifestyle.	You

NXP Medical Plan

The NXP Medical Plan offers many features, such as preventive health care coverage, well-baby care, behavioral health care and prescription drug coverage of **non-occupational illness and/or injury** 419.

If You Are a U.S. Expatriate or U.S. Inpatriate

Medical (including behavioral health and prescription drug), dental and vision coverage for U.S. Expatriates and U.S. Inpatriates on U.S. payroll are provided by separate Global plans that are not described in this SPD. All other benefits described below apply to U.S. Expatriates and U.S. Inpatriates as outlined in the NXP Benefits chart on page v.v

NXP offers multiple medical plan coverage options. These options give you the flexibility to choose the coverage that best meets your needs and your family's needs. All of the options provide similar medical and prescription drug benefits; what differs are plan features and what you pay (your contributions and out-of-pocket costs).

Medical Plan Enrollment Is Automatic

If you do not complete your benefits enrollment within 30 days of becoming eligible, you are automatically enrolled in the Medical Plan 1 coverage option with employee-only coverage. See 11 for more information.

Your medical **Participation** coverage options include:

- **UnitedHealthcare Medical Plan 1 with Health Savings Account (HSA):** Medical Plan 1 is a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), administered by Fidelity Investments. With this coverage option, there is a higher deductible, but you can use your HSA to pay for eligible expenses. To help you meet the higher deductible under Medical Plan 1, NXP makes an annual contribution to your HSA and you have the option to make pre-tax contributions to your account as well;
- **UnitedHealthcare Medical Plan 2 (PPO);**
- UnitedHealthcare Medical Plan 3 (EPO); and
- **UnitedHealthcare Out-of-Area (OOA) Plan:** This coverage option is available to you only if you live in an area where network providers are not available. If you are not sure if you live in a network area, contact the NXP Benefits Service Center. Medical Plan 1 is available if you live out-of-area.

Kaiser Permanente HMO

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on their home address. The HMO is only available if you are in Kaiser's service area. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-278-3296.

Only you can decide which coverage option is best for you and your family. For example:

- If your current providers are not in the network, you may want to consider an option where out-of-network providers are covered;
- If you anticipate having a lot of medical expenses, you may want to consider a plan that provides a low deductible for network services; or
- If you do not expect to use your medical benefits often and/or you want to save for future medical costs, you may want to consider Medical Plan 1, which allows you to save unused HSA amounts for future expenses, when you may need them.

If you need help deciding which option will work best for you, consider these resources:

Online: Meet Emma, your virtual benefit advisor. Emma asks you a few questions to better understand your health care needs and provides you with a comparison of how each plan works and which one may be best for you.

- Visit Emma at **nxp.bswift.com**;
- **On Demand**: Access your HSA account and learn more at **fidelity.com**; or
- **By Phone**: Call the NXP Rewards Center and ask to talk with an advocate. An advocate can walk you through the coverage options and help you understand the details for each option. The NXP Benefits Service Center is available at 888-375-2367, Monday through Friday, 8 a.m. to 8 p.m. (local time).

Medical Plan Benefits Summary

The following table shows you a side-by-side comparison of various cost-sharing features of each of the available coverage options. More detailed information about Plan coverage is included in **What's Covered** 89 and **What's Not Covered** 126.

	Medical Plan 1		Medical Plan 2		Medical Plan 3*	Out-of-Area Plan
	Network	**Out-of-Network****	**Network**	**Out-of-Network****	**Network**	**Out-of-Network**
Annual Deductible						
Individual	$1,600	$7,500	$300	$1,500	$200	$300
Family	$3,200	$15,000	$600	$3,000	$400	$600
NXP HSA Contribution						
Individual	$500		Not applicable		Not applicable	Not applicable
Family (You + Spouse, You + Child(ren) or You + Family)	$1,000		Not applicable		Not applicable	Not applicable
Annual Out-of-Pocket Maximum (includes deductible, copayments, if applicable, and coinsurance, including prescription drug spend) There is no out-of-pocket maximum for network services.						
Individual	$4,000	$12,500	$5,000	$12,500	$5,000	$5,000
Family	$7,350	$25,000	$10,000	$25,000	$10,000	$10,000
Coinsurance						
Preventive Services	You pay 0%; Plan pays 100%	After deductible, you pay 50%; Plan pays 50%	You pay 0%; Plan pays 100%	After deductible, you pay 50%; Plan pays 50%	You pay 0%; Plan pays 100%	You pay 0%; Plan pays 100%
Diagnostic Colonoscopy	After deductible, you pay 0%; Plan pays 100%	After deductible, you pay 50%; Plan pays 50%	You pay 0%; Plan pays 100%	After deductible, you pay 50%; Plan pays 50%	You pay 0%; Plan pays 100%	You pay 0%; Plan pays 100%

Medical Plan 1			Medical Plan 2		Medical Plan 3*	Out-of-Area Plan
	Network	**Out-of-Network****	**Network**	**Out-of-Network****	**Network**	**Out-of-Network**
Other Covered Services	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	After deductible, you pay 10%; Plan pays 90%	After deductible, you pay 20%; Plan pays 80%
Virtual Care Services (Access to a physician anytime, anywhere for minor medical needs125						
Virtual Care	You pay no more than $54	Not available	You pay $10 copay/ consultation	Not available	You pay $10 copay/ consultation	After deductible, you pay 20%; Plan pays 80%
Office Visits						
Primary Provider	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay $20 copay/visit	After deductible, you pay 50%; Plan pays 50%	You pay $20 copay/visit	After deductible, you pay 20%; Plan pays 80%
Specialty Provider	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay $40 copay/visit	After deductible, you pay 50%; Plan pays 50%	You pay $40 copay/visit	After deductible, you pay 20%; Plan pays 80%
Emergency Services						
Emergency Room (emergency admission only; any applicable cost sharing is waived if admitted; inpatient benefits apply)	After deductible, you pay 20%; Plan pays 80%	After in-network deductible, you pay 20%; Plan pays 80%	You pay $100 copay/visit plus 20% coinsurance	You pay $100 copay/visit plus 20% coinsurance	You pay $100 copay/visit plus 10% coinsurance; network and out-of-network providers	After deductible, you pay 20%; Plan pays 80%

Medical Plan 1			Medical Plan 2		Medical Plan 3*	Out-of-Area Plan
	Network	Out-of-Network**	Network	Out-of-Network**	Network	Out-of-Network
Urgent Care	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 20%; Plan pays 80%	You pay $30 copay/visit	After deductible, you pay 50%; Plan pays 50%	You pay $30 copay/visit	After deductible, you pay 20%; Plan pays 80%

* *Except for emergency services, only network provider services are covered under the Medical Plan 3.*

** *For most out-of-network coverage, the Plan pays based on allowed amounts; see Allowed Amount 73. For some out-of-network coverage, the Plan pays based on the recognized amount; see the definition of recognized amount 425.*

For information on prescription drug copayments and coinsurance, see **Prescription Drug Benefit Summary** 166

Key Terms

Emergency Services: The Plan covers Emergency Room (ER) treatment (and stabilization services) for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms. The Plan follows the prudent layperson ER policy in the Balanced Budget Act of 1997, as described in **Emergency Services** 72. Medical care determined in the sole and complete discretion UnitedHealthcare to be appropriate for the diagnosis, care or treatment of the disease or injury involved and consistent with generally accepted principles of professional medical practice. When a decision is based on a medical judgment, the Plan consults with a health care professional with appropriate training, who will be identified upon request. You have the right to receive the criteria UnitedHealthcare applies to determine medical necessity. If your claim for health care is denied, you have the right to know the reason for the UnitedHealthcare's decision.

Allowed Amounts: The allowed amount is the amount UnitedHealthcare determines the Plan will pay for benefits, based on reimbursement policy guidelines developed by UnitedHealthcare or as otherwise required by law (see **Allowed Amount** 73 for more information. For some out-of-network coverage, the Plan pays based on the **recognized amount**; see the definition of recognized amount 425.

How the Medical Plan Works

Contributions

You and NXP share the cost of your medical coverage under the NXP Medical Plan. Your contribution amount depends on:

- Your choice of an individual or a family enrollment category;
- Your choice of coverage option; and
- Whether you and/or your covered spouse/domestic partner (if any) use tobacco products.

Tobacco Use Status: When you enroll each year, you and your covered spouse/domestic partner must both complete a certification of tobacco use. The Plan offers contribution discounts to you and/or your spouse/domestic partner if you and/or your spouse/domestic:

- Have not used tobacco products for the past 6 months; or
- Are enrolled in a tobacco cessation program.

For the Medical Plan, tobacco use status can be changed during the calendar year if you attest to being tobacco -free for 6 months. To change tobacco use status for you or your spouse/domestic partner, call the NXP Benefits Service Center at 888-375-2367.

As a participant, your medical contributions come from your pay on a before-tax basis.

You are notified of the contribution amounts, available coverage options and tobacco use discounts when you first become eligible to participate as well as each year during the enrollment period. Contributions and tobacco use discounts are reviewed annually and are subject to change.

How You Access Benefits

Depending on which medical plan option you elect, you may be eligible to receive:

- Network Benefits; or
- Out-of-Network Benefits.

You must show your identification card (ID card) every time you request health care services from a network provider. If you do not show your ID card, network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Emergency Health Services

Emergency health services provided by an out-of-network provider will be reimbursed based on the allowed amount, as defined by the Plan. In addition, covered health services provided at certain network facilities by an out-of-network provided, when not emergency health services, will be reimbursed based on the allowed amount, as defined by the Plan. In this instance, a "certain" network facility is limited to a(n):

- Hospital, as defined in Social Security Act Section 1861(e);
- Hospital outpatient department;
- Critical access hospital, as defined in Social Security Act 1861(mm)(1)
- An ambulatory surgical center, as described in Social Security Act Section 1833(i)(1)(A); or
- Any other facility specified by the Claims Administrator.

Ambulance transport provided by an out-of-network provider will be reimbursed based on the allowed amount, as defined by the Plan.

Depending on the geographic area and the service area in which you receive care, you may have access negotiated discounts on certain covered health service claims when received from out-of-network providers.

Network Benefits

Network benefits apply to covered health services that are provided by a network physician or other network provider. You are not required to select a primary care physician in order to obtain network benefits.

For network benefits for covered health services provided by a network provider, once you pay your cost share, you are not responsible for any difference between the eligible expense and the amount the provider bills.

Finding Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a network. At your request, UnitedHealthcare will send you a directory of network providers free of charge. Network providers are independent practitioners and are not employees of the NXP or UnitedHealthcare. UnitedHealthcare credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

A provider's network status may change. Before receiving services, you should verify the network status of a provider. You can verify a provider's status or request a provider directory by calling UnitedHealthcare at 844-210-5428. A directory of providers is available online at **www.myuhc.com**.

If you receive a covered health service from an out-of-network provider and were informed incorrectly before receipt of the covered health service that the provider was a network provider, either through a database, provider directory or in a response to your request for the information (via telephone, electronic, web-based or internet-based means), you may be eligible for network benefits.

It is possible that you might not be able to obtain services from a particular network provider. Or you might find that a particular network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another network provider to get network benefits. However, if you are currently receiving treatment for covered health services from a provider whose network status changes from network to out-of-network during treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the network benefit level for specified conditions and timeframes. This does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you need help finding out if you are eligible for continuity of care benefits, call UnitedHealthcare at 844-210-5428

If you are currently undergoing a course of treatment using an out-of-network provider, you may be eligible to receive transition of care benefits. The transition period is available for specific medical services and for limited periods. If you have questions about transition of care, call UnitedHealthcare at 844-210-5428.

Do not assume that a network provider's agreement includes all covered health services. Some network providers contract with UnitedHealthcare to provide only certain covered health services, but not all. Some network providers choose to be a network provider for only some of UnitedHealthcare's products. Contact UnitedHealthcare at 844-210-5428 for more information.

Out-of-Network Benefits

Out-of-network benefits apply to covered health services that are provided by an out-of-network physician or other out-of-network provider or covered health services that are provided at an out-of-network facility.

Amounts You Owe When Using the Plan (Cost Sharing)

- **Deductible:** The annual deductible is the specific amount of eligible expenses you must pay each year before the Plan begins paying benefits for certain covered expenses. The deductible does not apply to network preventive care benefits.
  - The deductible starts over each January 1. Eligible expenses do not carry over from one year to the next, across health carriers (e.g., UnitedHealthcare, Kaiser), nor do they carry over from this Plan to the Post-Employment Benefits Plan in the year that your employment ends.
  - Amounts applied to your annual deductible are calculated based on eligible expenses or, for certain covered health services, the recognized amount, as applicable.
- **Coinsurance:** For some covered expenses, once the annual deductible is met (where required), you and the Plan share the cost; this known as coinsurance. When using network providers, the Plan generally pays a higher percentage of covered expenses.
  - ***Network Providers:*** The Plan pays the network coinsurance percentage. This percentage applies to the allowed amount for the specific treatment. You pay only the remainder of the allowed amount, as long as you follow the Plan's rules for receiving network care.
  - ***Out-of-Network Providers:*** The Plan pays the out-of-network coinsurance percentage. This percentage applies to the allowed amount (or recognized amount, as applicable) for that specific treatment. You pay all remaining charges, including any amounts above the allowed or recognized amount. Any charges over the allowed or recognized amount do not apply to the out-of-pocket maximum.

- **Copayments:** A copayment is a flat dollar amount you pay for certain services. Once you pay your copayment, the Plan pays covered expenses, up to allowed or recognized amount (other benefit provisions may apply).
- Separate copayment amounts apply to primary provider and specialty provider office visits. Generally, primary providers include:

– Family practitioners;
– General practitioners;
– Internists;
– Nurse practitioners, but only when billed by a primary physician's office; and
– Pediatricians.

All other providers are considered specialty providers, including obstetricians/gynecologists. You do not need a referral or prior authorization to receive treatment from a primary care physician or a specialist, including an obstetrician/gynecologist.

Note: You pay the lesser of your copayment or the actual eligible expense or recognized amount.

- **Out-of-Pocket Maximum:** To protect you and your family from financial hardship due to medical expenses, the Plan limits the amount you pay out-of-pocket each year. Once the annual out-of-pocket maximum is met, the Plan pays 100% of the allowed or recognized amount for most covered expenses for the remainder of the calendar year.

– Not all expenses you pay count toward meeting your annual out-of-pocket maximum. The following expenses do not apply toward meeting the out-of-pocket maximum:
  - Contributions;
  - Benefit reductions (expenses that are not paid or prior authorization benefit reductions because a required prior authorization was not obtained);
  - Amounts greater than maximum benefits;
  - Any expenses not covered by the Plan; and
  - Amount over the eligible expense or allowed amount (or recognized amount, as applicable) for out-of-network services.

Prescription drug expenses apply toward your out-of-pocket maximum in all NXP Employee Medical Plans. Any discounts related to manufacturer's coupons will not be applied to your deducible and out-of-pocket.

- The out-of-pocket maximum starts over each January 1. Eligible expenses do not carry over from one year to the next, nor do they carry over from the NXP Employee Medical Plan to the Post-Employment Benefits Plan in the year that your employment ends.
- **Lifetime Maximum:** The Plan has no aggregate lifetime maximum benefit.

How Cost Sharing Works under Medical Plan 1

The Medical Plan 1 coverage option covers a broad range of services, such as preventive care at 100% (with no deductible) and behavioral health services. In addition, Medical Plan 1 covers certain preventive generic drugs (maintenance medications only) at no cost. Review Caremark's **High Deductible Health Plan (HDHP) – Health Savings Account (HSA) Preventive Therapy Drug List** to understand the preventive generic drugs covered at no cost under Medical Plan 1.

What Makes Medical Plan 1 Different?

How deductibles are met is different under the Medical Plan 1 option. Regulations require that most health care coverage under a High Deductible Health Plan be subject to an annual deductible. Under these regulations, hearing and prescription drug benefits are considered health care coverage; while vision and dental benefits are not.

With Medical Plan 1, you pay substantially lower contributions; however, your deductible is higher – you are responsible for paying 100% of all expenses for medical and prescription drugs out of your pocket until you meet the deductible.

With Medical Plan 1

You Only Coverage	**You + Spouse, You + Children or You+ Family Coverage**
Deductible • The deductible does not apply to preventive care services. • You are responsible for paying 100% of all other covered expenses for medical and prescription drugs until you meet the deductible. • The deductible includes amounts you spend on medical and prescription drug expenses, minus any discounts from manufacturer's prescription coupons. In the other medical plan coverage options prescription drug expenses are not included in your deductible.	
You Only Coverage	**You + Spouse, You + Children or You+ Family Coverage**

You must reach the individual deductible before benefits begin. **Network:** The deductible for network services is $1,600. • **Out-of-Network:** The deductible for out-of-network services is $7,500.	You and your family must meet the family deductible before benefits begin for any one individual covered under the Plan. **Network:** The family deductible for network services is $3,200. • **Out-of-Network:** The family deductible for out-of-network services is $15,000. The family deductible can be met by one family member or a combination of family members; however, there are no coinsurance benefits for anyone in the family unit until expenses equaling the family deductible amount have been incurred.
Coinsurance • You have the flexibility of using network and out-of-network providers; your out-of-pocket costs will be less when you use network providers. • For medical expenses, if you see a network provider, you are responsible for the discounted amount the network has agreed to pay until your deductible is met. • For prescription expenses, the same is true – you are responsible for the discounted amount CVS Caremark has negotiated until your deductible is met.	
Once you meet the individual deductible: • **Network:** The network coinsurance is 80% – in other words, NXP pays 80% and you pay the remaining 20%. • **Out-of-Network:** The out-of-network coinsurance is 50% – NXP pays 50% and you pay the remaining 50%.	Once you and your family meet the family deductible: • **Network:** The network coinsurance is 80% – in other words, NXP pays 80% and you pay the remaining 20%. • **Out-of-Network:** The out-of-network coinsurance is 50% – NXP pays 50% and you pay the remaining 50%.

You Only Coverage	You + Spouse, You + Children or You+ Family Coverage
Out-of-Pocket Maximum • Once the out-of-pocket maximum is met, the Plan pays 100% of covered expenses for medical and prescription drugs for the remainder of the year. • The out-of-pocket maximum includes deductibles and coinsurance for medical and prescription drug expenses.	
The individual out-of-pocket maximum is: • **Network:** $4,000 • **Out-of-Network:** $12,500	The family out-of-pocket maximum is: • **Network:** $7,350 • **Out-of-Network:** $25,000 The family out-of-pocket maximum can be met by one family member or a combination of family members.

How Cost Sharing Works under Medical Plan 2

The Medical Plan 2 option covers a broad range of services, such as preventive care at 100%, doctor visits and behavioral health services. With Medical Plan 2:

- **Deductible:** You must reach a deductible before benefits for major services begin.
  - ***Network:*** The deductible for network services is $300 for individual (you only or employee-only) and $600 for family coverage (one or more individuals are covered).
  - ***Out-of-Network:*** The deductible for out-of-network services is $1,500 for individual (you only or employee-only) and $3,000 for family coverage (one or more individuals are covered).

The deductible includes coinsurance for your medical expenses; prescription drug expenses are not included in your deductible.

The deductible is met when any one family member reaches the limit.

  - ***Individual:*** Once one member in the family reaches their individual deductible, his or her coinsurance benefit begins.
  - ***Family:*** The family deductible can be met by one family member or a combination of family members. Once the family deductible is met, the coinsurance benefit begins for everyone in the family.
- **Copayments:** Doctor visits are covered at 100% after a copayment.

- **Coinsurance:** For major medical services, you pay coinsurance once you have met your deductible. You pay coinsurance per major medical service per covered individual.

You have the flexibility of using network and out-of-network providers; but your out-of-pocket costs will be less when you use network providers.

– ***Network:*** The network coinsurance is 80% – in in other words, NXP pays 80% and you pay the remaining 20%.
– ***Out-of-Network:*** The out-of-network coinsurance is 50% of the allowed or recognized amount. NXP pays 50% and you pay the remaining 50%.

- **Out-of-Pocket Maximum:**

– ***Network:*** The out-of-pocket maximum is $5,000 per person or $10,000 of combined expenses for a family.
– ***Out-of-Network:*** The out-of-pocket maximum is $12,500 per person or $25,000 of combined expenses for a family.

The out-of-pocket maximum includes amounts you pay for eligible services, including deductibles and coinsurance for medical and pharmacy expenses.

The out-of-pocket maximum is met when any one family member reaches the limit.

– ***Individual:*** Once any one family member meets the individual out-of-pocket maximum, the eligible services for that individual are paid by NXP at 100%.
– ***Family:*** If one or more members reach the family out-of-pocket maximum, eligible services for the entire family are paid by NXP at 100%.

How Cost Sharing Works under Medical Plan 3

The Medical Plan 3 option covers a broad range of network services, such as preventive care at 100%, doctor visits and behavioral health services. With Medical Plan 3:

- **Deductible:** You must reach a deductible before benefits for major service begin. The deductible for network services is $200 for individual (you only or employee-only) and $400 for family coverage (one or more individuals are covered).

The deductible includes coinsurance for your medical expenses; prescription drug expenses are not included in your deductible.

The deductible is met when any one family member reaches the limit.

- *Individual:* Once one member in the family reaches their individual deductible, his or her coinsurance benefit begins.
- *Family:* The family deductible can be met by one family member or a combination of family members. Once the family deductible is met, the coinsurance benefit begins for everyone in the family.

- **Copayments:** Doctor visits are covered at 100% after a copayment.
- **Coinsurance:** For major medical services, you pay coinsurance once you have met your deductible. You pay coinsurance per major medical service per covered individual. The coinsurance is 90% – in other words, NXP pays 90% and you pay the remaining 10% for most medical services.

Network

Medical Plan 3 covers network care only, except for emergencies, there are no benefits for services delivered out of network.

You do not need to use a network emergency provider for ground and Air Ambulance or emergency room if you experience an emergency. Your emergency care will be covered, regardless of network status for the provider ground and Air Ambulance or emergency room.

To determine if your providers are in the Choice Plus network, use the UnitedHealthcare provider search tool. When prompted for plan or network name, choose Choice Plus EPO (Open Access UnitedHealthcare Select).

- **Out-of-Pocket Maximum:** The out-of-pocket maximum amount you pay for eligible services is $5,000 per person or $10,000 (in combined expenses) for a family.

The out-of-pocket maximum includes copayments and coinsurance for medical and prescription drug expenses.

The out-of-pocket maximum is met when any one family member reaches the limit.

- *Individual:* Once any one family member meets the individual out-of-pocket maximum, the eligible services for that individual are paid by NXP at 100%.
- *Family:* If one or more members reach the family out-of-pocket maximum, eligible services for the entire family are paid by NXP at 100%.

How Cost Sharing Works under the Out-of-Area Plan

The Out-of-Area Plan covers a broad range of services, such as preventive care at 100%, doctor visits and behavioral health services. With out-of-area coverage:

- **Deductible:** You must reach a deductible before benefits for major services begin. The deductible for covered services is $300 for individual (you only or employee-only) and $600 for family coverage (one or more individuals are covered).

The deductible includes coinsurance for your medical expenses; prescription drug expenses are not included in your deductible.

The deductible is met when any one family member reaches the limit.

- *Individual:* Once one member in the family reaches their individual deductible, his or her coinsurance benefit begins.
- *Family:* The family deductible can be met by one family member or a combination of family members. Once the family deductible is met, the coinsurance benefit begins for everyone in the family.

- **Coinsurance:** For major medical services, you pay coinsurance once you have met your deductible. You pay coinsurance per major medical service per covered individual. The coinsurance is 80% – in other words, NXP pays 80% and you pay the remaining 20% for most medical services.

If you are covered under the Out-of-Area Plan option, you and your covered dependents may go to any provider or hospital you want (provided you request prior authorization, as required. 78. If you are able to travel to a network location for care, you may reduce your out-of-pocket costs by using an NXP network provider. You will save money because the provider charges will be based on the allowed amount (or recognized amount, as applicable), and except for your cost sharing obligations, you are not responsible for any difference between allowed or recognized amounts and the amount the provider bills.

- **Out-of-Pocket Maximum:** The out-of-pocket maximum amount you pay for eligible services is $5,000 per person or $10,000 (in combined expenses) for a family.

The out-of-pocket maximum includes copayments and coinsurance for medical and prescription drug expenses.

The out-of-pocket maximum is met when any one family member reaches the limit.

- *Individual:* Once any one family member meets the individual out-of-pocket maximum, the eligible services for that individual are paid by NXP at 100%.

- *Family:* If one or more members reach the family out-of-pocket maximum, eligible services for the entire family are paid by NXP at 100%.

If You Transfer from One Coverage Option or Plan to Another

If you transfer mid-year from one of this Plan's coverage options to another, most benefit maximums do not "start over." In most cases, deductibles, annual maximums and out-of-pocket maximums are accumulated and combined between coverage options.

If you transfer mid-year from this Plan to the Post-Employment Benefits Plan, deductibles and maximums start over. This means that if you transfer to the Post-Employment Benefits Plan, you will be required to meet separate, new annual deductible and out-of-pocket maximum, as well as meeting any new annual maximums. Contact the NXP Benefits Service Center for more information.

UnitedHealthcare Health Care Networks

UnitedHealthcare Health care networks are an integral part of the NXP Medical Plan. Unless you are covered under the Out-of-Area Plan option, you must use providers in the UnitedHealthcare network to receive the highest level of benefit available. The UnitedHealthcare networks in various locations across the U.S. include health care providers and hospitals that meet specific standards established by the network administrators and agree to charge a set amount (the allowed or recognized amount).

Benefit Details

NXP medical plans utilize UnitedHealthcare's national network of providers. When you use providers that participate in the network, you receive the network level of benefits. Network providers have proper credentials, meet specific standards and have agreed to accept the allowed amount, which is a pre-arranged fee for care provided for you and your covered dependents. It is important to understand the networks associated with the NXP medical plans and how they work.

To find a network provider:

- Go online to UnitedHealthcare find a doctor at **https://connect.werally.com/partner-login**; or
- Call UnitedHealthcare at 844-210-5428.

Medical Plan 3: UnitedHealthcare Choice Network

Medical Plan 3 uses UnitedHealthcare's Choice network. An Exclusive Provider Organization (EPO) requires you to use network providers to have coverage, except in emergencies. Before enrolling in Medical Plan 3, you should consider:

- Medical Plan 3 pays benefits only for care you receive from Open Access Select EPO network providers – except in a life-threatening emergency; and
- You should always check to see if your providers and facilities are in the EPO network before your visit.

Go to the UnitedHealthcare provider search tool on **myuhc.com**. You will be asked to select a plan, click on *Choice Plus EPO (Open Access UnitedHealthcare Select)*. Or, you can call UnitedHealthcare at 844-210-5428 to speak with a representative. You can:

- Search for providers by name and confirm that your current providers belong to the Choice Plus and Choice network;
- Locate network primary and specialty care providers near you; and
- Find the best care with the least out of pocket cost by utilizing cost estimate tool.

If you want coverage for out-of-network services, you should review the other NXP medical options during your enrollment period. To receive the highest level of benefits (from all coverage options except the Out-of-Area Plan coverage option), you must use network providers.

If you are enrolled in Medical Plan 3 and use out-of-network providers for non-emergency care, you are responsible for the full cost of out-of-network services; out-of-network services are not covered by the Plan and UnitedHealthcare-negotiated discounts are not applied.

However, Medical Plan 3 covers emergency services provided by out-of-network providers for emergency medical conditions, as described in **Emergency Services** 72. If your condition does not meet the definition of an emergency medical condition as defined in that section and you seek out-of-network care while enrolled in Medical Plan 3, you are responsible for the full cost of services. Services are not covered by Medical Plan 3 and UnitedHealthcare-negotiated discounts are not applied.

Medical Plan 1 and Medical Plan 2: UnitedHealthcare Choice Plus Network

Medical Plan 1 and Medical Plan 2 use UnitedHealthcare's Choice Plus network, which is a Preferred Provider Organization (PPO). As a member of a PPO, you have one set of benefits for care received from providers within the network, and another for care received outside the network. The Plan pays more when you receive care within the network.

You are responsible for paying the remaining charges up to the allowed amount and any applicable copayments (if applicable).

To receive the highest level of benefit (from all coverage options except the Out-of-Area Plan option), you must use network providers.

Go to the UnitedHealthcare provider search tool on **myuhc.com**. You will be asked to select a plan. Click on the plan that you are enrolled in or call UnitedHealthcare at 844-210-5428 to speak with a representative. You can:

- Search for providers by name and confirm that your current providers belong to the Choice Plus network;
- Locate network primary and specialty care providers near you; and
- Find the best care with the least out-of-pocket cost by using cost estimator tool.

UnitedHealthcare Behavioral Health Network

A network of quality behavioral health care providers is available in this Plan. Each network provider holds the proper credentials and meets specific standards. They also agree to an "allowed amount," or a pre-arranged fee, for care provided for you and your covered dependents. Specialty hospitals and facilities are included in the Plan's behavioral health network because of their expertise in psychiatric and chemical dependency services.

To receive the highest level of benefits (from all coverage options except the Out-of-Area Plan option), you must use UnitedHealthcare network providers.

To find a behavioral health network provider:

- Go online to UnitedHealthcare provider search tool at **myuhc.com** or call; or
- Call UnitedHealthcare at 844-210-5428.

Out-of-Network Benefits

- **Medical Plan 1 and Medical Plan 2:** If you choose to use the services of out-of-network providers under the Medical Plan 1 or Medical Plan 2 coverage options, your coverage for services is generally at the out-of-network level. You are responsible for paying any expenses that exceed the allowed or recognized amount.
- **Medical Plan 3:** If you chose to use the services of out-of-network providers for non-emergency care under Medical Plan 3, you are responsible for the full cost. Out-of-network services are not covered by Medical Plan 3 and UnitedHealthcare-negotiated discounts do not apply. If UnitedHealthcare determines that you live in a network area and you are unable to receive specialized services from a network provider in your area, benefits for the covered expense will be paid at the rate that otherwise applies to a network provider, if you get UnitedHealthcare's approval before incurring them. Contact UnitedHealthcare at 844-210-5428 for more information regarding this process.

Emergency Services

For Emergency Room (ER) treatment (and stabilization services) for conditions that reasonably appear to constitute an emergency, based on the presenting symptoms, the Plan follows the prudent layperson ER policy in the Balanced Budget Act of 1997.

Under this Act, an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

The symptoms related to the medical emergency usually occur suddenly and are severe in nature. When the emergency care is given in a facility's ER, the Plan will cover the care received (and stabilization services) provided the situation meets the criteria described above.

When You Travel

If you are traveling or vacationing away from home, you can go to the nearest facility that can treat your illness or injury. If you are admitted into a hospital, remember to request prior authorization, 78, within 48 hours to receive network coinsurance.

When Your Children Are Away at School

If your child attends school (for example, a child away at college) in an area with an UnitedHealthcare medical network, then he/she should choose a provider in that network for non-emergency care. Remember that under Medical Plan 3, out-of-network services are not covered (except for emergency services) and UnitedHealthcare-negotiated discounts are not applied. So, if your child uses out-of-network providers for non-emergency care under Medical Plan 3, you are responsible for the full cost. Under Medical Plan 1 and Medical Plan 2, if there is no network available, then coverage is provided at the out-of-network level, based on the allowed or recognized amount.

Allowed Amount

The allowed amount is the amount that UnitedHealthcare determines the Plan will pay for benefits. Allowed amounts are determined according to UnitedHealthcare's reimbursement policy guidelines, or as required by law.

- For designated network benefits and network benefits for covered health services provided by a network provider, once you meet your cost share, you are not responsible for any difference between the allowed amount and the amount the provider bills;
- Except as otherwise noted, for out-of-network benefits, once you meet your cost share, you are responsible for paying, directly to the out-of-network provider, any difference between the amount the provider bills you and the allowed amount.
- For covered ancillary services received at **certain network facilities** on a non-emergency basis from out-of-network providers, you are not responsible, and the out-of-network provider may not bill you, for recognized amounts in excess of any cost sharing you are responsible for paying (e.g., your deductible, copayment and/or coinsurance);

- For covered non-ancillary services received at certain network facilities on a non-emergency basis from out-of-network providers who have not satisfied any notice and consent criteria or for unforeseen or urgent medical needs that arise when the non-ancillary service is provided for which notice and consent has been satisfied, you are not responsible, and the out-of-network provider may not bill you, for recognized amounts in excess of any cost sharing you are responsible for paying;
- For covered emergency health services provided by a out-of-network provider, you are not responsible, and the out-of-network provider may not bill you, for recognized amounts in excess of any cost sharing you are responsible for paying;
- For covered emergency ground and Air ambulance transportation provided by an out-of-network provider, eligible expenses are determined based on the median amount negotiated with network providers for the same or similar service; out-of-network providers may bill you for any difference between the provider's billed charges and the eligible expense; and
- For covered ground and air ambulance services provided by a out-of-network provider, you are not responsible, and the out-of-network provider may not bill you, for recognized amounts in excess of any cost sharing you are responsible for paying based on the rates that would apply if the service were provided by a network provider.

Designated Network Benefits and Network Benefits

When covered health services are received from a(n):

- Designated network or network provider, allowed amounts are UnitedHealthcare's contracted fee(s) with that provider; or
- Out-of-network provider as arranged by UnitedHealthcare, including when there is no network provider reasonably accessible or available to provide the covered health services, allowed amounts are an amount negotiated by UnitedHealthcare or are an amount permitted by law.

Contact UnitedHealthcare if you are billed for amounts in excess of any cost sharing you are responsible for paying under the Plan. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

The allowed amount for covered health services received from out-of-network providers is based on the first of the following:

- The reimbursement rate determined by a state *All Payer Model Agreement*;
- The reimbursement rate as determined by state law;
- The initial payment made by UnitedHealthcare (or the amount subsequently agreed to by the out-of-network provider and UnitedHealthcare); or
- The amount determined by *Independent Dispute Resolution (IDR)*.

This applies to:

- Emergency health services provided by an out-of-network provider;
- Non-emergency covered health services received at **certain network facilities** from out-of-network providers when the services are either ancillary services or are non-ancillary services that have not satisfied required notice and consent criteria of Section 2799B-2(d) of the Public Health Service Act for a visit (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided);
- Ground and Air ambulance transportation provided by an out-of-network provider.

> **Note:** For the above listed items, you may not be billed for amounts in excess of your cost sharing of the recognized amount. Contact UnitedHealthcare if you are billed for amounts in excess of any cost sharing you are responsible for paying under the Plan.

For emergency ground and air ambulance transportation provided by an out-of-network provider, the allowed amount, which includes mileage, is a rate agreed upon by the out-of-network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with network providers for the same or similar service. Out-of-network providers may bill you for any difference between the provider's billed charges and the allowed Amount.

For covered health services received from other out-of-network providers not described above, the allowed amount is determined as follows:

- An amount negotiated UnitedHealthcare;
- A specific amount required by law (when required by law); or
- An amount UnitedHealthcare has determined is typically accepted by a provided for the same or similar service.

The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-network provider, your cost share. Contact UnitedHealthcare if you are billed for amounts in excess of your applicable cost share or cost to access Advocacy Services, as described in the next section. You are responsible for any allowed amounts once you have completed following advocacy services.

Advocacy Services

The Plan has contracted with UnitedHealthcare to provide advocacy services on your behalf for to out-of-network providers that have questions about the Plan's allowed amount and how UnitedHealthcare determines this amount. Contact UnitedHealthcare at the number on your ID card to access advocacy services if you are billed for amounts in excess of your applicable cost sharing.

In some instances, if UnitedHealthcare, or its designee, reasonably concludes that particular facts and circumstances related to the claim provide justification for reimbursement greater than that which would result from the applying the allowed amount, and UnitedHealthcare, or its designee, determines that it would be in the Plan's and the Employee's best interest (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the allowed amount for that particular claim. This applies when covered health care services are received from an out-of-network provider for:

- Non-ancillary services received at certain network facilities on a non-emergency basis from an out-of-network provider who has satisfied the Plan's notice and consent criteria; or
- Emergency ground and air Ambulance transportation provided by an out-of-network provider.

Under some circumstances, UnitedHealthcare, or it's designee, will either work with a provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your cost share. This applies when covered health care services are received from an out-of-network provider that are not:

- Ancillary services received at certain network facilities on a non-emergency basis;
- Non-ancillary services received at certain network facilities on a non-emergency basis;
- Emergency health care services;
- Ground and air Ambulance services; or
- Emergency ground and Air Ambulance transportation.

Virtual Care Services

When you enroll in a UnitedHealthcare medical plan, you have access to virtual care services. Virtual care for covered health services include the diagnosis and treatment of less serious medical conditions as well as remote physiologic monitoring. Virtual care provides communication of medical information in real-time between you and a distant physician or health specialist, outside of a medical facility (for example, from home or work).

Benefits are available only when services are delivered through a designated virtual network provider, You can find a designated virtual network provider by contacting UnitedHealthcare at **myuhc.com** or by calling 844-210-5428.

Virtual care services are available for urgent on-demand health care delivered or audio only technology for treatment of acute but non-emergency medical needs.

> Not all medical conditions can be treated through virtual care. The designated virtual network provider will identify any condition for which in-person physician treatment is needed.

Benefits do not include email, fax or standard telephone calls, or services that occur within medical facilities.

Your cost when you use virtual care services is:

- $10 per consultation if you are enrolled in the Medical Plan 2 or Medical Plan 3 option; or

Up to $54 per consultation if you are enrolled in Medical Plan 1.

My UHC

UnitedHealthcare's member website, **myuhc.com**, provides information anywhere and anytime you have access to the Internet. Myuhc.com provides you with access to a wealth of health information and self-service tools. With myuhc.com you can:

- Make real-time inquiries into the status and history of your claims;
- View eligibility and Plan benefit information;
- View and print your Explanation of Benefits (EOBs);
- Order a new or replacement ID card or print a temporary ID card.
- Research a health condition and treatment options to prepare for a discussion with your doctor;
- Search for network providers available under your Plan through the online provider directory;
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures.

You must register to take advantage of **myuhc.com**. If you have not already registered, go to **myuhc.com** and click on "Register Now." Have your ID card handy.

Prior Authorization

When you understand your health care options, you can make more informed decisions. That is why NXP's Medical Plan includes prior authorization. Prior authorization, which includes utilization review and case management services, allows health care professionals to work with you and your physician. The prior authorization process helps you be a more active participant in making your health care choices.

> Requesting prior authorization does not guarantee that the provider or facility is approved as a network provider, nor does prior authorization guarantee coverage.
>
> Any questions about coverage should be directed to UnitedHealthcare at 844-210-5428.

When to Request UnitedHealthcare Prior Authorization

> **Medical Plan 3:** Out-of-network care is only covered for emergency services, as described in **Emergency Services** 72.

Regardless of the coverage option you have chosen, certain types of care, including behavioral health care, require prior authorization.

When you use UnitedHealthcare network providers, in most cases, your provider will handle the prior authorization process for you.

When you use UnitedHealthcare out-of-network providers, you are responsible for requesting prior authorization when required. To request prior authorization, call UnitedHealthcare at 844-210-5428; representatives are available from 8 a.m. to 8 p.m. (local time), Monday through Friday. If you do not obtain prior authorization from UnitedHealthcare when required, benefits paid by the Plan will be reduced by 50% of the covered charges.

When you are admitted to an out-of-network facility, you are responsible for requesting prior authorization. You, a family member or your provider must request prior authorization at least 14 days before non-emergency admissions or medical services. Prior authorization is not required for a medical emergency or urgent care admission; however, you should contact UnitedHealthcare Member Services at 844-210-5428 within one business day after the emergency.

UnitedHealthcare determines whether care is medically necessary. You have the right to receive the criteria UnitedHealthcare applies to determine medical necessity. If your claim for care is denied, you have the right to know the reason for UnitedHealthcare's decision.

The following table highlights when to call to request prior authorization:

Benefit or Program	When to Call
Emergency Admission	Prior authorization is not required; however, contact UnitedHealthcare Member Services at 844-210-5428 within 48 hours or as soon as reasonably possible after any out-of-network provider admission
Urgent Admission	Request prior authorization before admission (an urgent admission is an admission due to the onset of or change in an illness, the diagnosis of an illness or an injury)
Emergency Outpatient Medical Services	Request prior authorization before the care, treatment or procedure if possible or as soon as reasonable possible
Benefit or Program	**When to Call**

Non-Emergency Inpatient Admission	Request prior authorization at least 14 days before the date you are scheduled to be admitted
Non-Emergency Outpatient Medical Services	Request prior authorization at least 14 days before the outpatient care is provided or the treatment or procedure is scheduled

Important Note: If you do not obtain prior authorization when required, the Plan's coinsurance is reduced by 50% of covered expenses. Any expenses you are responsible for because of a reduction due to failure to request prior authorization do not apply to your annual out-of-pocket maximum.

When UnitedHealthcare Prior Authorization Is Required

You may contact UnitedHealthcare to discuss alternatives to inpatient stays such as outpatient centers, home health care and hospice care.

For you to receive the highest level of benefit, you should use UnitedHealthcare network facilities for non-emergency medical and behavioral health care. To receive the highest level of benefit for inpatient behavioral health care, you must use one of the specialty hospitals and facilities that are included in the behavioral health network.

Medical Plan 3: Out-of-network care is only covered for emergency services, ambulance, clinical trials, obesity and transplant surgery. as described in **Emergency Services** 72.

When you use an out-of-network provider, you are responsible for requesting prior authorization for the following:

- Ground and Air Ambulance transportation by fixed-wing aircraft or elective (non-emergency) transportation by ground ambulance, including any affiliated non-emergency ground ambulance transport in conjunction with non-emergency air ambulance transport;
- Autologous chondrocyte implantation, Carticel;
- Behavioral health outpatient services, including:
  - Biofeedback;
  - Intensive outpatient program care;
  - Neuropsychological testing;

- Outpatient detoxification.
- Outpatient electroconvulsive therapy (ECT);
- Psychiatric home care services; and
- Psychological testing;

- Clinical trials;
- Cognitive skills development;
- Dialysis visits;
- Dorsal column (lumbar) neurostimulators (trial or implantation);
- Durable medical equipment (rental or purchase) costing $1,000 or more;
- Electric or motorized wheelchairs and scooters;
- Home health care;
- Hospice care (inpatient and outpatient);
- Hyperbaric oxygen therapy;
- Infertility treatment;
- Injectable drugs and medications, contact UnitedHealthcare for more information on which medications are subject to prior authorization;
- Inpatient confinements, including:

- Hospital, skilled nursing facility, rehabilitation facility stays for surgical and nonsurgical care, including maternity and newborn confinements that exceed standard lengths of stay;
- Inpatient residential treatment facility stays for mental disorder or substance use disorder treatment;
- Partial hospitalization program care for mental disorders or substance use disorders;
- Inpatient stay for gender reassignment;

- Limb prosthetics;
- Nonparticipating freestanding ambulatory surgical facility services;
- Oncotype DX;
- Private duty nursing care;
- Proton beam radiotherapy;
- Reconstructive or other procedures that may be considered cosmetic, such as:

- Blepharoplasty/canthoplasty or related procedures;
- Breast reconstruction/enlargement;

- Brest reduction/mammoplasty (unless the procedure is in connection with a mastectomy for cancer) and removal of breast implants and capsulotomy of the breast;
- Cervicoplasty;
- Chemical peels;
- Excision of excessive skin due to weight loss;
- Gastroplasty/gastric bypass;
- Injection of filling material;
- Lipectomy or excess fat removal;
- Rhinoplasty (with or without septoplasty); and
- Sclerotherapy or surgery for varicose veins;

• Sleep studies;
• Spinal procedures, including intervertebral disc surgery, cervical, lumbar and thoracic laminectomy/laminotomy procedures and spinal infusion surgery;
• Surgeries (inpatient and outpatient) and procedures, including:

- Abdominoplasty (includes diastasis recti);
- Dental implants;
- Extracorporeal shock wave therapy;
- Gastrointestinal tract imaging through capsule endoscopy;
- Genioplasty;
- Jaw joint disorder surgery;
- Mastectomy;
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of temporomandibular joint;
- Osseo integrated implant;
- Osteochondral allograft/knee;
- Palatopharyngoplasty/uvulectomy;
- Penile prosthesis operation;
- Uvulopalatopharyngoplasty, including laser-assisted procedures;

• Temporomandibular joint disorder treatment;
• Transplants, including bone marrow transplants;
• Ventricular assist devices.

For outpatient surgeries and procedures, at least 14 days advance notice is required.

In an Emergency

In an emergency, you or your covered dependent should immediately seek whatever care is necessary to safeguard health and wellbeing.

Note: For emergency admissions, you do not need to request prior authorization for inpatient services for cellular and gene therapy, hospital inpatient, mental health care/substance-related and addictive disorders services, neurobiological disorders/autism spectrum disorder services, reconstructive procedures, skilled nursing facility/inpatient rehabilitation or transplantation services.

Emergency Behavioral Health Treatment

UnitedHealthcare determines whether behavioral health care is medically necessary. You have the right to request the criteria UnitedHealthcare applies to determine medical necessity. If your claim for behavioral health care is denied, you have the right to know the reason for the UnitedHealthcare's decision.

To request prior authorization, call UnitedHealthcare at 844-210-5428.

If You Do Not Request Prior Authorization

If prior authorization is not requested when required (as described in this section) or if prior authorization is requested and denied because a stay is not necessary, then the Plan's coinsurance is reduced to 50% of covered expenses. This reduction applies to:

- Inpatient hospital stays;
- Treatment facility stays (intensive outpatient, partial hospitalization and residential treatment centers);
- Convalescent facility stays;
- Home health care;
- Hospice care (inpatient and outpatient);
- Private duty nursing;
- Ambulance (non-emergency), including any affiliated non-emergency ground ambulance transport in conjunction with non-emergency air ambulance transport;
- Clinical trials;
- Congenital heart disease;

- Durable medical equipment over $1,000;
- Habilitative services;
- Sleep studies;
- Mental health care and substance-related and addictive disorders services;
- Obesity surgery;
- Pregnancy inpatient stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery;
- Prosthetics over $1,000;
- Sleep apnea surgery;
- Therapeutic treatments (dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound);
- Transplant (network) services; and
- Transgender surgical treatment.

Contact UnitedHealthcare if you are not sure when you need to request prior authorization.

Mental Health and Substance-Related and Addictive Disorders Services Prior Authorization

- For a scheduled admission for mental health and substance-related and addictive disorder services at an out-of-network provider, including an admission for services at a residential treatment facility, you must get prior authorization five business days before the admission (or as soon as reasonably possible for a non-scheduled admission.
- For partial hospitalization/day treatment, intensive outpatient treatment, outpatient electro-convulsive treatment, psychological testing, transcranial magnetic stimulation, intensive behavioral therapy, including Applied Behavior Analysis (ABA) at an out-of-network provider, you must get prior authorization before the services are received.

When in doubt, it is better to request prior authorization when you receive out-of-network care.

How Prior Authorization Works

When you call for prior authorization, you must provide the following information:

- Employee's name and identification number;
- Patient's name and birth date;
- Physician's name and telephone number;
- Hospital's name and telephone number;
- Reason for proposed hospital admission; and
- Proposed date of admission.

All medical information provided for prior authorization is held in strict confidence.

Then UnitedHealthcare will:

- Give you a patient control number (if proposed admission date is given) to confirm that UnitedHealthcare was notified;
- Contact your physician; and
- Discuss outpatient versus inpatient care and treatment alternatives, if needed.

If you do not live in a network location, UnitedHealthcare attempts to negotiate fees with the hospital you selected. Any discounts are passed on to you.

There are some things that the prior authorization process will not do, such as:

- Make your health care decisions for you;
- Interfere in your relationship with your physician;
- Diagnose your condition;
- Deliver medical care;
- Prescribe medication;
- Delay the processing of your medical claim; or
- Determine your benefit coverage.

UnitedHealthcare Chronic Condition Management Program

If you or a covered family member suffers from a chronic condition, UnitedHealthcare offers special assistance through the Chronic Condition Management Program. Participation is voluntary and confidential.

The Program's services are provided by UnitedHealthcare. Registered nurses and other health care professionals help patients to:

- Better understand and follow their doctor's recommendations;
- Take charge of their care;
- Make lifestyle changes to improve their general health; and
- Alert their doctors to opportunities to improve their care.

The Chronic Condition Management Program covers 30 chronic conditions, ranging from asthma to congestive heart failure to sickle cell disease to seizure disorders. UnitedHealthcare reviews claims data to identify people who may qualify for the Program. To see if you or your covered family member may qualify, contact your Advocate by calling UnitedHealthcare at 844-210-5428.

Behavioral Health Program

NXP offers a Behavioral Health Program to all UnitedHealthcare Medical Plan participants. The goal is to help you and your covered dependents remain healthy and to provide access to quality providers.

Kaiser Permanente HMO

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on their home address. The HMO is only available if you are in Kaiser's service area. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-278-3296.

UnitedHealthcare Behavioral Health Benefits Summary	
Benefit	**Description**
Eligible Providers	Licensed psychiatrists, licensed nurse practitioners, licensed clinical psychologists, licensed social workers and other licensed behavioral health counselors. (If you are enrolled in the Medical Plan 3, you must use network providers, except for emergency services, or your care will not be covered.)
UnitedHealthcare Behavioral Health Benefits Summary	
Benefit	**Description**

Inpatient Treatment Program	• **Acute:** 24-hour intensive nursing and medical attention • **Sub-Acute:** 24-hour nursing and medical monitoring as needed (therapeutic rehabilitation) • **Day Care/Evening Treatment or Partial Hospitalization:** A structured program in which you meet for individual, group and family therapy UnitedHealthcare Advocate prior authorization is required for non-emergency care. The program's benefits are determined the same as your inpatient medical benefits. For uncertified treatment, the program's coinsurance is 50% of negotiated rates for covered treatment; you pay the remaining charges.
Residential Treatment	Prior authorization is required for medically necessary treatment in an overnight environment.
Intensive Outpatient Treatment (beyond office visits)	A structured program in which you meet for individual, group and family therapy at least three hours each day for three days or more per week. The program's benefits are the same as your outpatient medical benefits.
Outpatient Physician/ Therapist Visits	For network care, you pay any applicable office visit copayment for each office visit and the Plan pays the rest. For out-of-network care, the program's coinsurance is the same percentage of the allowed amount as your other out-of-network outpatient treatment; you pay the remaining charges.

When You Use a Network Provider

If you use an UnitedHealthcare network provider, the Program pays its network level of benefit for inpatient care, partial hospitalization, residential treatment or intensive outpatient treatment. You are responsible for the remaining charges, up to the allowed amount in your medical plan coverage choices. The amounts you pay count toward your coverage option's annual network out-of-pocket maximum.

UnitedHealthcare network providers handle prior authorization when it is required.

For network outpatient office visits, you pay only your office visit copayment and the program pays the rest.

When You Use an Out-of-Network Provider

Medical Plan 3: Out-of-network care is only covered for emergency services, as described in **Emergency Services** 72.

When you are enrolled in Medical Plan 1 or Medical Plan 2, you may use providers who are not in the behavioral health network and receive the out-of-network level of benefit of your medical option. You are responsible for all remaining charges, including amounts above the allowed amount (or recognized amount, as applicable). You must use a licensed psychiatrist, licensed social worker or behavioral health counselor to receive out-of-network benefits.

If You Live Out-of-Area

The Behavioral Health Program is available to you and your covered dependents even if you do not live in an area served by the Program's network. In this case, you may see any state-licensed behavioral health provider you choose, and the Program pays 80% of allowed amount for covered medical services. For office visits, you pay your copayment and the Program pays the rest, up to the allowed amount for that service. You are responsible for paying any amounts above the allowed amount.

When you receive care from an out-of-network provider, you may be responsible for paying charges to the provider at the time of service and then filing for reimbursement (See the behavioral health portions of the **Filing for Your Benefits** table 344. ***You are responsible for getting prior authorization for out-of-network care when it is required*** (see **Prior Authorization** 78. Contact your Advocate by calling UnitedHealthcare at 844-210-5428 to request prior authorization.

Medical Program: What's Covered

The NXP Medical Plan pays benefits for covered services and expenses only. The Plan provides coverage for a wide array of services. It is your responsibility to use the services of network providers and to follow your UnitedHealthcare Advocate requirements whenever applicable to receive the highest benefit possible.

Failure to follow the guidelines for contacting your UnitedHealthcare Advocate when required reduces your benefit.

Kaiser Permanente HMO

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on their home address. The HMO is only available if you are in Kaiser's service area. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-278-3296.

Preventive Care

When you receive certain preventive care services as the primary reason for seeing a network provider (or any licensed provider under the Out-of-Area Plan coverage option), you will not pay an office visit copayment or a deductible; the Plan pays 100% of covered charges.

When you are covered under Medical Plan 1 or Medical Plan 2 and use an out-of-network provider for preventive care, the Plan's benefit level and deductible are dependent on whether you received the services in a physician's office, hospital or radiology or other outpatient facility. If you are covered under Medical Plan 3, you must use network providers (including network providers for any lab work completed relating to the care) for your preventive care to be covered.

Voluntary health screenings are sometimes offered outside the Medical Plan at NXP worksites; see **Activity Centers** 181.

Preventive care services provided on an outpatient basis at a physician's office, an alternate facility or a hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings for infants, children and adolescents, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a physician. You can find more information on how to access benefits for breast pumps by contacting UnitedHealthcare at **myuhc.com** or by calling 844-210-5428.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental; and
- Timing of purchase or rental.

Applied Behavioral Analysis (ABA)

Educational therapy for autism, Pervasive Development Disorders (PDD) and other similar disorders.

Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy; and
- Nausea that is related to surgery, pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.

Alcohol, Drug Treatment

Treatment of alcoholism or drug addiction is covered as part of behavioral health benefits; see **Behavioral Health Program** 86for details.

Allergy Treatment

Physician-prescribed testing, treatment and injections for allergies; exclusions apply.126

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as determined appropriate by UnitedHealthcare) to the nearest hospital where the required emergency care services can be performed.

Non-emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as UnitedHealthcare determines appropriate) between facilities, including any affiliated non-emergency ground ambulance transport in conjunction with non-emergency air ambulance transport, only when the transport meets one of the following:

- From an out-of-network hospital to the closest network hospital when covered health services are required;

- To the closest network hospital that provides the required covered health services that were not available at the original hospital; and
- From a short-term acute care facility to the closest network Long-Term Acute Care (LTAC) facility, network inpatient rehabilitation facility or other network sub-acute facility where the required covered health services can be delivered.

For the purpose of this benefit the following terms have the following meanings:

- **Long-Term Acute Care (LTAC) Facility:** A facility or hospital that provides care to people with complex medical needs requiring long-term hospital stay in an acute or critical setting;
- **Short-Term Acute Care Facility:** A facility or hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting, such as for recovery following a surgery, care following sudden sickness, injury or flare-up of a chronic sickness; and
- **Sub-Acute Facility:** A facility that provides intermediate care on short-term or long-term basis.

For out-of-network services, you must obtain prior authorization as soon as possible before any out-of-network non-emergency ground and Air Ambulance services. See **Prior Authorization**, 78for more information.

Ambulatory Surgery (Outpatient)

Professional services and facility fees for outpatient surgery. UnitedHealthcare Advocate prior authorization is required78.

Anesthesia

Services provided by an anesthesiologist who is in constant attendance during the operation for the sole purpose of administering the anesthesia. Services provided by a Certified Registered Nurse Anesthetist (CRNA), when billed in conjunction with services of a supervising anesthesiologist. Charges not to exceed 50% of the lesser of the allowed amount for the procedure, for each provider.

Blood

Administration of whole blood, blood plasma or artificial blood products (excluding autologous blood, except for an impending surgical procedure).

Casts, Dressings, Prosthetic Appliances

Casts, dressings, splints, trusses, braces and crutches, prosthetic appliances and custom-made orthotics (limited to two pair per year) and Jobst Stockings, as prescribed by physician. UnitedHealthcare Advocate prior authorization is required for rental or purchase in an amount greater than $1,000.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office.

Benefits for CAR-T therapy for malignancies are provided as described in **Transplantation Services** 122.

> For out-of-network non-emergency services, you must obtain prior authorization as soon as the possibility of cellular or gene therapy arises. In addition, you must contact UnitedHealthcare 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions. See **Prior Authorization**, 78 for more information.

Chiropractic (Spinal Manipulation) Treatment

Manipulative (adjustive) treatment or other physical treatment for conditions caused by or related to biomechanical or nerve conduction disorders of the spine, by a physician or Doctor of Chiropractic Medicine on an outpatient basis. Limited to 20 office visits per calendar year, network and out-of-network combined. Specialist office visit benefit applies.

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition (for this benefit, a life-threatening disease or condition is one that is likely to cause death unless the course of the disease or condition is interrupted);
- Cardiovascular disease (cardiac/stroke) that is not life threatening, when UnitedHealthcare determines the clinical trial meets the qualifying clinical trial criteria stated below;

- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when UnitedHealthcare determines the clinical trial meets the qualifying clinical trial criteria stated below; and
- Other diseases or disorders that are not life threatening, when UnitedHealthcare determines the clinical trial meets the qualifying clinical trial criteria stated below.

For out-of-network services, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. See **Prior Authorization**, 78for more information.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered health services for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for:
  - Providing the experimental or investigational service(s) or item;
  - Clinically appropriate monitoring of the effects of the service or item; or
  - Prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the receipt of an experimental or investigational service(s) or item.

Routine costs for clinical trials do not include:

- The experimental or investigational service(s) or item; the only exceptions to this are:
  - Certain Category B devices, as defined by the CMS 400;
  - Certain promising interventions for patients with terminal illnesses; and
  - Other items and services that meet specified criteria according to UnitedHealthcare's medical and drug policies;
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient;

- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

For cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition; provided it meets any of the criteria listed below.

For cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders that are not life-threatening, a qualifying clinical trial is a Phase I, Phase II or Phase III clinical trial that takes place in relation to the detection or treatment of such non-life-threatening disease or disorder; provided it meets the criteria listed below.

Criteria include:

- Federally funded trials, which means the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH), includes National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above, the Department of Defense (DOD) or the Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants;
  - The Department of Veterans Affairs, the DOD or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the Secretary of Health and Human Services to:
    - Be comparable to the system of peer review of studies and investigations used by the NIH; and
    - Ensure unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

- The study or investigation takes place under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant Institutional Review Boards (IRBs) before you are enrolled in the trial. UnitedHealthcare, at any time, request documentation about the trial; and
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries that are ordered by a physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta;
- Aortic stenosis;
- Tetralogy of fallot;
- Transposition of the great vessels; and
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for physician services are described in **Physician Fees – Surgical and Medical Services**114.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

> For out-of-network services, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. See **Prior Authorization**, 78for more information.

You can call UnitedHealthcare at 844-210-5428 for information about specific guidelines regarding benefits for CHD services. It is important to notify UnitedHealthcare of your intention to have CHD surgery. When you notify UnitedHealthcare, UnitedHealthcare will provide you with the opportunity to enroll in programs that are designed to help you achieve the best outcomes for you.

Contraceptives

Physician-administered contraceptives such as IUDs, Norplant implants and progestin injections to prevent conception. Excludes prescription contraceptives; for prescription contraceptives, see **What's Covered** 178.

Dental Services – Accident Only

Dental services provided:

- Treatment is needed because of accidental damage;
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry; and
- The dental damage is severe enough that first contact with a physician or dentist happened within 72 hours of the accident. (You may request this period be longer if you do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury.)

Dental damage that happens due to normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

To be covered, treatment for dental services to repair damage caused by accidental injury must be:

- Started within three months of the accident, or if you are not covered at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care); and
- Completed within 12 months of the accident, or if you were not covered at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental injury are limited to:

- Emergency exam;
- Diagnostic X-rays;
- Endodontic (root canal) treatment;
- Temporary splinting of teeth;
- Prefabricated post and core;
- Simple minimal restorative procedures (fillings);

- Extractions;
- Post-traumatic crowns if such are the only clinically acceptable treatment; and
- Replacement of lost teeth due to injury with implant, dentures or bridges.

Diabetes Services

Covered diabetes services include:

Diabetes -Self Management and Training/Diabetic Eye Exams/Foot Care: Outpatient -self management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a physician and provided by appropriately licensed or registered health care professionals. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes; and

Diabetic -Self Management Items: Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs, include:

- Insulin pumps are subject to all the conditions of coverage stated in **Durable Medical Equipment (DME), Orthotics and Supplies** 99;
- Blood glucose meters including continuous glucose monitors;
- Insulin syringes with needles;
- Blood glucose and urine test strips;
- Ketone test strips and tablets; and
- Lancets and lancet devices.

Diagnostic Laboratory, Radiology and Pathology

A series of tests, invasive or noninvasive, used to determine a particular diagnosis. Benefit level, copayment and/or deductible (if any) depend on your coverage option and whether you receive the services in your physician's office, at an independent lab or in a hospital setting (either inpatient or outpatient).

Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies from a provider designated by the Claims Administrator or purchased directly from your prescribing network physician. If more than one item can meet your functional needs, benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan pays only the amount that the Plan would have paid for the item that meets the minimum specifications, and you are responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair;
- A standard hospital-type bed;
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks);
- Negative pressure wound therapy pumps (wound vacuums);
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage);
- Burn garments;
- Insulin pumps and all related needed supplies as described in **Diabetes Services** 98;
- External cochlear devices and systems; benefits for cochlear implantation are provided under the applicable medical/surgical benefit categories in this SPD;
- Lymphedema stockings for the arm, as required by the Women's Health and Cancer Rights Act of 1998; and
- Dedicated speech generating devise and tracheoesophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to sickness or injury; benefits for the purchase of these devices are available only after completing a required three-month rental period.

Benefits are limited as stated in **What's Not Covered** 126.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are also covered.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator or monitor that is fully implanted into the body (implantable devices are a covered health service for which benefits are available under the applicable medical/surgical covered health service categories of this Plan);
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a covered health service; and
- Powered exoskeleton devices.

UnitedHealthcare decides if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in **What's Not Covered** 126.

Emergency Health Services – Outpatient

Services that are required to stabilize or begin treatment in an emergency. Emergency health services must be received on an outpatient basis at a hospital or alternate facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a hospital for an inpatient stay).

Benefits are available for services to treat a condition that does not meet the definition of an emergency.

Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

Experimental or Investigational Treatment (Clinical Trials Therapies)

Clinical trials are covered as described in **Clinical Trials** 93. This coverage does not cover:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e., protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except medically necessary Category B, as defined by the CMS 400 investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with UnitedHealthcare's claim policies).

Eye Examinations

Non-refractive examination of the eye performed by an eligible provider due to an injury or illness performed at a hospital or at a physician's office. In general, refractive eye examinations are not covered; however, a refractive eye examination required for the diagnosis and treatment of a sickness or injury is covered, up to once each year. (A refractive eye exam is one that measures near and far sightedness.)

See **Vision Plan** 206, for information on coverage of routine vision care.

Eye Wear

Medically necessary prescription eyeglass lenses or contact lenses only for immediate treatment or postoperative care of medical conditions directly caused by trauma or disease. When the Vision Plan also pays a benefit for medically necessary contact lenses, the Medical Plan benefit is secondary.

Gastric Bypass

If medically necessary, gastroplasty, lap banding and bypass that is approved pursuant to procedures maintained by UnitedHealthcare (see **Obesity – Weight Loss Surgery** 112 for more information). UnitedHealthcare Advocate prior authorization is required78.

Gender Reassignment

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

EAP Support

Professional, confidential support is available to you, your spouse/domestic partner and your children through NXP's EAP, Live and Work Well. You and your family members can receive up to five free counseling visits per year with a masters-level counselor who specializes in dysphoria and transgender issues. If an issue extends beyond short-term resolution through the EAP, you can access further services through your behavioral health benefits.

To learn more, call Work Life Solutions at 866-248-4094 or visit **liveandworkwell.com** (access code: NXP).

Habilitative Services

Habilitative services are skilled care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. UnitedHealthcare decides if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. Therapies provided for general wellbeing or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy;
- Occupational therapy;
- Manipulative treatment;
- Speech therapy;
- Post-cochlear implant aural therapy and
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition provided:

- Treatment is administered by a:
  - Licensed speech-language pathologist;
  - Licensed audiologist;
  - Licensed occupational therapist;

  - Licensed physical therapist; or
  - Physician; and
- Treatment is proven and not experimental or investigational.

The following are not habilitative services:

- Custodial care;
- Respite care;
- Day care;
- Therapeutic recreation;
- Educational/vocational training;
- Residential treatment;
- A service or treatment plan that does not help you meet functional goals;
- Services solely educational in nature; and
- Educational services otherwise paid under state or federal law.

UnitedHealthcare may require the following be provided:

- Medical records; and
- Other necessary data to allow UnitedHealthcare to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress UnitedHealthcare may request additional medical records.

Habilitative services provided in your home by a home health agency are provided as described under **Home Health Care** 105. Habilitative services provided in your home other than by a home health agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are covered as described under **Durable Medical Equipment (DME), Orthotics and Supplies** 99 and **Prosthetic Devices** 116.

Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound that may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing air dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

If more than one type of hearing aid can meet your functional needs, benefits are available only for the hearing aid that meets the minimum specifications for your needs.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a covered health service for which benefits are available under the applicable medical/surgical covered health services categories of this Plan. Benefits are only available if you have:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid; or
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

Hearing Examinations

Routine hearing exams/care performed by an eligible provider are covered but are limited to one examination during any 24-month period.

Home Health Care

Services received from a home health agency provided they are:

- Ordered by a physician;
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- Provided on a part-time, intermittent care schedule; and
- Provided when skilled care is required.

UnitedHealthcare determines if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management.

Hospice Care

Hospice care that is recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill and includes:

- Physical, psychological, social, spiritual and respite care for the terminally ill person; and
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

Call UnitedHealthcare at 844-210-5428 for information about guidelines for hospice care.

Hospital – Inpatient Stay

Devices and supplies provided during an inpatient stay in a hospital, including:

- Supplies and non-physician services received during the inpatient stay;
- Room and board in a semi-private room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and emergency room physicians.

(Benefits for other physician services are described in **Physician Fees – Surgical and Medical Services** 114).

Hospital – Outpatient

Charges made by a hospital for outpatient treatment, such as outpatient surgery. UnitedHealthcare Advocate prior authorization is required in some cases78.

Hospital – Emergency Room, ER Physician

Charges made by a hospital or ER physician for emergency treatment. If an out-of-network provider bills for amounts above the recognized amount, contact UnitedHealthcare at 844-210-5428 to have your claim reprocessed, so you will not have to pay those additional charges.

Infertility Treatment

Therapeutic services for the treatment of infertility when provided by or under the direction of a physician. Benefits are limited to:

- Assisted Reproductive Technologies (ART), including, but not limited to:
  - In Vitro Fertilization (IVF);
  - Egg/oocyte retrieval;
  - Fresh or frozen embryo transfer;
  - Intracytoplasmic Sperm Injection (ICSI);
  - Cryopreservation and storage of embryos for 12 months; and
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD);
- Frozen embryo transfer cycle, including the associated cryopreservation and storage of embryos;
- Insemination procedures, including Artificial Insemination (AI) and Intrauterine Insemination (IUI);
- Ovulation induction or controlled ovarian stimulation;
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA); male factor associated surgical procedures for retrieval of sperm;
- Surgical procedures, including, but not limited to:
  - Laparoscopy;
  - Lysis of adhesions;

  - Tubotubal anastomosis;
  - Fimbrioplasty;
  - Salpingostomy;
  - Resection and ablation of endometriosis;
  - Transcervical catheterization;
  - Tubal catheterization; and
  - Ovarian cystoplasty;
- Electroejaculation; and
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Fertility Preservation for Medical Reasons - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, InVitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Treatment for the diagnosis and treatment of the underlying cause of infertility is covered as part of this benefit.

Benefits for diagnostic tests are described under **Scopic Procedures – Outpatient Diagnostic and Therapeutic** 118.

Any combination of medical and prescription drug (network and out-of-network) benefits are limited to a maximum of $40,000 per covered person during the entire period you are covered under the Plan (medical benefits are limited to $30,000 and prescription drug benefits are limited to $10,000). This limit does not include physician office visits for the treatment of Infertility for which benefits are described under **Physician's Office Services – Sickness and Injury**114.

Only charges for the following apply toward the infertility lifetime maximum:

- Surgeon;
- Assistant surgeon;
- Anesthesia;

- Lab tests; and
- Specific injections.

See **Infertility Treatment** 106for more information about what this benefit does not cover.

Fertility Solutions

Fertility Solutions is a program administered by UnitedHealthcare that provides you with access to:

- Specialized clinical consulting services to educate you on infertility treatment options; and
- A specialized network of providers for infertility services.

When you use designated providers, the program provides education, counseling and infertility management services and access to a national network of premier infertility treatment clinics. If you do not live within a 60 mile radius of a Fertility Solutions designated provider, you will need to contact a Fertility Solutions case manager to determine a network provider before starting treatment. For infertility services and supplies to be covered health services through this program, you must contact Fertility Solutions and enroll with a nurse consultant before receiving services. You or a covered dependent may:

- Be referred to Fertility Solutions by the Claims Administrator;
- Call the telephone number on your ID card; or
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the program, call a Fertility Solutions nurse at 866-774-4626. The Plan only pays Fertility Solutions program benefits if Fertility Solutions provides the proper notification to the designated provider performing the services (even if you self-refer to a provider in the designated network).

Lab, X-Ray and Diagnostic – Outpatient

Services for sickness and injury-related diagnostic purposes, received on an outpatient basis in a physician's office or at a hospital or alternate facility include:

- Lab and radiology/X-ray; and
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment;

- Physician services for radiologists, anesthesiologists and pathologists (benefits for other physician services are described under **Physician Fees – Surgical and Medical Services** 114;
- Genetic testing ordered by a physician that results in available medical treatment options following genetic counseling; and
- Presumptive drug tests and definitive drug tests.

Benefits may be covered under other parts of the plan as follows:

- When these services are performed in a physician's office, benefits are covered as described under **Physician's Office Services – Sickness and Injury** 114;
- Lab, X-ray and diagnostic services for preventive care are covered as described under **Preventive Care** 89; and
- CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are covered as described under **Major Diagnostic and Imaging – Outpatient** (in the next section).

Major Diagnostic and Imaging – Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a hospital or alternate facility.

Benefits include:

- The facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other physician services are described in **Physician Fees – Surgical and Medical Services** 114). When these services are performed in a physician's office, benefits are described under **Physician's Office Services – Sickness and Injury** 114.

Mastectomies

In connection with a covered mastectomy:

- All stages of reconstruction of the breast on which the mastectomy is performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prosthesis and physical complications of mastectomy including lymphedemas.

UnitedHealthcare Advocate prior authorization is required78.

Mental Health Care and Substance-Related and Addictive Disorders Services

Mental health care and substance-related and addictive disorders services include those received on an inpatient or outpatient basis in a hospital, an alternate facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider who is acting within the scope of their licensure.

Benefits include:

- Inpatient treatment;
- Residential treatment;
- Partial hospitalization/day treatment;
- Intensive outpatient treatment; and
- Outpatient treatment.

Inpatient treatment and residential treatment include room and board in a semi-private room (a room with two more beds).

Services include:

- Diagnostic evaluations, assessment and treatment or procedures;
- Medication management;
- Individual, family and group therapy; and
- Crisis intervention.

Mental health care services for autism spectrum disorder (including Intensive behavioral therapies, such as Applied Behavior Analysis (ABA)) that are:

- Focused on the treatment of core deficits of autism spectrum disorder;
- Provided by a Board Certified Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical covered health services categories of this Plan.

The mental health/substance-related and addictive disorders provider provides administrative services for all levels of care.

You are encouraged to contact the mental health/substance-related and addictive disorders designee for referrals to providers and coordination of care.

Virtual Behavioral Health Therapy and Coaching

The Virtual Behavioral Health Therapy and Coaching program identifies covered individuals with chronic medical conditions that frequently co-occur with mental health challenges and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This may mean you get a call from by a licensed clinical social worker or coach; however, you can initiate your own participation in the program by calling and speaking with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for individuals enrolled in the program for monitoring your progress toward meeting participation criteria. You are encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for behavioral health.

The program is provided through AbleTo, Inc. Participation is completely voluntary and provided at no extra charge. If you think you may be eligible to participate or would like additional information regarding the program, contact the number on the back of your ID card.

With this Program, you can receive specialized virtual behavioral health care from AbleTo designated network providers.

- **Medical Plan 1 and Medical Plan 2:** When you use an AbleTo designated network provider, the Plan pays 100% of covered expenses, with no deductible required.
- **Medical Plan 3:** When you use an AbleTo designated network provider, the Plan pays 100% of covered expenses after you meet your deductible; however, the deductible does not apply to your initial consultation, which is covered at 100%.

Nuclear Medicine, MRI, CT Scan, Ultrasound, Specialty Lab Procedures

Specialty diagnostic procedures performed at a hospital or other health care facility.

Nutritional Counseling

Services provided by a registered dietician in individual sessions for covered persons with medical conditions requiring a special diet. Examples include diabetes mellitus, gestational diabetes, coronary artery disease, heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria (PKU) and hyperlipidemias.

Obesity – Weight Loss Surgery

Surgical treatment of obesity when provided by or under the direction of a physician provided you have a Body Mass Index (BMI) of:

- Greater than 40; or
- Greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity.

Occupational Therapy (Short -Term Rehabilitation Therapy Services)

Occupational therapy by a registered and licensed therapist, necessary due to an illness, injury or congenital birth defect, provided the physician who prescribed it regularly reviews the treatment. Benefits, combined with physical therapy and speech therapy, are limited to 120 visits per calendar year.

Oral Surgery

Surgery for the treatment of fractures or dislocations of the jaw or the cutting procedures of the mouth.

Orthognathic Surgery

Surgery to alter relationships of dental arches and/or supporting bones, usually accomplished with orthodontic therapy. Surgery and postoperative therapy. Covered expenses include charges made for treatment of a congenital cleft lip or palate or of a condition related to the cleft lip or palate. UnitedHealthcare Advocate prior authorization is required78. **Note:** Orthodontic treatment and crowns associated with TMJ treatment are not covered under this benefit.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts;
- Irrigation sleeves, bags and ostomy irrigation catheters; and
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items not listed above.

Outpatient Emergency, Urgent Care

Treatment for emergency, accident or urgent care at an outpatient treatment center such as the outpatient department of a hospital or other ambulatory care center.

Pharmaceutical Products – Outpatient

Pharmaceutical products for covered health services administered on an outpatient basis in a hospital, alternate facility, physician's office or in your home.

Benefits are provided for pharmaceutical products that, due to their traits (as determined by UnitedHealthcare), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the pharmaceutical product is administered, benefits will be provided for administration of the pharmaceutical product under the corresponding benefit category of this Plan.

If you require certain pharmaceutical products, including specialty pharmaceutical products, UnitedHealthcare may direct you to a designated dispensing entity. Dispensing entities may include an outpatient pharmacy, specialty pharmacy, home health agency provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you or your provider are directed to a designated dispensing entity and you or your provider choose not to get your pharmaceutical product from a designated dispensing entity, network benefits are not available for that pharmaceutical product.

Certain pharmaceutical products are subject to step therapy requirements. This means that to receive benefits for such pharmaceutical products, you must use a different pharmaceutical product and/or prescription drug product first. You may find out whether a particular pharmaceutical product is subject to step therapy requirements by contacting UnitedHealthcare at **myuhc.com** or by calling 844-210-5428.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions, such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. For more information on these programs, contact UnitedHealthcare at **myuhc.com** or by calling 844-210-5428.

Physician Fees – Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility, or for physician house calls.

Physician's Office Services – Sickness and Injury

Services provided in a physician's office for the diagnosis and treatment of a sickness or injury. Benefits are provided regardless of whether the physician's office is freestanding, located in a clinic or located in a hospital.

Covered health services include medical education services that are provided in a physician's office by appropriately licensed or registered health care professionals when:

- Education is required for a disease in which patient self-management is a part of treatment; and
- There is a lack of knowledge regarding the disease that requires the help of a trained health professional.

Covered services include genetic counseling, allergy injections and lab, radiology/X-ray or other diagnostic services performed in the physician's office.

Covered health services for preventive care provided in a physician's office are described under **Preventive Care** 89.

Physical Therapy (Short-Term Rehabilitation Therapy Services)

Physical therapy by a registered and licensed therapist, provided the physician who prescribed it regularly reviews the treatment. Benefits, combined with occupational therapy and speech therapy, are limited to 120 visits per calendar year.

Pregnancy – Maternity Support Program

Benefits for pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a pregnancy, benefits include the services of a genetic counselor when provided or referred by a physician. These benefits are available to all covered persons in the immediate family. Covered health services include related tests and treatment.

UnitedHealthcare also offers special prenatal programs to help during pregnancy. They are voluntary and there is no extra cost for taking part in a program. To sign up, contact UnitedHealthcare at 844-210-5428 during the first trimester, but no later than one month before the expected date of delivery.

The Plan pays benefits for an inpatient stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery; and
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Prescription Medicine

Charges for drugs prescribed by a physician and dispensed in an inpatient setting, outpatient hospital or surgical center. If the allowed amount is not available, benefit is based on average wholesale price of the drug. Certain specialty drugs must be purchased through **CVS Caremark Specialty Pharmacy Services** to be covered 171.

Private Duty Nursing (Skilled Nursing Care)

Outpatient nursing care when the attending physician states in writing that the care is necessary; covered up to a maximum of 120 visits per calendar year. Private duty nursing care must be provided by a registered nurse or licensed practical nurse. The services provided must be for treatment, not for custodial care.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands;
- Artificial face, eyes, ears and nose; and
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

Benefits include mastectomy bras and lymphedema stockings for the arm (as described under **Durable Medical Equipment (DME), Orthotics and Supplies** 99.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a covered health service for which benefits are available under the applicable medical/surgical covered health service categories of this Plan.

If more than one prosthetic device can meet your functional needs, benefits are available only for the prosthetic device that meets the minimum specifications for your needs.

If you purchase a prosthetic device that exceeds these minimum specifications, the Plan pays only the amount the Plan would have paid for the prosthetic that meets the minimum specifications; you are responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a physician.

Radiation Therapy and Chemotherapy

Coverage for radiation therapy (X-ray, radium and radioactive isotope treatment) and chemotherapy. If network negotiated fee (network) or recognized amount (out-of-network) is not available, benefit is based on average wholesale price of the drug. Certain specialty drugs must be purchased through **CVS Caremark Specialty Pharmacy Services** to be covered 171.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is:

- Treatment of a medical condition; or
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures that are related to an injury, sickness or congenital anomaly provided the primary result of the procedure is not a changed or improved physical appearance.

Cosmetic procedures are not covered. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that you may suffer psychological consequences or socially avoidant behavior due to an injury, sickness or congenital anomaly does not classify surgery (or other procedures done to relieve the consequences or behavior) as a reconstructive procedure.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other covered health service. Contact UnitedHealthcare at 844-210-5428 for more information about benefits for mastectomy-related services.

Rehabilitation Services – Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy;
- Occupational therapy;
- Manipulative treatment;
- Speech therapy;
- Pulmonary rehabilitation therapy;
- Cardiac rehabilitation therapy;

- Post-cochlear implant aural therapy; and

Rehabilitation services must be performed by a physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a physician's office or on an outpatient basis at a hospital or alternate facility. Rehabilitative services provided in your home by a home health agency are provided as described under home health care. Rehabilitative services provided in your home other than by a home health agency are provided as described under this section.

> ***Musculoskeletal Rehabilitation Services***
>
> For Medical Plan 2, Medical Plan 3 and the Out-of-Area Plan, the first three visits for any combination of manipulative treatment and physical therapy for new low back pain are covered at 100%. This does not apply to Medical Plan 1.

Benefits can be denied or shortened if:

- You are not progressing in goal-directed rehabilitation services; or
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy, the Plan pays benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly or autism spectrum disorder. The Plan pays benefits for cognitive rehabilitation therapy only when medically necessary following a post-traumatic brain injury or cerebral vascular accident.

Respiratory Therapy

Respiratory therapy prescribed by a physician.

Scopic Procedures – Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a hospital or alternate facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy (see the **Medical Plan Benefits Summary**, 55for how the Plan covers diagnostic colonoscopies);

- Sigmoidoscopy; and
- Diagnostic endoscopy.

Benefits include:

- The facility charge;
- Supply and equipment charges; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits do not include surgical scopic procedures that are for performing surgery. Benefits for surgical scopic procedures are described under **Surgery – Outpatient** 120.

Benefits for all other physician services are described in **Physician Fees – Surgical and Medical Services** 114. Benefits that apply to certain preventive screenings are described under **Preventive Care** 89.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility. Benefits are available for:

- Supplies and non-physician services received during the inpatient stay;
- Room and board in a semi-private room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other physician services are described in **Physician Fees – Surgical and Medical Services** 114.

Benefits are available only if:

- The first confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost-effective option to an inpatient stay in a hospital; and
- You will receive skilled care services that are not primarily custodial care.

UnitedHealthcare will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services; or
- Discharge rehabilitation goals have previously been met.

Sleep Studies

Diagnostic testing for the determination of sleep disorders. UnitedHealthcare Advocate prior authorization is required.78.

Speech Therapy (Short-Term Rehabilitation Therapy Services)

Speech therapy by a licensed and registered therapist, provided the physician who prescribed it regularly reviews the treatment. Benefits, combined with occupational therapy and physical therapy, are limited to 120 visits per calendar year.

Sterilization

Routine sterilization, including vasectomy and tubal ligation for the employee and covered spouse/domestic partner, but not reversal of such procedure.

Surgery – Outpatient

Surgery and related services received on an outpatient basis at a hospital or alternate facility or in a physician's office. Benefits include certain scopic procedures.

Examples of surgical scopic procedures include:

- Arthroscopy;
- Laparoscopy;
- Bronchoscopy; and
- Hysteroscopy.

Examples of surgical procedures performed in a physician's office are mole removal and ear wax removal.

Benefits include:

- The facility charge;
- Supply and equipment charges; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other physician services are described in **Physician Fees – Surgical and Medical Services** 114.

Surgical Assistant

If medically necessary, surgical assistant charges not exceeding 20% of the primary surgeon's contracted rate for all procedures.

Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles. Diagnosis must be made by exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment includes:

- Clinical exams;
- Oral appliances (orthotic splints);
- Arthrocentesis; and
- Trigger-point injections.

Benefits are provided for surgical treatment if:

- There is radiographic evidence of joint abnormality;
- Non-surgical treatment has not resolved the symptoms; and
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis;
- Arthroscopy;
- Arthroplasty;
- Arthrotomy; and
- Open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Therapeutic Treatments – Outpatient

Therapeutic treatments received on an outpatient basis at a hospital or alternate facility or in a physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis);

- Intravenous chemotherapy or other intravenous infusion therapy; and
- Radiation oncology.

Covered health services include medical education services that are provided on an outpatient basis at a hospital or alternate facility by appropriately licensed or registered health care professionals when:

- Education is required for a disease in which patient self-management is a part of treatment; and
- There is a lack of knowledge regarding the disease that requires the help of a trained health professional.

Benefits include:

- The facility charge
- Supply and equipment charges; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other physician services are described in **Physician Fees – Surgical and Medical Services** 114.

Tobacco Cessation Programs

Physician-prescribed and regularly reviewed medical treatment and prescription medicines provided as part of a tobacco cessation program. Coverage includes preventive counseling visits, treatment visits and class visits to aid in ceasing the use of tobacco products. Annual maximum benefit is two 12-week cycles of treatment.

Transplantation Services

Organ transplants are covered under all Medical Plan options.

Transplantation services should be received from a designated provider. UnitedHealthcare does not require that corneal transplants be received from a designated provider for you to receive benefits. However, you must obtain prior authorization as soon as the possibility of a transplant arises (and before a pre-transplantation evaluation is performed at a transplant center).

Organ and tissue transplants, including CAR-T cell therapy when ordered by a physician, are available for transplants when the transplant meets the definition of a covered health service, and is not an experimental or investigational or unproven service.

Examples of transplants for which benefits are available include:

- One marrow, including CAR-T cell therapy;
- Heart;
- Heart/lung;
- Lung;
- Kidney;
- Kidney/pancreas;
- Liver;
- Liver/small bowel;
- Pancreas;
- Small bowel; and
- Cornea.

Donor costs that are directly related to organ removal are covered health services for which benefits are payable through the organ recipient's coverage under the Plan.

> **Note:** For inpatient transplantation services due to an emergency admission, you do not need to request prior authorization.

Call UnitedHealthcare at 844-210-5428 for information about specific guidelines regarding benefits for transplant services.

See **Transplants** 138 for more information about what this benefit does not cover.

Travel and Lodging Assistance Program for Complex Medical Conditions

The Plan provides you with travel and lodging assistance for cancer resources services, congenital heart disease and transplant programs. Travel and lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a designated provider and the distance from your home address (on file with the Plan) to the facility is at least 50 miles.

Eligible expenses are reimbursed after the expense forms have been completed and submitted with appropriate receipts.

Travel and lodging expenses are only available if the covered person resides at least 50 miles from the designated provider. Expenses covered for a covered (non-Medicare) person and a travel companion include:

- Transportation of the covered person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a designated provider for covered (if the covered person is a dependent minor child, transportation expenses for two companions will be covered); and
- Lodging expenses for the covered person while not a hospital inpatient and one companion. Lodging reimbursement assistance is based on a rate of up to:
  - $50 per day for the covered person or the caregiver if the covered person is in the hospital; or
  - $100 per day for the covered person and one caregiver or two persons may accompany a child if the child is the covered person.

Travel and lodging assistance limited to an overall lifetime maximum of $10,000 per person for all cancer resources services, congenital heart disease and transplant programs services combined.

The Plan only covers incurred reasonable travel and lodging expenses and is independent of any existing medical coverage available. You must save travel and lodging receipts to submit for reimbursement. Reimbursement for certain lodging expenses may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the daily rate.

If you would like additional information regarding travel and lodging benefits, contact UnitedHealthcare at **myuhc.com** or call 844-210-5428.

Travel and Lodging Services

The Plan provides a travel and lodging allowance for covered health service that are not available in your state of residence due to law or regulation when such services are received in another state, as legally permissible.

The Plans travel and lodging allowance may be used toward reasonable travel and lodging expenses for a covered individual and travel companion when the individual must travel at least 50 miles from their address, as reflected in the Plans records, to receive covered health services.

The travel and lodging assistance allowance is limited to an annual maximum of $2,000, with an overall lifetime maximum of $10,000 per person for all covered health services combine. Lodging expenses are also limited to $50 per day for the covered individual only or $1000 per day for the covered individual and a travel companion. Be sure to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, contact UHC at www.myuhc.com or the telephone number on your ID card.

Urgent Care Center Services

Covered health services received at an urgent care center. When services to treat urgent health care needs are provided in a physician's office, benefits are available as described in **Physician Fees – Surgical and Medical Services** 114.

Urinary Catheters

Indwelling, intermittent and external urinary catheters for incontinence or retention, including related urologic supplies for indwelling catheters, which are limited to:

- Urinary drainage bag and insertion tray (kit);
- Anchoring device; and
- Irrigation tubing set.

Virtual Care Services

Virtual care for covered health services that include the diagnosis and treatment of less serious medical conditions through live audio with video and audio only technology as well as remote physiologic monitoring. Virtual care provides communication of medical information in real-time between the patient and a distant physician or health specialist, through use of live audio and video technology outside of a medical facility (for example, from home or from work).

Network benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by contacting UnitedHealthcare at **myuhc.com** or by calling 844-210-5428.

Note: Not all medical conditions can be treated through virtual care. The designated virtual network provider will identify any condition for which treatment by in-person physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (**CMS** defined originating facilities).

Well-Child and Baby Care

Office visits and immunizations for well-child and baby care. Includes routine nursery care for a newborn, while the mother is hospitalized for maternity care.

Wigs

Wigs and hairpieces prescribed by a physician for hair loss caused by, but not limited to, chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery or severe burns. Benefits are limited to one wig or hair piece and $500 per calendar year.

What's Not Covered

When no statement is made in the Plan regarding a specific service, that specific service is not covered. Listed below are examples of services that ***are not*** covered under the NXP Medical Plan. Contact the NXP Benefits Service Center for additional information.

Alternative Treatments

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing;
- Wilderness, adventure, camping, outdoor or other similar programs; and
- Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health. This exclusion does not apply to manipulative treatment and non-manipulative osteopathic care for which benefits are provided as described in **What's Covered** 89.

Dental

- Dental care, which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia. This exclusion does not apply to:

– Accident-related dental services for which benefits are provided as described in **Dental Services – Accident Only** 97; or

– Dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the Plan, limited to:

  - Transplant preparation;
  - Before the initiation of immunosuppressive drugs; and
  - The direct treatment of acute traumatic Injury, cancer or cleft palate;

- Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication;
- Endodontics, periodontal surgery and restorative treatment are excluded;
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

– Removal, restoration and replacement of teeth;

– Medical or surgical treatments of dental conditions; and

– Services to improve dental clinical outcomes.

- This exclusion does not apply to:

– Preventive care for which benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement; or

– Accident-related dental services for which benefits are provided as described in **Dental Services – Accident Only**97;

- Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which benefits are provided as described in **Dental Services – Accident Only** 97;
- Dental braces (orthodontics); and
- Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a congenital anomaly.

Devices, Appliances and Prosthetics

- Devices used as safety items or to help performance in sports-related activities;
- Orthotic appliances and devices that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to diabetic footwear (which may be covered for covered individuals with diabetic foot disease), cranial molding helmets and cranial banding that meet clinical criteria or covered DME as described in **Durable Medical Equipment (DME), Orthotics and Supplies** 99;
- The following items are excluded, even if prescribed by a physician:
  - Blood pressure cuff/monitor;
  - Enuresis alarm;
  - Non-wearable external defibrillator;
  - Trusses; and
  - Ultrasonic nebulizers;
- Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheoesophageal voice devices for which benefits are provided as described in **Durable Medical Equipment (DME), Orthotics and Supplies** o99;
- Oral appliances for snoring; and
- Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

- Prescription drug products for outpatient use that are filled by a prescription order or refill;
- Self-administered or self-injectable medications (this exclusion does not apply to medications that, due to their traits (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting; in addition, this exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to the covered individual for self-administration);

- Non-injectable medications given in a physician's office. This exclusion does not apply to non-injectable medications that are required in an emergency and used while in the physician's office;
- Over-the-counter drugs and treatments;
- Growth hormone therapy;
- New pharmaceutical products and/or new dosage forms until the date they are reviewed; and
-
- Certain pharmaceutical products that have not been prescribed by a specialist.

Experimental or Investigational Services

Experimental or investigational services and all services related to experimental and investigational services are excluded. The fact that an experimental or investigational service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational in the treatment of that particular condition.

This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided as described in **Clinical Trials** 93.

Foot Care

- Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which benefits are provided as described under **Diabetes Services** 98;
- Nail trimming, cutting, or debriding;
- Hygienic and preventive maintenance foot care. Examples include:

– Cleaning and soaking the feet; and

– Applying skin creams in order to maintain skin tone;

This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes;

- Treatment of flat feet;
- Treatment of subluxation of the foot;
- Shoes;

- Shoe orthotics;
- Shoe inserts; and
- Arch supports.

Gender Reassignment

Gender reassignment benefits do not include cosmetic procedures, including, but not limited to:

- Abdominoplasty;
- Blepharoplasty;
- Body contouring, such as lipoplasty;
- Brow lift;
- Calf implants;
- Cheek, chin and nose implants;
- Injection of fillers or neurotoxins;
- Face lift, forehead lift or neck tightening;
- Facial bone remodeling for facial feminizations;
- Hair removal (except when part of a genital reconstruction procedure by a physician for the treatment of gender dysphoria);
- Hair transplantation;
- Lip augmentation;
- Lip reduction;
- Liposuction (except when done for lipedema);
- Mastopexy;
- Pectoral implants for chest masculinization;
- Rhinoplasty; and
- Skin resurfacing.

Medical Supplies and Equipment

- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Compression stockings;

- Ace bandages; and
- Gauze and dressings;

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which benefits are provided as described in **Durable Medical Equipment (DME), Orthotics and Supplies** 99and **Prosthetic Devices** 116;
- Administration of medical food products; and
- Diabetic supplies for which benefits are provided as described in **Diabetes Services** 98;
- Ostomy supplies for which benefits are provided as described in **Ostomy Supplies** on 113;
- Urinary catheters and related urologic supplies for which benefits are provided as described in **Urinary Catheters** 125

- Tubings and masks except when used with DME as described in **Durable Medical Equipment (DME), Orthotics and Supplies** 99;
- Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes; and
- Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this section, the exclusions listed directly below apply to services described in **Mental Health Care and Substance-Related and Addictive Disorders Services** 110:

- Services performed in connection with conditions not classified in the *Mental and Behavioral Disorders* section of the current edition of the *International Classification of Diseases* or current edition of the *Diagnostic and Statistical Manual of Mental Disorders* used by the American Psychiatric Association;
- Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* used by the American Psychiatric Association;

- Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders (except for a primary diagnosis), pyromania, kleptomania, gambling disorder and paraphilic disorders;
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes;
- Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act;
- Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* used by the American Psychiatric Association; and
- Transitional living services.

Nutrition

- Individual and group nutritional counseling, including non-specific disease nutritional education, such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to:
  - Preventive care for which benefits are provided under the United States Preventive Services Task Force requirement; or
  - Medical or behavioral/mental health related education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when:
    - Nutritional education is required for a disease in which patient self-management is a part of treatment; and
    - There is a lack of knowledge regarding the disease that requires the help of a trained health professional;
- Food of any kind, infant formula, standard milk-based formula and donor breast milk (this does not apply to specialized enteral formula and other modified food products for which benefits are provided, as described in **Enteral Nutrition** 100); and
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

- Television;
- Telephone;
- Beauty/barber service;
- Guest service; and
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

– Air conditioners, air purifiers, air filters and dehumidifiers;
– Batteries and battery chargers;
– Breast pumps. This exclusion does not apply to breast pumps for which benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
– Car seats;
– Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
– Exercise equipment;
– Home modifications such as elevators, handrails and ramps;
– Hot and cold compresses;
– Hot tubs;
– Humidifiers;
– Jacuzzis;
– Mattresses;
– Medical alert systems;
– Motorized beds;
– Music devices;
– Personal computers;
– Pillows;
– Power-operated vehicles;
– Radios;
– Saunas;
– Stair lifts and stair glides;
– Strollers;
– Safety equipment;
– Treadmills;

- Vehicle modifications such as van lifts;
- Video players; and
- Whirlpools.

Physical Appearance

- **Cosmetic Procedures** 402, which include:
- Pharmacological regimens, nutritional procedures or treatments;
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
- Skin abrasion procedures performed as a treatment for acne;
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin;
- Treatment for spider veins; and
- Hair removal or replacement by any means;
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See **Reconstructive Procedures** 117;
- Treatment of benign gynecomastia (abnormal breast enlargement in males);
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility; and
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Procedures and Treatments

- Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty;
- Medical and surgical treatment of excessive sweating (hyperhidrosis);
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;

- Rehabilitation services and manipulative treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment;
- Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from injury, stroke, cancer, **Congenital Anomaly** 401, or **Autism Spectrum Disorder** 398;
- Habilitative services for maintenance/preventive treatment;
- Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
- Biofeedback;
- The following services for the diagnosis and treatment of TMJ:

– Surface electromyography;
– Doppler analysis;
– Vibration analysis;
– Computerized mandibular scan or jaw tracking;
– Craniosacral therapy;
– Orthodontics;
– Occlusal adjustment; and
– Dental restorations;

- Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a congenital anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea;
- Non-surgical treatment of obesity;
- Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

- Breast reduction surgery that is determined to be a cosmetic procedure. This exclusion does not apply to breast reduction surgery which UnitedHealthcare determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which benefits are described under **Reconstructive Procedures** 117; and
- Helicobacter pylori (H. pylori) serologic testing.

Providers

- Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
- Services performed by a provider with your same legal address;
- Services provided at a **freestanding facility** 409 or diagnostic hospital-based facility without an order written by a physician or other provider;
- Services that are self-directed to a freestanding facility or diagnostic hospital-based facility; and
- Services ordered by a physician or other provider who is an employee or representative of a freestanding facility or diagnostic hospital-based facility, when that physician or other provider:

– Has not been involved in your medical care before ordering the service; or
– Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

Reproduction

- Treatment-related services, including:

– Cryopreservation and other forms of preservation of reproductive materials, except as described in **Infertility Treatment** 106(This does not apply to short-term storage less than one year or retrieval of reproductive materials);
– Long-term storage (greater than one year) of reproductive materials, such as sperm, eggs, embryos, ovarian tissue and testicular tissue;
– Donor services and non-medical costs of oocyte or sperm donation, such as donor agency fees;
– Embryo or oocyte accumulation defined as a fresh oocyte retrieval before the depletion of previously banked frozen embryos or oocytes;

- Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor; and
- Ovulation predictor kits;

• **Gestational carrier** 410 or **surrogate** 430 related services:

- Fees for the use of a gestational carrier or surrogate;
- Insemination or In Vitro fertilization procedure costs of surrogate or transfer embryo to gestational carrier; and
- Pregnancy services for a gestational carrier or surrogate administration, agency fees or compensation;

• Donor, gestational carrier or surrogate administration, agency fees or compensation;

• For donor services of donor sperm, ovum (egg cell) or oocytes (eggs) or embryos (fertilized eggs), costs of:

- Known egg donor (altruistic donation; i.e., friend, relative or acquaintance) medical costs related to donor stimulation and egg retrieval (this refers to purchasing or receiving a donated egg that is fresh or one that has already been retrieved and is frozen);
- Purchased egg donor (i.e., clinic or egg bank) medical costs related to donor stimulation and egg retrieval (this refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database);
- Known donor sperm (altruistic donation; i.e., friend, relative or acquaintance) sperm collection, cryopreservation and storage costs (this refers to purchasing or receiving donated sperm that is fresh or that has already been obtained and is frozen); and
- Purchased donor sperm (i.e., clinic or sperm bank) procurement and storage of donor sperm costs (this refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database);

• Storage and retrieval of reproductive materials (e.g., eggs, sperm, testicular tissue, ovarian tissue) ; this does not apply to short-term storage less than one year;

• The reversal of voluntary sterilization;

• Infertility services not received from a designated provider;

• In vitro fertilization that is not an ART for the treatment of infertility;

- ART done for non-genetic disorder sex selection or eugenic (selective breeding) purposes;
- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation);
- Infertility treatment following unsuccessful reversal of voluntary sterilization; and
- Infertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis, vasectomy reversal/vasovasostomy or vasoepididymostomy);
- Elective fertility preservation.

Services Provided under Another Plan

- Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation or similar legislation;
- Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy;
- Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you; and
- Health care services during active military duty.

Transplants

- Health care services for organ and tissue transplants, except those described under on **Transplantation Services** 122;
- Health care services connected with the removal of an organ or tissue from you to transplant to another person (donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's benefits under the Plan); and
- Health care services for transplants involving permanent mechanical or animal organs.

Services should be received from a designated provider. UnitedHealthcare does not require that corneal transplants be received from a designated provider for you to receive benefits. For benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). Prior authorization is not required for inpatient transplantation services due to an emergency admission.

Travel

- Health care services provided in a foreign country, unless required as emergency health services; and
- Travel or transportation expenses, even though prescribed by a physician. Some travel expenses related to covered health services received from a designated or other network provider may be paid back at the UnitedHealthcare's discretion. This exclusion does not apply to ground and Air Ambulance transportation for which benefits are provided as described in **Ambulance Services** 91.

Types of Care

- Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain;
- Custodial care or maintenance care;
- Domiciliary care;
- Private duty nursing;
- Respite care. This exclusion does not apply to respite care for which Benefits are provided as described in the **Hospice Care**;105
- Rest cures;
- Services of personal care aides; and
- Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

- Cost and fitting charge for eyeglasses and contact lenses;
- Routine vision exams, including refractive exams to determine the need for vision correction;
- Implantable lenses used only to fix a refractive error (such as Intacs corneal implants);
- Eye exercise or vision therapy;

- Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery;
- Bone anchored hearing aids, except when you have:

– Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid; and

– Hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid;

- More than one bone anchored hearing aid per covered person who meets the above coverage criteria during the entire period you are covered under the Plan; and
- Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

- Health care services and supplies that do not meet the definition of a covered health service. Covered health services are those health services, including services, supplies, or pharmaceutical products, which UnitedHealthcare determines to be:

– Medically necessary;

– Described as a covered health service of this Plan in **What's Covered** 89and in **Medical Plan Benefits Summary** 55 and

– Not otherwise excluded by the Plan, as listed in **What's Not Covered** 89;

- Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:

– Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption;

– Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be medically necessary;

– Conducted for medical research. This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided as described in **Clinical Trials** 93; and.

– Required to get or maintain a license of any type;

- Health care services received due to war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war or terrorism in non-war zones;
- Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended;
- Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan;
- In the event an out-of-network provider waives, does not pursue or fails to collect copayments, coinsurance and/or any deductible or other amount owed for a particular health care service, no benefits are provided for the health care service when the copayments, coinsurance and/or deductible are waived, not pursued, or not collected
- Charges in excess of the allowed amount or in excess of any specified limitation;
- Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products;
- Autopsy;
- Foreign language and sign language interpretation services offered by or required to be provided by a network or out-of-network provider;
- Health care services related to a non-covered health service: When a service is not a covered health service, all services related to that non-covered health service are also excluded. This exclusion does not apply to services UnitedHealthcare would otherwise determine to be covered health services if the service treats complications that arise from the non-covered health service; and
- When a complication (an unexpected or unanticipated condition) is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a complication are bleeding or infections following a cosmetic procedure that require hospitalization.

Medical Program Compliance

Maternity or Newborn Infant Coverage

Per the Newborns' and Mothers' Health Protection Act of 1996, a plan may not restrict benefits for any hospital length of stay in connection with childbirth for a mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, a mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a provider is not required to get authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours). See **Pregnancy – Maternity Support Program** 115 for information on this Plan's coverage.

Women's Health and Cancer Rights Act

In compliance with the Women's Health and Cancer Rights Act, the Plan provides coverage for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, including:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The covered procedures will be performed in a manner determined in consultation with the attending physician and the patient and are subject to the same annual deductibles and coinsurance provisions consistent with other covered services.

Mental Health Parity and Addiction Equity Act

The Plan provides coverage for mental health and substance use disorder treatment on the same basis as other medical and surgical benefits. The Plan does not require different cost sharing provisions, treatment limitations (i.e., annual and/or lifetime limits) or coverage decision requirements for these benefits.

Affordable Care Act (ACA)

- **Pre-Existing Condition Limitations:** The Plan does not include any pre-existing condition exclusions. A pre-existing condition is an illness or condition you had before you were under the Plan.
- **Lifetime Limits:** There are no dollar limits on the amount the Plan will pay for essential health benefits, as defined by the ACA. However, the Plan may impose non-dollar limits, such as day or visit limits, consistent with other ACA guidance, on essential health benefits as long as they comply with other applicable statutory provisions. Additionally, the Plan may impose dollar limits on benefits that are not defined by the ACA as essential health benefits.
- **Primary Care Physicians:** You have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you or your family members. In addition, for children, you may designate a pediatrician as the primary care provider.
- **OB/GYN Services:** You do not need prior authorization for obstetrical or gynecological care from a network health care professional who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, such as requesting prior authorization for certain services.
- **Preventive Care:** The Plan provides preventive care at 100%, with no deductible required when you use network providers. Preventive care provided at 100% is subject to age and/or gender guidelines of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). In addition to preventive procedures, some medications are included as preventive services; however, these medications do require a prescription.
- **Emergency Services:** The Plan does not require prior authorization for emergency services (as described in **Emergency Services** 72) or require higher copayments or coinsurance for out-of-network emergency services. Remember that Medical Plan 3 provides network benefits only; except for emergency services.
- **Rescission of Coverage:** Once you or a dependent are covered under this Plan, a retroactive termination (that is, a rescission) is prohibited unless you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact, as prohibited by Plan terms.

- **Health Insurance Consumer Information:** Each state designates an independent office for health insurance consumer assistance (ombudsman). This office is available to work directly or in coordination with insurance regulators and consumer assistance organizations in your state to respond to complaints and inquiries about federal insurance requirements and state law. If you receive a denial on a claim or appeal, the determination notice will include contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care, get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center (when covered by the Plan) or are transported by an out-of-network ground or air Ambulance, you are protected from balance billing. In these cases, you should not be charged more than the Plan's applicable deductible, coinsurance and/or copayment.

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a deductible, coinsurance and/or copayment, as applicable. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in the Plan's network.

Out-of-network means providers and facilities that have not signed a contract with the Plan's administrators to provide services. Out-of-network providers may bill you for the difference between what the Plan pays and the full amount charged for a service; this is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your deductible or annual out-of-pocket maximum under the Plan.

Surprise billing is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

- **Emergency Services:** If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is the Plan's in-network cost sharing amount (i.e., deductible, coinsurance and/or copayment, as applicable). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post stabilization services.
- **Certain Services at In-Network Hospitals or Ambulatory Surgical Centers:** When you get services at an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is the Plan's in-network cost sharing amount (i.e., copay or coinsurance). This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.
- **Certain Air Ambulance Transportation:** If you get certain transportation services from an air ambulance provider, the most those providers may bill you is the Plan's in-network cost sharing amount (i.e., copay or coinsurance). You cannot be balance billed for these transportation services.

You are never required to give up your protections from balance billing. You are also not required to get care out-of-network. You can choose a provider or facility in the Plan's network.

When balance billing is not allowed, you have the following protections:

- You are only responsible for paying your share of the cost (i.e., your deductible, coinsurance and/or copayment, as applicable) that you would pay if the provider or facility was in-network. The Plan will pay any additional costs to out-of-network providers and facilities directly when the service is covered by the Plan.

- Generally, the Plan will:
  - Cover emergency services without requiring you to get approval for services in advance (which may also be known as prior authorization);
  - Cover emergency services by out-of-network providers;
  - Base what you owe a provider or facility (cost sharing) on what the Plan would pay an in-network provider or facility and show that amount in your explanation of benefits; and
  - Count any amount you pay for emergency services or out-of-network services toward your applicable in-network deductible and/or out-of-pocket limit.

If you think you have been wrongly billed, contact UnitedHealthcare at 844-210-5428 or call the NXP Benefits Service Center at 888-375-2367. You may also contact the Federal No Surprises Help Desk at 800-985-3059. Visit www.cms.gov/nosurprises/consumers or www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Confidentiality of Health Information

NXP respects the confidentiality of your health information. As part of NXP's efforts to continually improve the quality of care and customer service of the health plans, NXP and its health care vendors look for opportunities to improve performance. As part of this effort, aggregate health care information (e.g., Austin compared with Phoenix) collected by the health plans and wellness providers is evaluated and reported. In some cases, courses of treatment are examined and compared with peer group norms.

Based on reviews of health care information, a vendor may contact an individual regarding health care programs designed to enhance the care of the individual or his or her dependent. Otherwise, NXP does not report the information to those vendors in a way that reveals the identity of individual NXP employees or their family members.

As a participant in NXP's health plans, your "protected health information" is subject to safeguard under the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, the health plans have adopted policies that restrict the use and disclosure of your protected health information. Generally, use and disclosure are limited to payment and health care operation functions and only the "minimum necessary" information may be used or disclosed.

A complete privacy notice that describes the important uses and disclosures of protected health information and your rights under **HIPAA** 373.

Subrogation and Reimbursement – For UHC Medical Plans

UHC's medical program (referred to as the "plan" in this section) has the right to subrogation and reimbursement, as explained in this section. This section applies to you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that the plan is substituted and succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the plan has paid that are related to the sickness or injury for which any third party is considered responsible.

> ***Subrogation Example***
>
> If you are injured in a car accident that is not your fault and you receive benefits under the Plan to treat your injuries, the plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment or other recovery from any third party, you must use those proceeds to fully return to the plan 100% of any benefits you receive for that sickness or injury. The right of reimbursement applies to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example

Suppose you are injured in a boating accident that is not your fault, you receive benefits under the Plan due to your injuries and you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

Third parties may include:

- Any person or entity alleged to have caused you to suffer a sickness, injury or damages or who is legally responsible for the sickness, injury or damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages;
- Your employer in a workers' compensation case or other matter alleging liability;
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators;
    - Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party; and
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

Subrogation and Reimbursement Agreement

You will cooperate with the plan in protecting the plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable;
- Providing any relevant information requested by the plan;
- Signing and/or delivering documents the plan or the plan's agents reasonably request to secure the subrogation and reimbursement claim;
- Responding to requests for information about any accident or injuries;
- Making court appearances;

    - Obtaining the plan's consent or the plan's agents' consent before releasing any party from liability or payment of medical expenses; and
- Complying with the terms of this section.

If you do not cooperate with the plan, this is considered a breach of contract and the plan has the right to:

- Terminate or deny future benefits;
    - Take legal action against you; and/or
- Set off from any future benefits the value of benefits the plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan.

If the plan incurs attorneys' fees and costs to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold that should have been returned to the plan.

The plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including, but not limited to, hospitals or emergency treatment facilities that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, will be deducted from the plan's recovery without the plan's express written consent. No so-called "fund doctrine," "common fund doctrine" or "attorney's fund doctrine" will defeat this right.

Regardless of whether you have been fully compensated or made whole, the plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic and punitive damages. No "collateral source" rule, "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment or any other equitable limitation will limit the plan's subrogation and reimbursement rights.

Benefits paid by the plan may also be considered to be benefits advanced.

If you receive any payment from any party as a result of sickness or injury, and the plan alleges some or all of those funds are due and owed to the plan, you and/or your representative will hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

By participating in and accepting benefits under the plan, you agree that:

- Any amounts recovered by you from any third party constitute plan assets (to the extent of the amount of benefits provided on behalf of the covered individual);
    - You and your representative are fiduciaries of the plan (within the meaning of ERISA) with respect to those amounts; and
- You will be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the plan to enforce its reimbursement rights.

The plan's right to recovery will not be reduced due to your own negligence.

By participating in and accepting benefits from the plan, you agree to assign to the plan any benefits, claims or rights of recovery you have under any automobile plan (including no-fault benefits, PIP benefits and/or medical payment benefits), other coverage or against any third party to the full extent of the benefits the plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim and you agree to this assignment voluntarily.

The plan may, at its option, take necessary and appropriate action to preserve the plan's rights under these provisions, including, but not limited to:

- Providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party;
- Filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible; and
- Filing suit in your name or your estate's name that does not obligate the plan in any way to pay you part of any recovery the plan might obtain.

Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the plan is governed by a six-year statute of limitations.

You may not accept any settlement that does not fully reimburse the plan without the plan's written approval.

The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated in this section.

If you die, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate and your heirs or beneficiaries. If you die, the plan's right of reimbursement and right of subrogation applies if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the plan is not extinguished by a release of claims or settlement agreement of any kind.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party is valid if it does not reimburse the plan for 100% of the plan's interest unless the plan provides written consent to the allocation.

The provisions of this section apply to the parents, guardian or other representative of a dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause applies to that claim.

If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under the plan, the provisions of this section continue to apply, even after you are no longer covered.

In the event that you do not abide by the terms of the plan pertaining to reimbursement, the plan may:

- Terminate benefits for you, your dependents or the participant;
- Deny future benefits;
    - Take legal action against you; and/or
- Set off from any future benefits the value of benefits the plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to your failure to abide by the terms of the plan.

If the plan incurs attorneys' fees and costs to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold that should have been returned to the plan.

The plan and all administrators administering the terms and conditions of the plan's subrogation and reimbursement rights have the powers and duties as are necessary to discharge its duties and functions, including the exercise of the plans discretionary authority to:

- Construe and enforce the terms of the plan's subrogation and reimbursement rights; and
- Make determinations relating to the subrogation amounts and reimbursements owed to the plan.

When the Plan Receives Refunds of Overpayments

If the plan pays benefits for expenses incurred on your account, you or any other person or organization that was paid must make a refund to the plan if all or some of the:

- Expenses were not paid or did not legally have to be paid by you;
    - Payment the plan made exceeded the benefits under the plan; and/or
- Payment was made in error.

The refund equals the amount the plan paid in excess of the amount the plan should have paid. If the refund is due from another person or organization, you agree to help the plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, the plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, from your future benefits that are payable under the plan. If the refund is due from a person or organization other than you, the plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part from:

- Future benefits payable relating to services provided to other individuals covered under the plan; or
- Future benefits that are payable in connection with services provided to persons under other plans for which the claims administrator processes payments, pursuant to a transaction in which the plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. The plan may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against the plan or the Medical Claims Administrator to recover reimbursement until you have completed all the steps in this plan's appeal process. After completing the plan's process, if you want to bring a legal action against the plan or the Medical Claims Administrator, you must do so within three years of the date the plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the plan or the Medical Claims Administrator.

Health Savings Account (HSA)

The Medical Plan 1 coverage option is a High Deductible Health Plan with a Health Savings Account (HSA).

An HSA is designed to help you pay for eligible expenses now or you can build savings for future medical expenses. There is no "use it or lose it" rule with HSAs, which means you can carry over any unused HSA balance from year to year. Plus, you can take the money with you if you retire or leave NXP.

When you enroll in Medical Plan 1, Fidelity Investments, the HSA Plan Administrator, establishes an HSA with Fidelity Investments in your name. NXP contributes to your HSA. In addition, you have the option to make pre-tax contributions to your HSA, up to federal limits. And – your HSA earns interest, tax-free.

You can use your HSA to pay for qualified medical expenses that you are required to pay out of pocket, such as expenses that apply toward meeting your deductible or qualified expenses not covered under the Plan. You may also use your HSA to pay for, among other things, certain qualified medical expenses not covered under the Plan. As long as you use your HSA for qualified medical expenses, you pay with tax-free dollars. Contributions go into your HSA pre-tax and you pay qualified medical expenses pre-tax. Amounts may be distributed from the HSA to pay nonmedical expenses; however, these amounts are subject to federal, state or local income tax and may be subject to a 20% penalty.

> You must be covered under NXP's Medical Plan 1 to be eligible for HSA contributions. The HSA is not available under the Medical Plan 2, Medical Plan 3 or Out-of-Area Plan coverage options.

The federal government regulates HSAs, which means there are certain eligibility requirements, restrictions and tax considerations. These provisions affect administration of your HSA and specific benefit provisions. To help you make an informed choice, detailed information will be provided in the enrollment materials that you receive when you are eligible and annually thereafter. Because HSA laws change frequently, the most up-to-date information will be included in your open enrollment materials each year.

HSA Highlights

- Once money is deposited into your HSA, it is yours – even when you are no longer eligible for coverage under this Plan; any unused balance rolls over from year to year.
- You may elect to contribute to your HSA; you can start, change or stop your contributions at any time (however, changes are effective the first of the following month). You also can contribute different amounts from one year to the next (up to IRS limits).
- Contributions made to your HSA, and any earnings on those contributions, grow tax-free (under federal tax law) – that means your HSA gains interest, and that interest is not taxable as long as you use the money to pay for eligible expenses and you do not contribute more to your HSA than allowed by law.
- If you do not use all the money in your HSA, your HSA balance continues to grow each year through your contributions or the NXP seed money. You can use this money in years when you have larger health care expenses or in retirement.
- You may direct the investment of the money in your HSA (certain fees may apply).
- You can continue to use your HSA to pay for qualified health care expenses, tax-free, when you are no longer eligible under this Plan.
- If you die, your HSA may be transferred to your designated beneficiary. The HSA will continue to be considered an HSA for your spouse. You may designate other beneficiaries (other than your spouse); however, it will no longer be considered an HSA and they will be required to pay taxes on the HSA.
- Money in your HSA may be considered part of your assets when going through divorce proceedings. Therefore, your HSA may be subject to division under the terms of the divorce or a Qualified Domestic Relations Order. If an ex-spouse receives a portion of your HSA, that money is taxable income to your ex-spouse.

HSA Eligibility

While eligibility for Medical Plan 1, which is -HSA eligible, is the same as other coverage options, there are certain restrictions as to whether or not you can participate in this coverage option. To enroll:

- You cannot be covered under any other type of health insurance coverage (as an individual, spouse or dependent, including a spouse's Healthcare Flexible Spending Account), unless the other coverage is a High Deductible Health Plan or other permitted insurance. Coverage under an ancillary plan, such as vision or dental or any other permitted insurance as defined by the IRS, is not considered as impermissible.
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be entitled to Medicare due to disability, end-stage renal disease or age, which means that you are age 65 or older and enrolled for or receiving Social Security and/or Medicare benefits. If contributions are made to a Health Savings Account when you are entitled to Medicare, the contributions will be considered taxable income and there may be tax penalties. For those eligible for Medicare, you must decline Part A, Part B and Part D to be eligible to contribute to an HSA.

> If you are eligible for Medicare, you may be eligible for this coverage option if you are actively working and not receiving (or have not applied for) Social Security and/or Medicare benefits.

Eligibility for HSA contributions continue on a month-by-month basis, as long as you are eligible for this coverage option, do not become covered under another plan that would otherwise make you ineligible or fail to meet any other requirements described above.

HSAs and FSAs, MSAs and HRAs

If you are covered under Medical Plan 1, you (and any of your dependents covered under this coverage option, including your spouse) cannot also have coverage for the same expenses under a:

- Health Care Flexible Spending Account (FSA), except a limited use health care FSA (see **Limited Use Health Care Flexible Spending Account** 219);
- Medical Savings Account (MSA); or
- Health Reimbursement Account (HRA).

> **Limited Use Health Care Flexible Spending Account:** To help pay other eligible expenses, such as dental and vision expenses, with pre-tax dollars, you may enroll in the Limited Use Health Care FSA.

You should consult with a tax advisor or other qualified professional if you or a dependent have coverage under another health care FSA, MSA or HRA.

Adult Children

While the NXP Medical Plan covers adult children up to age 26, the IRS has not changed the definition of a dependent eligible for reimbursement from an HSA. This means that you can only use your HSA if your child meets the IRS's definition of a qualifying child. A qualifying child is a daughter, son, stepchild, sibling, stepsibling or any descendant of these who:

- Has the same principal residence as you for more than one-half of the taxable year;
- Has not provided more than one-half of his or her own support during the taxable year;
- Is not yet age 19 (or, if a student, not yet age 24) at the end of the tax year or is permanently and totally disabled.

If you cannot claim the child as a dependent on your tax return, you cannot use your HSA for services provided for that child.

Alternatively, if you can claim an individual as your dependent on your tax return, you may use your HSA for that individual's eligible expenses, even if he or she is not covered under NXP's Medical Plan.

It is your responsibility to determine if an expense is eligible for payment from your HSA. Since NXP cannot offer you any tax or legal advice, you may want to consult with a tax advisor or other qualified professional if you have any questions about a child's expenses.

Domestic Partners

The same eligibility rules apply to a domestic partner as anyone else for opening an HSA. If the domestic partner meets the HSA eligibility requirements, he or she would be eligible to open an HSA. Furthermore, since domestic partners are not considered spouses by the IRS, domestic partners are considered to be two unattached individuals, and each would have their own HSA contribution limit if they both have HSAs. However, domestic partners cannot use their HSA to pay for their partner's health expenses, unless they claim their partner as a federal tax dependent. Individuals who can be claimed as dependents on another person's tax return are not eligible to open their own HSA.

Establishing an Account

When you enroll in the Medical Plan 1 coverage option, NXP works with Fidelity Investments to establish an account in your name with an HSA with Fidelity Investments.

> You will also receive an HSA debit card that you can use to pay for eligible expenses; see **Accessing and Using Your HSA** 161 for more information.

There are fees associated with these accounts. NXP pays the initial set-up fee and monthly account fee while you are covered under the Plan. Any other fees are your responsibility, including any fees related to investing your HSA and any monthly fees once you are no longer covered under NXP's Plan. HSAs are standard bank accounts and as such are subject to standard risk and customer due diligence screening both before being opened and during the life of the account. In some circumstances, Fidelity Investments may request additional information from you to open your HSA. It is possible that Fidelity Investments could decline to open your HSA.

While NXP works with Fidelity Investments, the HSA Plan Administrator, to establish an account in your name, you have the option of opening an HSA account with a bank other than Fidelity Investments. However, any start-up fees or extra monthly fees are your responsibility. You will also not be eligible for payroll deductions to another HSA account.

Neither NXP nor Fidelity Investments insures HSAs described in this SPD. Furthermore, an HSA is not subject to ERISA, the federal law that governs the NXP Medical Plan. As a result, you, not NXP or Fidelity Investments, are responsible for how you invest your account. Accordingly, establishment of an HSA is completely voluntary on your part and NXP does not:

- Limit your ability to move your funds to another HSA or impose conditions on usage of HSA funds beyond those allowed under the Internal Revenue Code of 1986. However, NXP will only fund the HSA as part of Medical Plan 1.
- Make or influence the investment decisions relating to funds contributed to an HSA.
- Represent that the HSA is an employee welfare benefit plan established or maintained by the employer.

HSA Contributions

Your HSA contributions are deposited into a federally insured, -interest-bearing savings account with Fidelity Investments.

NXP Contributions

Each year that you are enrolled in Medical Plan 1, NXP contributes to your HSA. For 2023, NXP's annual contribution is:

$500 if you have individual (-employee only) coverage; or

- $1,000 if you have family (yourself and one or more dependents) coverage.

Contributions for new hires after the first of the plan year are pro-rated.

NXP's contribution to your HSA is not taxable income to you.

NXP makes a lump sum contribution to your HSA at the beginning of the year or within one month of your enrollment date if you enroll during the year.

Federal regulations do not allow contributions to an HSA and/or Limited Use Health Care Flexible Spending Account and a standard Health Care Flexible Spending Account during the same year.

Your Contributions

In addition to NXP's contribution, you can also contribute to your HSA. You choose how and when you want to contribute. You can:

- Have contributions automatically deducted from your pay on a pre-tax basis over the course of the calendar year (reducing your taxable income);
- Make a direct, after-tax, contribution to your HSA and take a deduction on your income tax return; or
- Both.

In addition, you can make a one-time direct trustee-to-trustee transfer from your IRA (other than a Simple IRA or a SEP IRA) to your HSA. The most you can transfer is the maximum HSA contribution limitation for the year. The amount transferred is not included in your income, is not deductible and reduces your HSA contribution limit for the year.

You also choose how much you contribute. However, the IRS sets limits on the maximum amount that may be contributed to an HSA each year. The combined total of NXP's contributions and your HSA contributions cannot exceed IRS limits. For 2024, IRS HSA contribution limits are:

$4,150 if you have individual coverage – that means you can contribute up to $3,650 ($4,150 limit – $500 NXP contribution); or

$8,300 if you have family coverage – that means you can contribute up to $7,300 ($8,300 limit – $1,000 NXP contribution).

If you contribute more than you are eligible to contribute in a year, you may be responsible for income and excise tax penalties (see **Tax Considerations** 163for more information). So, be sure that you do not contribute more than legally allowed, based on the months that you are eligible.

What Happens When HSA Contributions Exceed Legal Limits

A contribution made by you or NXP to an HSA that exceeds the amount allowed by law or that is made during any year when you are not eligible to contribute, is called an excess contribution. Excess contributions are not deductible by you or NXP and are included in your gross tax for each year they remain in your HSA. In addition, excess contributions are subject to a 6% excise tax. However, you can avoid the excise tax if you remove the excess contribution from your HSA, together with any net income attributable to the excess contribution, before the due date for filing your federal income tax return, including extensions, for the year for which the excess contribution was made. In this case, the net income attributable to the excess contribution would be taxable as income for the year in which the distribution is made, but, the removed excess contribution would not be taxable as income to you. Rollover contributions do not count in determining whether an excess contribution has been made.

Fidelity Investments will return contributions that they believe in good faith would exceed the sum of the maximum annual family contribution plus the catch-up contribution amount as determined by the IRS as soon as administratively possible. Since maximum annual contribution limits may vary depending on whether you have individual or family coverage, you should not rely on Fidelity Investments to determine if your contributions exceed the maximum annual contribution. Fidelity Investments will also return contributions when you notify them that you have made an excess contribution. You may be charged a fee if Fidelity Investments returns a contribution.

Federal regulations do not allow contributions to an HSA and/or Limited Use Health Care Flexible Spending Account and a standard Health Care Flexible Spending Account during the same year (see **Health Care/Limited Use Health Care Flexible Spending Account (FSA)** 219.

Catch-Up HSA Contributions

If you are at least age 55, but not yet age 65 (or otherwise entitled to Medicare), you may make "catch-up" contributions to your HSA each year, up to the IRS limit. The IRS catch-up contribution limit for 2024 is $1,000, regardless of whether you have individual or family coverage.

Accessing and Using Your HSA

Like any other bank account, you have, you own your HSA and have complete access at all times based on your coverage status. You can go online and check your balance, receive balance statements, use your HSA to pay eligible expenses, etc. To access your HSA as an NXP employee visit **NXP.com/benefits**.

To access your HSA when you no longer work for NXP, if you have previously registered with **Fidelity.com** or NetBenefits®, you do not need to register again. Use your existing username and password to access your account.

Although NXP's contribution to your HSA is made at one time, as a lump sum contribution, your contributions are made to your account over the course of the year; this means that your entire annual contribution may not be immediately available. So, like a regular bank account, you can only pay eligible expenses up to your account balance. If your eligible health care expenses are more than your account balance, you may need to pay for expenses out of your own pocket and reimburse yourself once your HSA balance grows.

> Under federal law, you can use your HSA for anything. However, to avoid taxes and penalties, you should only use your account to pay for qualified medical, prescription drug, dental and vision expenses for you and your eligible dependents.

You may use your HSA, tax-free, to pay for qualified health care expenses for yourself, your spouse and/or your dependents, each as defined by the IRS.

To pay for eligible expenses:

- You can use your debit card to pay eligible expenses.
- You can request direct deposit from your HSA directly into a personal checking or savings account at any time to pay for eligible expenses.
- While checks are not offered by Fidelity Investments, if you would like to make payments by check, you may purchase third-party checks for your HSA.

- You may choose the bill pay option, which directly pays your doctor, hospital or other facility. So, you do not have to do a thing; your claims are paid automatically while there is money in your account.

> You have the flexibility to use your account (with NXP's and any of your own contributions) when you want. For example, you may choose to cover your expenses using your own personal funds now and save your HSA balance for medical expenses in future years or in retirement. The balance in your savings account will earn interest.

While you do not need to submit receipts to Fidelity Investments for reimbursement, you should save all receipts for expenses paid from your HSA, per IRS rules.

Eligible Expenses

The HSA is designed to help you pay for qualified medical expenses. In general, qualified medical expenses are non-reimbursed medical, prescription drug, vision, hearing and dental expenses for you and your eligible IRS dependents that you could deduct on your individual tax return.

> When you use your HSA to pay qualified health care expenses, the money is not taxed. However, if you pay for an expense through your HSA, you cannot deduct that expense on your individual tax return.

Eligible expenses may include:

- Health care expenses you must pay before you meet your individual or family deductible;
- Coinsurance and copayment amounts;
- Expenses not covered by the Plan but considered eligible medical expenses by the IRS, such as certain prescribed Over-the-Counter (OTC) medications;
- Expenses in excess of specific Plan limits;
- Additional amounts you pay when you do not use a network provider (for examples, amounts over the allowed amount); and
- Certain coverage costs that you may have when you are not covered under this Plan, such as:
  - Medicare premiums (including Part A, Part B, Part C, Medicare Prescription Drug Coverage) or employer or Plan sponsored health coverage premiums or self-payments once you retire (when you are age 65 or older);
  - COBRA continuation coverage;

- Coverage you have while you are receiving unemployment compensation benefits;
- Qualified long-term care insurance contract; and
- Health plan coverage during a period in which you are receiving unemployment compensation under any federal or state law.

> Generally, health insurance may not be purchased with money from your HSA. For example, you cannot use your HSA to pay for coverage while you are employed or for Medigap policies after you retire.

You are responsible for determining if an expense is eligible for payment from your HSA. NXP and/or Fidelity Investments (as the Plan Administrator) will not review expenses and cannot offer you any advice. You should keep detailed records of your expenses and payments from your HSA to demonstrate to the IRS that you used the money to pay for eligible expenses. If you use the money in your account to pay for non-eligible expenses, you may have to pay taxes on that money and, in most instances, you may also be subject to a penalty. NXP and Fidelity Investments are not responsible or liable if you misuse HSA funds or if you use HSA funds for nonqualified expenses.

For the most up-to-date listing of expenses eligible for reimbursement from an HSA, go to **IRS.gov** and type "Publication 502" in the Search box.

Tax Considerations

As long as you use your HSA for eligible expenses, you pay with tax-free dollars. However, there are many rules and tax implications with HSAs, such as:

- Any after-tax contributions you make to your HSA are tax deductible on your federal income tax; however, you cannot deduct NXP's contributions.
- You cannot claim any expenses you pay for with your HSA as a deduction on your tax return.
- While HSA contributions and your Health Savings Account are tax-favored for federal tax purposes, HSA contributions and Health Savings Accounts are taxable in California and New Jersey. Please check your local state laws for further tax limitations.
- If you use your HSA to pay for non-eligible expenses before age 65 (unless you are disabled), the amount you paid will be treated as ordinary income and be subject to taxes as well as a 20% penalty.

- Contributions that you or NXP makes that exceed IRS annual limits are subject to excise tax and any excess contribution made by NXP is considered taxable income to you; check with a tax advisor for more information.

Since NXP cannot offer you any tax or legal advice, be sure to consult with a tax advisor or other qualified professional if you have any tax questions.

Prescription Drug Program

As part of the NXP Medical Plan, you and your covered dependents fill your covered prescriptions through the Prescription Drug Program. This program covers medications prescribed by your (or your covered dependent's) doctor as deemed medically necessary by the prescribing doctor and within Federal Drug Administration (FDA) guidelines. Some drugs and medicines are not covered by the program and certain NXP Plan limitations apply. Contact CVS Caremark Customer Care for information on covered drugs.

You can review the Preferred Drug List and the Generic Drug List online at **Caremark.com**.

All NXP UnitedHealthcare Medical Plan participants are eligible to use the Prescription Drug Program. There is no need to enroll for these benefits.

Kaiser Permanente HMO

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on their home address. The HMO is only available if you are in Kaiser's service area. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-278-3296.

Prescription Drug Benefit Summary

All prescriptions must be filled at a network pharmacy and all benefits are based on negotiated fees.

Type of Prescription Drug	Medical Plan 1*	Medical Plan 2, Medical Plan 3 and Out-of-Area Plan**
	Network Retail Pharmacy – Up to a 30-day supply	
Generic Drugs	After deductible, you pay 20%, Plan pays the rest	You pay $5 copayment, Plan pays the rest
Preferred Drugs	After deductible, you pay 20%, Plan pays the rest	You pay 30% up to $75, Plan pays the rest
Non-Preferred Drugs	After deductible, you pay 20%, Plan pays the rest	You pay 50% up to $100, Plan pays the rest
	*Home Delivery Service*** – 90-day supply*	
Generic Drugs	After deductible, you pay 20%, Plan pays the rest	You pay $10 copayment, Plan pays the rest
Preferred Drugs	After deductible, you pay 20%, Plan pays the rest	You pay 30% up to $175, Plan pays the rest
Non-Preferred Drugs	After deductible, you pay 20%, Plan pays the rest	You pay 50% up to $250, Plan pays the rest

* *The Medical Plan 1 deductible applies to medical and prescription drug expenses and prescription drug expenses apply toward meeting your medical deductible. You must meet your annual medical deductible before the Plan begins to pay for medical and prescription drug expenses. However, generic maintenance medications are available at no cost; for all other generics, you pay 20% after the deductible, as noted above. For the latest list of generic maintenance medications, visit Caremark.com or call CVS Caremark at 877-505-8360.*

** *Medical Plan 2, Medical Plan 3 and Out-of-Area Plan coverage options prescription drug expenses apply toward meeting your medical out-of-pocket maximum.*

*** *Required for long-term, maintenance drugs.*

Prescription Drug Plan Features

Medical Plan 1 Coverage Option

Here is how the Program works under the Medical Plan 1 coverage option:

- **Deductible:** You must meet your deductible before the Plan begins to pay medical and prescription drug benefits. Amounts you pay for covered prescriptions (and medical expenses) apply toward meeting your deductible. As with your medical benefits, you can use money in your HSA to pay for covered prescription medications. For more information about your deductible, see **Amounts You Owe When Using the Plan (Cost Sharing)** 61.
- **Coinsurance:** Once you meet your deductible, you pay 20% of the network negotiated cost of your prescription to the network pharmacy and the Plan pays the rest.

Medical Plan 2, Medical Plan 3 and Out-of-Area Plan Coverage Options

Here is how the Plan works under Medical Plan 2, Medical Plan 3 and Out-of-Area Plan coverage options:

- **Copayment:** You pay only a copayment for generic drugs, as shown in the chart above. You pay your copayment directly to the pharmacy. The Plan pays the remainder of the network negotiated cost of the generic drug.
- **Coinsurance:** For all other covered prescription drugs, you pay a percentage of the network negotiated cost of your prescription, up to the maximums shown in the chart above. If the network negotiated cost of the drug is more than the Plan's coinsurance and your maximum share of the cost, the Plan will pay any remaining cost.

Example: Hope has the Medical Plan 2 coverage option. Her doctor prescribes a preferred brand drug with a network negotiated fee of $280 for a 30-day supply. Here is how Hope and the Plan share the cost of this medicine:

Network negotiated charge	$ 280
Hope's 30% share	*$ 84*
Cap: Hope's actual share	$ 75
Plan's share ($280 – $75)	$ 205

Preventive Medications

The Program, which complies with federal legislation, provides certain preventive medications at no cost to you. When your doctor prescribes certain preventive medications, the Plan pays the full cost; there is no copayment or other cost for you to pay. Preventive medications available at no cost with a physician's prescription include:

- Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- For women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Types of medications included as part of preventive medications include, but are not limited to:

- Aspirin to prevent cardiovascular disease for individuals age 50 to 59;
- Aspirin to prevent morbidity and mortality from preeclampsia for females age 12 to 59 who are capable of pregnancy;
- Oral fluorides for children up to age 5;
- Folic acid supplements for females up to age 55 capable of pregnancy;
- Tobacco cessation products;
- Immunizations (vaccines); limited to specific immunizations depending on gender and age;
- Vitamin D supplements for adults age 65 or older who are at risk for falls in community -dwellings;
- Bowel preparation medications for colorectal cancer screenings for adults age 60 to 74;

- Statins for the primary prevention of cardiovascular disease in adults age 40 to 75; and
- Contraception for females, which may include oral contraceptives, emergency contraceptives, injectables, intrauterine devices, subdermal rods, vaginal rings, transdermal patches, barrier methods, over-the-counter contraceptives and medications for risk reduction of primary breast cancer in women.

If you enroll in Medical Plan 1, preventive generic medications (maintenance medications only) are covered at no cost to you.

Generic Drugs

A generic drug is the chemical copy of a brand name prescription drug. Generic drugs cost about 50% less than brand name drugs and they are:

- Dispensed in the same dosage;
- Taken in the same way; and
- Packaged in the same unit strength.

To help preserve the quality of your health care and help control costs, you are encouraged to use generic drugs whenever they are medically appropriate for your illness or condition. It is standard pharmacy practice to substitute generic equivalents for brand name drugs whenever possible. You will receive generic substitutes unless your physician will not allow it.

If your physician allows a generic and you select a brand name drug, you pay the difference between the generic and brand name drug, in addition to your brand name share of the negotiated charge. If you are enrolled in Medical Plan 1 this provision applies after you meet your deductible. A Generic Drug List identifying generic drugs covered under the Program is available at **Caremark.com**.

Preferred and Non-Preferred Drugs

Preferred drugs are medications selected by clinical experts after meeting clinical and therapeutic criteria. These drugs help reduce overall out-of-pocket expenses without compromising quality or effectiveness. Your share of the cost of non-preferred drugs is the highest under the program.

The Preferred Drug List (**Advanced Control Formulary**) includes preferred drug choices in selected drug categories. You and your doctor are encouraged to choose a preferred drug when it is medically appropriate. If you have questions about the Preferred Drug List or want a copy of the list to share with your doctor, contact CVS Caremark at 877-505-8360 or visit **Caremark.com**.

When new drugs come on the market, they enter the schedule as Non-Preferred Drugs. The Preferred Drug List is reviewed and updated periodically. When changes are made that will require you to pay more for a drug you use, you will be notified.

Step Therapy Program

The Step Therapy Program requires you to try a generic drug for at least 30 days before using specific brand name drugs for certain types of treatment. This Program applies only to patients who have not filled one of the specific brand name drugs during the past 180 or 365 days (depending on the drug class, "look back" periods and their associated drug classes. The Program follows current medical literature, manufacturer recommendations and U.S. Food and Drug Administration guidelines.

If you have questions about the treatments or drugs, "look back" periods and associated drug classes that are part of the Step Therapy Program, contact CVS Caremark at 877-505-8360 or visit **Caremark.com**.

> More information on the Step Therapy Program is available online at **Caremark.com**.

If your doctor feels that you need to be prescribed a drug that does not follow this treatment order, he/she may request an exception by calling CVS Caremark Prior Authorization at 888-413-2723. This line is not for patient use.

Prior Authorization

Certain drug classes, such as compounds and growth hormones, need prior authorization from CVS Caremark before the Prescription Drug Program covers them. These drugs have the potential for serious side effects or for inappropriate uses. For a detailed list of medications that fall into these drug classes, please visit **Caremark.com**.

The best way to avoid inconvenience is to have your physician call CVS Caremark's prior authorization department at 888-413-2723 before you go to the pharmacy (this line is not for patient use).

CVS Caremark Specialty Pharmacy Services

Specialty medications or biotech drugs typically refer to medications made from living sources (e.g., microorganisms, blood cells, proteins), as opposed to traditional drug therapies, which are synthetic. Specialty drugs are often administered by injection by either the patient or the physician. Because biotech drugs are similar to substances found in the human body, they may be more effective in fighting hard-to-treat conditions, such as multiple sclerosis, rheumatoid arthritis and growth hormone deficiency.

CVS Caremark Specialty Pharmacy Services offers specialty medications for a variety of chronic conditions including multiple sclerosis, rheumatoid arthritis, cystic fibrosis, hemophilia, immunologic disorders, Crohn's disease, Gaucher disease, pulmonary hypertension, Fabry disease, MPS 1, blood dyscrasia, growth hormone deficiency, hepatitis C, macular degeneration, infertility, cancer and more.

If you or a covered dependent has a condition that requires treatment with specialty drugs such as injectable medications, then you must contact Caremark at 800-237-2767 to apply for the Caremark Specialty Guideline Management Program. Clinical specialists at Caremark will discuss treatment options with your physician. When you are approved for the program, you will have direct access to the CVS Caremark Specialty Pharmacy Care Team. Specialty prescriptions must be filled by the Specialty Pharmacy, but in many instances the Specialty Pharmacy will offer you the option to pick up the medicine at a retail CVS pharmacy.

The Caremark Specialty Guideline Management Program supports safe, clinically appropriate and cost-effective use of specialty medications. Their service delivers patient medication within 48 to 72 hours and provides refill and delivery notification calls and easy refill ordering options. The Care Team offers expert care services for participants such as counseling, informative disease-related materials and easy access to health experts 24 hours daily.

Because most specialty drugs require frequent patient care and supervision, it is important for you and your physician to determine the necessary drug treatment plan. Therefore, it is not mandatory for you to refill your specialty medications in 90-day supplies for drugs purchased through the CVS Caremark Specialty Pharmacy Service.

For specialty drugs purchased through CVS Caremark Specialty Pharmacy Service, the length of time covered by your prescription determines your Plan benefits.

- For specialty drug prescriptions, you use for 30 days or less, the Plan uses the 30-day retail pharmacy benefit of your coverage option to calculate your benefit; or
- For specialty drug prescriptions, you use for 31 – 90 days, the Plan uses the 90-day home delivery benefit of your coverage option to calculate your benefit.

Most specialty drug prescriptions are only covered up to a 30-day supply; generally, a 90-day supply is only covered for Hepatitis B, HIV and transplant medications.

A complete list of specialty drugs that you are required to get through CVS Caremark Specialty Pharmacy Services is located at **Caremark.com**. You may also call CVS Caremark at 877-505-8360.

Medical Plan 1, Medical Plan 2, and Medical Plan 3: PrudentRx Specialty Medications Program

In addition to CVS Caremark Specialty Pharmacy, if you are enrolled in Medical Plan 2 or Medical Plan 3, you have access to the PrudentRx Solution for certain specialty medications. The PrudentRx Solution helps you enroll in manufacturer copay assistance programs. Through the PrudentRx Solution, when you have a prescription filled for a medication included in the PrudentRx Program Drug List, rather than pay your Plan's 30% coinsurance (as shown in the **Prescription Drug Benefit Summary** table 166), you will receive your medication at no cost. The PrudentRx Program Drug List may be updated periodically.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications; in particular, specialty medications. The PrudentRx Solution assist you in getting copay assistance from drug manufacturers to reduce the cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but this is done in compliance with HIPAA privacy regulations.

You must call PrudentRx at 800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx may reach out to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 800-578-4403. If you do not enroll in an available manufacturer copay assistance program or opt out of the PrudentRx Solution, you will be responsible for the Plan's regular coinsurance, as shown in the **Prescription Drug Benefit Summary** table166.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 800-578-4403 to address any questions regarding the PrudentRx Solution.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution do not count toward your deductible or out-of-pocket maximum unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an essential health benefit under the Affordable Care Act do not count toward your deductible or out- of-pocket maximum unless otherwise required by law. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

MinuteClinic

MinuteClinic, the walk-in clinic in CVS, offers a broad range of services to help keep you and your family healthy. In addition to diagnosing and treating illnesses, injuries and skin conditions, MinuteClinics provide wellness services including vaccinations, physicals, screenings and monitoring for chronic conditions.

As part of the Plan's prescription drug coverage, you and your covered dependents have access to MinuteClinic services. If you are enrolled in the:

- Medical Plan 1 option, you pay a $50 copay per visit, after you meet your deductible; or
- Medical Plan 2, Medical Plan 3 or Out-of-Area Plan coverage option, you pay a $10 copayment per visit, with no deductible required.

For more information about MinuteClinic services, visit **CVS.com/minuteclinic**.

Using Your Prescription Drug Benefits

This Program provides two ways to fill your covered prescriptions:

- Up to a 30-day supply plus two 30-day-supply refills through retail network pharmacies (refillable for up to 90 days from the date of prescription); and
- Up to a 90-day supply plus three 90-day-supply refills through the home delivery service or a CVS retail pharmacy (refillable for up to one year from the date of prescription).

You pay a percentage of the network negotiated charge or a flat copayment for each prescription you purchase through retail or home delivery.

All maintenance prescriptions taken in 90-day supplies must be filled at a CVS retail pharmacy or through the home delivery service. Your doctor may forward your prescription to CVS Caremark by telephone at 800-378-5697 or by fax at 800-378-0323.

Using a Retail Pharmacy

Short-Term Prescriptions Only

You may use a retail network pharmacy for medicines that need to be taken for just a short time. The program has a nationwide network of pharmacies to serve you and your covered dependents. You may fill your original prescription (up to a 30-day supply) and up to two refills at any retail network pharmacy.

Steps to follow:

- Locate a network pharmacy near you by calling 877-505-8360 (TDD: 800-231-4403) or check online at: **Caremark.com**;
- Before the pharmacist fills your prescription, present your prescription and ID card. Pay your copayment or share of the negotiated network charge at the time of purchase; and
- Sign the pharmacy's signature log when you receive your prescription if you are asked to do so.

Long-Term Prescriptions Only

For Maintenance Medications

Home delivery fulfillment or a CVS retail pharmacy is required for all prescriptions used on a regular basis or for more than 90 days. Through home delivery or a CVS retail pharmacy, your prescription is filled for the exact amount prescribed by your physician (up to the 90-day-supply limit). For home delivery, allow 14 days for receipt of your medicine.

Through the home delivery service, prescriptions are delivered by either the U.S. Postal Service or United Parcel Service. In an emergency, your prescriptions can be shipped overnight for an additional fee. Medications cannot be shipped outside of the United States. If you are planning a trip, have your prescription filled before your departure date.

You have the option to fill a 90-day maintenance medicine prescription at a CVS retail pharmacy, rather than through the home delivery service. Under the Maintenance Choice program, the CVS retail pharmacy will apply the home delivery prescription drug benefits of your coverage option to your 90-day prescription.

Questions about home delivery benefits may be addressed to CVS Caremark at 877-505-8360.

Steps to Follow

Your physician may contact CVS Caremark by either telephone or fax to submit your prescription.

Physician Orders by Telephone

Ask your doctor to call CVS Caremark Home Delivery Service at 800-378-5697 to provide your basic patient health history profile, including any known medication allergies. Your doctor should then fax the prescription to 800-378-0323. This fax line is not for patient use.

Physician Orders by Fax

Ask your doctor to call CVS Caremark Home Delivery Service at 800-378-5697 for information about the fax program. CVS Caremark Home Delivery Service will fax an order form to the doctor's office. The form includes instructions on how to use the program.

The doctor should include any known medication allergies in the health history section. The form must be faxed directly from the physician's office to the CVS Caremark Home Delivery Service pharmacy at 800-378-0323. This fax line is not for patient use.

Payment for Telephone and Fax Orders

If your doctor submits your prescription, CVS Caremark Home Delivery Service contacts you to verify your address information and to determine your preferred method of payment. Mail a check (include your prescription plan identification number on your check) for your share of the network negotiated charge or copayment payable to CVS Caremark Home Delivery Service or provide your credit card number (Visa, MasterCard, American Express or Discover). Please do not send cash.

Does Your Home Delivery Service Require Special Treatment?

All home delivery prescriptions received by CVS Caremark Home Delivery Service are filled and shipped to you as soon as they are received and processed. If your prescription requires special treatment, such as being held for a period, please call CVS Caremark Home Delivery Service at 877-505-8360 before placing your order by phone, fax or mail.

Ordering Home Delivery Service by Mail

To begin home delivery service:

- Online:
  - Go to **Caremark.com**.
  - Select "Start a New Prescription."
  - Click on "FastStart."
- By Phone: Call 877-505-8360.
  - Be ready with your prescription ID card, mailing information, long-term medicine, prescription payment method and doctor's information.

If you transfer a prescription from a retail pharmacy to home delivery, request a new prescription written for a 90-day supply.

To select pharmacy pick-up:

- Online: Register at **Caremark.com** and select your preferred CVS retail pharmacy;

- In Person: Visit your local CVS pharmacy and talk to a pharmacist; or
- By Phone: Call 877-505-8360 and talk to a representative.

Ordering Refills by Telephone or Online

- To order refills by phone, call 877-505-8360 (TDD: 800-231-4403); or
- To order refills online, visit **Caremark.com**.

Drug Utilization and Therapeutic Interchange

CVS Caremark clinical pharmacists may review your prescription drug use from time to time as part of their drug utilization and therapeutic interchange programs. They may offer suggestions to you and your physicians that can reduce your out-of-pocket expenses with lower-cost drugs or simplified drug therapies. These professionals may also identify potential problems from side effects caused by unnecessary or inefficient prescribing or over- or under-prescribing.

If your physician prescribes a non-preferred brand name drug, CVS Caremark electronically asks your pharmacist to tell you about potential substitute drugs on the Preferred Drug List. With your consent, the pharmacist will contact your physician to get permission to prescribe the substitute medicine. If your physician allows the substitution, you will receive a preferred drug at the preferred drug plan benefit. If not, you will receive the prescribed brand name drug at the non-preferred plan benefit.

Other Important Facts

You cannot refill a prescription at a retail pharmacy until you have used at least 75% of your current prescription. When filling via mail order, you must use 60 days of the 90-day supply before requesting a refill. For medications with prescription limits, all medication must be used before a refill is requested.

If your physician allows a generic and you select a brand name drug, you pay the difference in price between the generic and brand name drug in addition to your regular share of the negotiated network charge.

If your physician's practice is in Texas, the law requires him or her to hand write "brand necessary" or "brand medically necessary" on prescriptions when he or she feels that generic substitution is not appropriate.

ExtraCare® Health Card Saves You Money at CVS

You can save 20% on regular-priced CVS products with your ExtraCare Health Card. CVS Caremark provides the ExtraCare Health Card to you and your covered family members when you enroll in the Plan. This discount applies to CVS brand health care related items that you buy at a CVS/pharmacy or online at **CVS.com**. See the CVS website for other features of the ExtraCare Health Card.

What's Covered

Following is a short list of some common drugs that are covered:

- AIDS-related medicines;
- Allergy serum and syringes;
- Blood glucose testing strips and lancets;
- Drugs, biologicals, compound prescriptions or any other medical substance that federal law requires to be dispensed by a qualified pharmacist as prescribed by a physician;
- Fluoride supplements for children through age 18 (limited to two per calendar year);
- Growth hormones;
- Injectables except as otherwise noted;
- Insulin and disposable hypodermic needles and syringes necessary to administer insulin;
- Medicines for prior authorized treatment of **infertility** 106, up to $10,000 per lifetime (any combination of medical and prescription drug, network and out-of-network, benefits are limited to a maximum of $40,000 per covered person during the entire period covered under the Plan; medical benefits are limited to $30,000 and prescription drug benefits are limited to $10,000);
- Prenatal, pediatric and geriatric vitamins;
- Prescription contraceptives;
- Prescription laxatives;
- Progesterone suppositories;
- Retin-A for patients through age 25 and Retin-A for patients without any age restriction for the treatment of severe acne and acne keratosis;

- Schedule V controlled substances; and
- Smoking deterrents, such as nicotine gum and nicotine patches, and medicines for tobacco cessation purposes, such as those covered under the Tobacco Cessation Program.

If you want to find out if a particular drug is covered, call 877-505-8360 (TDD: 800-231-4403).

What's Not Covered

Following is a list of some common drugs that are not covered under the Program:

- Accutane through mail order (available through retail only);
- Anorexiants;
- Anti-wrinkle agents (e.g., Renova);
- Any retail cost of drugs above the negotiated network fee;
- Cosmetic hair removal products (e.g., Vaniqa);
- Drugs labeled "Caution, limited by federal law to investigational use," or experimental drugs;
- Fluoride supplements for patients older than age 18 (or more than two per year);
- Hair growth stimulants or other medicines for treatment of hair loss;
- Medical devices;
- Mifeprex;
- Norplant;
- Nutritional supplements;
- OTC medications that can be purchased without a prescription, except preventive health services medications, such as aspirin, folic acid, iron and Vitamin D (see **Preventive Care** 89;
- Prescription drugs purchased at a non-network pharmacy;
- Vitamins prescribed for dietary purposes or non-medical purposes; and
- Compounds with non-FDA approved ingredients, which include multi-ingredient compounds that contain bulk chemicals or powders in preparations where safety has not been established or implied based on FDA-review and labeling of ingredients as evidence of appropriate therapeutic use.

Contact CVS Caremark for more details on medicines that are not covered.

Drugs with Prescription Limits

Certain drugs have limits based on FDA-approved prescribing guidelines, approved medical guidelines and/or the average utilization quantity for the drugs.

The limits affect only the medication amount that the Prescription Drug Program pays for, not whether you can get greater quantities. The final decision regarding the medication amount you receive remains between you and your physician.

For drugs with prescription limits, after you have the initial prescription filled, your prescription goes through the prior authorization process where the limits are then applied for future fills. If you have questions about treatments or medications with prescription limits, contact CVS Caremark at 877-505-8360.

> You can review the Preferred Drug List and the Generic Drug List online at **Caremark.com**.

Work Site Wellness Programs

Watch for information at your local U.S. work site about on-site wellness programs that may be available to you. All eligible NXP employees are encouraged to take advantage of work site wellness programs when they are available to them.

- **Onsite Activity Centers:** A fitness and general wellness center available onsite at some U.S. NXP locations.
- **Lactation Rooms:** Dedicated areas for mothers to breast pump while at work.
- **Educational Classes:** Information includes healthy eating, physical activity, resilience and a variety of other topics throughout the year.

Online Wellness Resources

Visit **liveandworkwell.com** for life and work, mind and body, financial and legal, crisis support, behavioral health care search and suicide prevention hotline.

Visit **the Wellbeing Hub** for guidance, resources and support you need to cheer you on as you work towards a healthier lifestyle. Build healthy habits, get daily inspiration and experience the rewards of living your best life.

Enrollment in an NXP Onsite Activity Center

Some U.S. NXP offices have access to an onsite NXP Activity Center. As an NXP employee, you are eligible for a paid membership in an NXP Activity Center or reimbursement up to $240 (less applicable taxes) annually for membership in an eligible non-NXP fitness center or for approved fitness, sports or health education-related activities of your choice.

If you join an NXP Activity Center in the U.S., NXP pays the entire cost of your membership. Membership in one NXP Activity Center gives you access to all other centers if you live near more than one facility or travel to other company locations. You are responsible for paying any additional expenses, such as locker rental. .

Membership at an NXP Activity Center renews automatically each January 1, unless you cancel it during the annual Activity Center withdrawal period every December; specific dates are communicated each year through the Activity Center member newsletter and flyers posted in the Activity Center, café and approved NXP bulletin boards. To cancel your membership, complete a cancellation form at your local Activity Center or your membership will automatically renew. If you miss the disenrollment deadline because you were traveling out of the country, you may appeal; see your Activity Center manager to inquire about the appeals process.

If You Are a U.S. Expatriate or U.S. Inpatriate

You are eligible for one membership each calendar year at either an onsite NXP Activity Center or a fitness center of your choice, including one abroad.

If you join an onsite NXP Activity Center, NXP pays the entire cost of your membership automatically each calendar year. If you join a fitness center (including one abroad), NXP reimburses you for up to U.S. $240 (less applicable taxes) of your annual fitness center membership costs.

If you have any questions, contact your onsite NXP Activity Center or call the NXP Benefits Service Center at 888-375-2367.

A physician's release may be required for enrollment if two or more risk factors are present. Risk factors may be identified during the voluntary enrollment interview process and are based on risk factor guidelines set forth by the American College of Sports Medicine. Examples of risk factors include certain diseases or conditions, family history, medications and symptoms. For more information, contact your onsite NXP Activity Center.

If You Retire

You will be eligible to join as a retiree and pay the applicable membership rate, if you:

- Terminate employment with NXP; and
- Are eligible for a "NXP Activity Center Retiree Membership" because you meet the eligibility requirements for retiree health care benefits (i.e., Rule of 75).

When Membership Ends

Your membership ends on your last day of employment if you:

- Terminate employment with NXP;
- Are a member of an NXP Activity Center;
- Are not eligible for an "NXP Activity Center Retiree Membership" because you do not meet the eligibility requirements for retiree health care benefits (i.e., Rule of 75); and

Enrollment in a Fitness Center, Other than an Onsite Activity Center

If you join a fitness center (other than an onsite NXP Activity Center), including one outside the U.S., NXP reimburses you for up to $240 (less applicable taxes) of your annual fitness center membership costs.

An eligible facility must provide the opportunity to improve the following measurable elements of health -related physical fitness:

- Cardiovascular endurance;
- Body composition; and
- Musculoskeletal fitness.

> For more information on what wellness activities are considered eligible for reimbursement, call the NXP Benefits Service Center at 888-375-2367 or visit nxp.com/benefits.

Examples of fitness centers include YMCA, Gold's Gym, Bally's, Club One, LA Fitness or other professionally run fitness centers.

Eligible Expenses

Membership fees for the NXP employee are the only expense eligible for reimbursement, up to a maximum of $240 (less applicable taxes). All additional fees, such as locker rental, are not eligible.

Other Eligible Wellness Activities

You may choose to participate in other fitness, sports or health education -related activities, rather than joining a fitness center. You may be reimbursed up to $240 (less applicable taxes) per year for the cost of these approved activities.

Eligible Expenses

To be eligible for reimbursement, you must participate in an approved fitness, sports or health education -related activity.

Fitness or sports activities must provide the opportunity to improve these elements of -health-related physical fitness: Cardiovascular endurance, body composition and musculoskeletal fitness.

Examples of eligible fitness or sports activities include:

- Organized community activities such as recreational sports leagues and classes (i.e., aerobics, martial arts, basketball, volleyball or soccer); and
- Individual sports such as running, triathlon, cycling and swimming.

Examples of eligible health education -related activities include:

- Cardiovascular health classes;
- Cancer prevention classes;
- CPR and first aid training;
- Stress management;
- Tobacco cessation programs; and
- Weight management.

Expenses That Are Not Eligible

Expenses for items such as health food and supplements, sports apparel and sports equipment are not eligible for reimbursement. -Also, sports considered high-risk activities are not eligible for reimbursement, for example: skiing or snowboarding, skydiving, rock climbing, sports involving firearms and horseback riding.

Reimbursement for Fitness Centers and Activities

If you join a fitness center or participate in other eligible wellness activities, you submit your reimbursement requests online. To submit a reimbursement request visit **NXP.com/benefits**.

Keep a copy of your receipts for your records. Receipts and other documentation should be in English. Receipts must include:

- Your name;
- Name of service provider, facility or retailer;

- Date of service or purchase;
- Identification of product or description of service;
- Purchase amount for each product or service in U.S. dollars; and
- Total purchase amount in U.S. dollars.

Incomplete claims cannot be processed. Please include all necessary documentation no later than March 31 of the following year.

Once your claim and receipts are received, a decision will be made within five days. If approved, a reimbursement from your account will be submitted to you through payroll. You will see the reimbursement included on your paycheck, listed as "Other Taxable."

You are reimbursed for up to $240 (less applicable taxes) per year in membership costs for a non -NXP facility (or, for domestic employees only, for other eligible activities). Once approved, the amount will be reimbursed through payroll within two pay cycles from the date the claim was approved.

Deadline

You have until March 31 of the following plan year to submit gym reimbursement expenses for the prior year.

> ***Wellbeing Programs***
>
> NXP offers a variety of wellbeing programs and resources designed to help you stay on track and achieve your health goals. For example, Wellbeing@NXP, powered by Virgin Pulse is a voluntary wellness platform that helps you make small, everyday changes to your wellbeing that are focused on the areas you want to improve the most. For more information on programs and resources available to you, go to **NXP.com**.

NXP Dental Plan

Regular dental care is important to maintaining good health. That's why NXP offers the Dental Plan. Regardless of your medical choice, you can choose -cost-effective dental coverage. The Dental Plan is offered to all eligible employees and their eligible dependents.

If You Are a U.S. Expatriate or U.S. Inpatriate

Medical (including behavioral health and prescription drug), dental and vision coverage for U.S. Expatriates and U.S. Inpatriates on U.S. payroll are provided by separate Global plans that are not described in this SPD. All other benefits described below apply to U.S. Expatriates and U.S. Inpatriates as outlined in the NXP Benefits chart on page v.v

Dental Benefits Summary

Dental Carrier	**Delta Dental**
Annual Deductible	**Individual:** $50 **Family:** $150 The annual deductible is waived for diagnostic and preventive, and orthodontic services.
Annual Maximum Benefit	$2,000 per person in combined basic and major benefits The annual maximum is waived for diagnostic and preventive services (except for periodontal maintenance).
Diagnostic and Preventive Services	Plan pays 100% of contracted fees (PPO and Premier providers) or program allowance (non-Delta providers), no deductible.
Basic Services	Plan pays 80% of contracted fees (PPO and Premier providers) or program allowance (non-Delta providers), after deductible.
Major Services	Plan pays 50% of contracted fees (PPO and Premier providers) or program allowance (non-Delta providers), after deductible.

Orthodontic Services	Plan pays 80% of contracted fees (PPO and Premier providers) or program allowance (non-Delta providers), up to $2,000 per person per lifetime, includes benefits paid under any current or former NXP, Freescale or Motorola dental plan.

Program Allowance

As noted above, the Dental Plan pays non-Delta provider benefits based on the **Maximum Contract Allowance** 416.

Dental Plan Features

Network Providers

You may see any provider for covered treatment; whether the provider is a PPO provider, Premier provider or a non-Delta Dental provider. However, you should verify your provider's participation status within Delta Dental before each appointment.

To locate PPO and Premier providers:

- Go online to **deltadentalins.com**; or
- Call the Delta Dental Customer Service Center at 800-521-2651.

Representatives can provide you with information regarding a provider's network participation, specialty and office location.

How the Plan pays benefits depends on the type of provider you choose:

- **PPO Provider:** PPO providers provide dental benefits at a contractually agreed upon rate. Payment for covered services is based on the maximum contract allowance, which generally provides for the greatest reduction in your out-of-pocket expenses;

- **Premier Provider:** A Premier provider is a Delta Dental provider who has not agreed to the features of the PPO plan. Payment for covered services performed by a Premier provider is based on the maximum contract allowance; however, the amount a Premier provider charges may be above that accepted by PPO providers, but no more than the Delta Dental Premier contracted fee; and
- **Non-Delta Dental Provider:** A non-Delta Dental provider is any dental provider that does not participate in Delta Dental's network as a PPO or Premier provider. Payment for covered services performed by a non-Delta Dental provider is based on the maximum contract allowance. A non-Delta Dental provider may charge you more the maximum contract allowance; you are responsible for the balance of any amounts billed over what the Plan pays.

When you use a PPO or Premier provider:

- The provider accepts assignment of benefits; this means you do not have to file claims; your provider will submit claims to Delta Dental and they will be paid directly by Delta Dental; and
- The provider accepts contracted fees as payment in full for covered services; this means you will not be balance billed if there is a difference between submitted fees and contracted fees.

Annual Deductible

Before the Dental Plan pays its share of some dental expenses, you pay an annual deductible. This is the amount of eligible dental expenses that you must pay each calendar year before the Dental Plan pays most benefits. You do not pay a deductible for diagnostic and preventive and orthodontic services before the Dental Plan begins paying benefits.

A separate $50 deductible applies to each covered person in your family. The $150 family deductible is a combined amount for all family members. However, to meet the family deductible, no more than $50 for any one family member can be applied.

The deductible starts over each January 1. Eligible expenses do not carry over from one year to the next, nor do they carry over from this Plan to the Post-Employment Benefits Plan.

Coinsurance

You share the cost of covered dental services with the Dental Plan. Generally, the Dental Plan pays:

- 100% for diagnostic and preventive services, no deductible;
- 80% for basic services, after the deductible;
- 50% for major services, after the deductible; and
- 80% for orthodontic services, no deductible.

You pay the remaining amount, including amounts above the program allowance, when you use a non-Delta Dental provider.

Annual Maximum Benefit

The Dental Plan has an annual maximum benefit of $2,000 per covered person for eligible dental services (not including orthodontic services), The annual maximum is waived for diagnostic and preventive services (except for periodontal maintenance).

Orthodontic Services

The Plan pays 80% of covered expenses, up to the annual maximum and orthodontic lifetime maximum. You do not need to satisfy the Dental Plan deductible before you receive benefits for orthodontic services. The overall lifetime maximum benefit for orthodontic services is $2,000 per covered person. This amount includes any benefits paid under any current or former NXP or Freescale dental plans.

Pre-Treatment Estimate

Pre-treatment estimate requests are not required. However, if you want to request a pre-treatment estimate, your provider may file a claim form before beginning treatment, showing the services to be provided to you. Delta Dental will estimate the amount of benefits payable under the Plan for the service. By asking your provider for a pre-treatment estimate before you agree to receive any prescribed treatment, you will have an estimate up front of what Delta Dental will pay and the difference you will need to pay. The benefits will be paid when the treatment is actually performed.

Pre-treatment estimates are valid for 365 days, unless other services are received after the date of the pre-treatment estimate, or until the earliest of the date:

- The Plan's contract with Delta Dental ends;

- Plan benefits are amended and the amendment affects the benefits included in the pre-treatment estimate;
- Your coverage under the Plan ends; or
- Your provider no longer has an agreement with Delta Dental.

A pre-treatment estimate does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are covered under the Plan and meet all Plan requirements at the time the treatment you have planned is completed. The pre-treatment estimate may not take into account any deductibles; so, remember to figure in your deductible, if necessary.

If your pre-treatment estimate is no longer valid, you should have your dentist submit another pre-treatment estimate request.

Optional Services

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called optional services. Optional services also include the use of specialized techniques instead of standard procedures.

If you receive optional services, an alternate benefit is allowed, which means Delta Dental will base benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the optional service. You will be responsible for the difference between the higher cost of the optional service and the lower cost of the customary service or standard procedure.

Examples of optional services include, but are not limited to:

- A composite restoration instead of an amalgam restoration on posterior teeth;
- A crown where a filling would restore the tooth;
- An inlay/onlay instead of an amalgam restoration;
- Porcelain, resin or similar materials for crowns placed on a maxillary second or third molar or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); and
- An overdenture instead of denture.

What's Covered

The Dental Plan covers several categories of covered expenses, including diagnostic and preventive services, basic services, major services, orthodontic services and dental accident services.

> The Dental Plan pays covered expenses only. To be covered, an expense must be incurred while you or your dependent(s) are covered by the Dental Plan for that benefit, and it must be an eligible Dental Plan expense.
>
> If you incur an expense that is not eligible for coverage under the Dental Plan (see What's Not Covered 203), you are responsible for paying 100% of that expense.
>
> Contact Delta Dental at 800-521-2651 for more information.

Diagnostic and Preventive Services

You are encouraged to see your dentist for diagnostic and preventive care to reduce the risk of more serious and costly dental treatment. These services include:

- Diagnostic procedures, which are procedures to aid in determining required dental treatment; and
- Preventive procedures, such as cleanings and topical application of fluoride solutions and space maintainers.

The Dental Plan pays 100% of the contracted fee (PPO and Premier providers) or program allowance (non-Delta providers) for diagnostic and preventive services. These benefits are not subject to the Dental Plan's deductible or applied to the annual maximum.

Diagnostic and Preventive Services	What's Covered/Limits
Oral Evaluations	• Oral examinations (except after-hours exams and exams for observation); limited to two per calendar year. • Caries risk assessments are limited to once in 36 months.

Diagnostic and Preventive Services	What's Covered/Limits
Cleanings (routine prophylaxis)	• Routine cleanings, including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth and periodontal maintenance in the presence of inflamed gums; limited to two per calendar year. • See **Additional Benefits During Pregnancy** 200for more information on benefits during pregnancy. • See **SmileWay Wellness Benefits** 201 for benefits for participants diagnosed with cardiovascular (heart) disease, diabetes, cerebrovascular disease (stroke), HIV/AIDS and rheumatoid arthritis.
X-Rays	• Bitewing X-rays: – Limited to two sets of bitewing X-rays per calendar year; – Bitewings of any type are disallowed within 12 months of a full mouth series, unless warranted by special circumstances; and – Limited to two images for participants younger than age 10. • Total reimbursable amount is limited to the provider's accepted fee for a complete intraoral series when the fees for any combination of intraoral X-rays in a single treatment series meet or exceed the accepted fee for a complete intraoral series. • When a panoramic film is submitted with supplemental film(s), the Dental Plan limits the total reimbursable amount to the provider's accepted fee for a complete intraoral series. • If a panoramic film is taken in conjunction with an intraoral complete series, the Dental Plan considers the panoramic film to be included in the complete series. • A complete intraoral series is limited to once every 36 months. • Panoramic films are limited to once every 36 months.
Emergency Care	• Emergency evaluations and palliative (emergency) treatment for relief of dental pain. • Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required X-rays or select diagnostic procedures.

Diagnostic and Preventive Services	What's Covered/Limits
Full Mouth or Panoramic X-Rays	• Limited to one every 36 months.
Miscellaneous X-Rays	• Including, but not limited to, periapical X-rays.
Sealants	• Sealants are topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for preventing decay. – Limited to all permanent molars for participants through age 15 if they are without caries (decay) or restorations on the occlusal surface; and – Limited to repair or replacement of a sealant on any tooth once in a lifetime of its application, which is included in the fee for the original placement.
Space Maintainers	• For fixed or removable appliances to maintain a space created by the premature loss of a primary tooth or teeth. – Limited to dependent children through age 13 only. – Space maintainers are limited to the initial appliance and are a benefit for a participant up to age 14. • A distal shoe space maintainer-fixed-unilateral is limited to children eight and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. • Recementation of space maintainer is limited to once per lifetime. • The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different provider/provider's office.
Topical Fluoride	• For dependent children to age 19 only. • Limited to two per calendar year.

Basic Services

The Dental Plan pays 80% of the contracted fee (PPO and Premier providers or program allowance (non-Delta providers) for basic services, after you pay your deductible. Treatment records may be required by Delta Dental to determine benefits. See the chart below for **examples of covered basic services.**

Basic Services	What's Covered/Limits
Denture Repairs	• Denture repairs are repairs to partial or complete dentures, including rebase procedures and relining. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means. • Delta Dental limits payment for dentures to a standard partial or complete denture (coinsurances apply). • Denture rebase is limited to one per arch in a 24-month period and includes any relining and adjustments for 24 months following placement. • Dentures, removable partial dentures and relines include adjustments for six months following installation. After the initial six months of an adjustment or reline, adjustments are limited to two per arch in a calendar year and relining is limited to one per arch in a six-month period. • Tissue conditioning is limited to four per arch in a calendar year. However, tissue conditioning is not allowed as a separate benefit when performed on the same day as a denture, reline or rebase service. • Recementation of fixed partial dentures is limited to once in a lifetime.
Endodontics	• Endodontics is the treatment of diseases and injures of the tooth pulp, which includes, but not limited to, root canal treatments. • Retreatment of root canal therapy by the same provider within 24 months is considered part of the original procedure.
Extractions	• Includes routine extractions, orthodontic extractions of primary teeth and surgical extractions of erupted teeth.

Basic Services	What's Covered/Limits
Fillings	• Amalgam and composite. • Multiple restorations on one surface are considered one restoration. • Replacement of an amalgam or resin-based composite restoration (filling) is not covered more than once in a 24-month period if the service is provided by the same provider. • Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
General Anesthesia or IV Sedation	• When administered by a dentist for a covered oral or dental surgery or selected endodontic or periodontal surgical procedures, and when dentally necessary or necessary due to a medical condition that presents a high risk to the patient. • Not covered for routine extractions or surgical removal of erupted teeth.
Night/Occlusal Guards	• Night/occlusal guards are intraoral removable appliances provided for treatment of harmful oral habits associated with periodontal disease. • Limited to once every 60 months.
Oral Surgery	• Includes surgical extractions of impacted teeth (pre- and post-operative care), including osseous (bone) surgery. • Oral surgery services are limited to once per lifetime, except removal of cysts and lesions and incision and drainage procedures, which are limited to only one in the same day. • Transseptal fiberotomy/supra crestal fiberotomy is limited to participants through age 18. • Surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth are limited to participants through age 18. • Frenulectomy and frenuloplasty are only considered in cases of ankyloglossia (tongue-tie) interfering with feeding or speech as diagnosed and documented by a physician.

Basic Services	What's Covered/Limits
Periodontics	• Periodontics is the treatment of gums and bones supporting teeth. • Periodontal limitations: – Cleanings are subject to a 30-day wait after periodontal scaling and root planing if performed by the same provider office; – Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period; – See **Additional Benefits During Pregnancy** 200 for more information on benefits during pregnancy; – See **SmileWay Wellness Benefits** 201 for benefits for participants diagnosed with cardiovascular (heart) disease, diabetes, cerebrovascular disease (stroke), HIV/AIDS and rheumatoid arthritis; – No more than two quadrants of scaling and root planing will be covered on the same date of service; – Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same provider; – Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periarticular surgery, ridge augmentation or implants; – When implant procedures are covered, scaling in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure limited to once in a 24-month period; – Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area; and – Periodontal surgery is subject to a 30-day wait after periodontal scaling and root planing in the same quadrant.

Major Services

The Dental Plan pays 50% of the contracted fee (PPO and Premier providers) or program allowance (non-Delta providers) for major services, after you pay your deductible. Treatment records may be required by Delta Dental to determine benefits. Following are examples of covered major services, including limitations that may apply:

- Crowns, inlays and onlays, which are treatment for carious lesions (visible decay of the hard tooth structure), when teeth cannot be restored with amalgam or resin-based composites:

– Prefabricated crowns are covered on baby (deciduous) teeth and permanent teeth up to age 16 (replacement restorations within 24 months are included in the fee for the original restoration);

– Replacement of prefabricated crowns is not covered within 24 months of treatment if the service is provided by the same provider;

– Crowns and inlays/onlays are limited to participants age 12 and older and are not covered more than once in any 60-month period, except when the Dental Plan determines the existing crown or inlay/onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues;

– Crown repairs are not covered more than twice in any 60-month period;

– Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation; and

– Recementation of crowns, inlays/onlays or bridges is included in the fee for the crown, inlay/onlay or bridge when performed by the same provider/provider office within six months of the initial placement; after six months, payment will be limited to one recementation in a lifetime by the same provider/provider office; and

- Prosthodontics, which are procedures for:

– Construction of fixed bridges, partial or complete dentures and the repair of fixed bridges;

– Implant surgical placement and removal; and

– Implant supported prosthetics, including implant repair and recementation.

Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when the Dental Plan determines that there is extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to participants age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be covered if the Dental Plan determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. The Dental Plan's payment for implant removal is limited to one for each implant during the participant's lifetime whether provided under the Dental Plan or any other dental care plan.

Orthodontic Services

The Dental Plan pays 80% of the contracted fee (PPO and Premier providers) or program allowance (non-Delta providers) for orthodontic services, no deductible required. The Dental Plan's lifetime maximum benefit for orthodontic services is $2,000, which includes orthodontic benefits paid under any current or former NXP or Freescale dental plans.

Treatment records may be required by Delta Dental to determine benefits. Benefits for orthodontic services do not apply toward the Dental Plan annual benefit maximum.

Orthodontic services are procedures performed by a provider using appliances to treat malocclusion of teeth and/or jaws that significantly interfere with their function. Covered orthodontic services are braces and necessary adjustments and expenses incurred for:

- Services related to covered orthodontic treatment, including records and extractions of permanent teeth; and
- Cephalometric X-rays, oral/facial photographic images and diagnostic casts, limited to once per lifetime in conjunction with orthodontic services; 3D X-rays are not covered.

Benefits for orthodontic services will be provided in two payments, as long as you are eligible. Following the initial claim payment, the remaining orthodontic benefit will be paid within 12 months provided there has been no lapse in coverage.

Orthodontia benefits do not include coverage for:

- Repair or replacement of any orthodontic appliance received under this Plan;
- Orthodontic retreatment procedures;
- Self-administered orthodontics (treatment must be provided by a licensed dentist); or
- The removal of fixed orthodontic appliances for reasons other than completion of treatment;

Dental Accident Services

The Dental Plan covers treatment for an injury to the mouth or structures within the oral cavity that is caused by an external traumatic force that occurs while you are covered by the Dental Plan. Services must be provided within 180 days after the dental accident and while you are still covered by the Dental Plan. Procedures covered include reimplantation, splinting and stay plate.

Coverage does not include damage to the teeth that due to biting into food or other substances.

Additional Limitations

In addition to any other limitations listed in the previous section, the following limitations apply:

- Cephalometric X-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with orthodontic services only when orthodontic services are a covered benefit; if orthodontic services are covered, age limits may apply (3D X-rays are not a covered benefit);
- Screenings of patients and assessments of patients are limited to once per lifetime per provider and count toward the oral exam frequency;
- Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth;
- Pulpal therapy (resorbable filling) is limited to once in a lifetime; retreatment of root canal therapy by the same provider/provider office within 24 months is considered part of the original procedure;

- Apexification is only a benefit on permanent teeth with incomplete root canal development or for the repair of a perforation; apexification visits have a lifetime limit per tooth of one initial visit, four interim visits and one final visit to age 19;
- Retreatment of apical surgery by the same provider/provider office within 24 months is considered part of the original procedure;
- Core buildup, including any pins, are covered not more than once in any 60-month period; and
- Post and core services are covered not more than once in any 60-month period.

Additional Benefits During Pregnancy

If you are pregnant, Delta Dental will pay for additional services to help improve your oral health during pregnancy. The additional services each calendar year while you are covered under the Plan include any combination of two of the following:

- Routine cleanings;
- Periodontal scaling and root planing per quadrant; or
- Periodontal maintenance procedure.

You or your provider must provide written confirmation of your pregnancy when the claim is submitted.

SmileWay Wellness Benefits

SmileWay Wellness Benefits are available to help improve your oral health if you have certain qualifying medical conditions. You are eligible for SmileWay Wellness Benefits if you have one or more of the following qualifying medical conditions:

- Cancer;
- Cardiovascular (heart) disease;
- Chronic Kidney Disease;
- Cerebrovascular disease (stroke);
- Diabetes;
- Heart disease;
- HIV/AIDS;
- Huntington's Disease;
- Joint Replacement;
- Lupus;
- Opioid misuse and addiction;
- Parkinson's disease;
- Rheumatoid arthritis;
- Sjogren's syndrome; and
- Stroke

The SmileWay Wellness Benefits in the following table replace the coverage for routine cleanings, periodontal maintenance and periodontal scaling and root planing as described in **What's Covered** 191if you are eligible for SmileWay Wellness Benefits.

Service	PPO Providers	Premier and Non-Delta Dental Providers	Limitations
Routine Cleaning and Periodontal Maintenance	Plan pays 100%	Plan pays 100%	Any combination of four each calendar year
Periodontal Scaling and Root Planing	Plan pays 100%	Plan pays 100%	Once every calendar year per quadrant with no more than two quadrants covered on the same date of service.

If you are eligible for a pregnancy benefit and also eligible for SmileWay Wellness Benefits, SmileWay Wellness Benefits replace the additional pregnancy benefits described in **Additional Benefits During Pregnancy** 200, except you will be entitled to one additional oral exam each calendar year while pregnant provided you submit written confirmation of your pregnancy.

All other benefits, limitations and exclusions remain unchanged. SmileWay Wellness Benefits is subject to applicable deductibles and maximums.

Signing Up for SmileWay Wellness Benefits

- Go to **deltadentalins.com**;
- Log in to your online services account (if you do not have one, click Register);
- Click on the "Optional Benefits" tab in the left column;
- Click on "Opt In" next to the name of the person you want to enroll; you can enroll yourself or a dependent child; and
- Complete and submit the form.

What's Not Covered

Although the Dental Plan covers a large number of dental services, there are certain exclusions and limitations.

The Dental Plan does not provide benefits for:

- Treatment of injuries or illness covered by workers' compensation or employers' liability laws;
- Services received without cost from any federal, state or local agency, unless prohibited by law;
- Cosmetic surgery or procedures for purely cosmetic reasons;
- Maxillofacial prosthetics;
- Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or younger); provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service;
- Services for congenital (hereditary) or developmental (following birth) malformations, including, but not limited to, cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities;
- Treatment to stabilize teeth, to restore tooth structure lost from wear, erosion or abrasion or to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; examples include, but are not limited to, equilibration, periodontal splinting, complete occlusal adjustments and abfraction;
- Any single procedure provided before the date you became eligible under this Plan;
- Prescribed drugs, medication, pain killers, antimicrobial agents or experimental/investigational procedures;
- Charges for anesthesia, other than general anesthesia and IV sedation administered by a provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures (local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures);

- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues);
- Laboratory processed crowns participants younger than age 12;
- Fixed bridges and removable partials for participants younger than age 16;
- Interim implants and endodontic endosseous implants;
- Indirectly fabricated resin-based inlays/onlays;
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the provider for treatment in any such facility;
- Treatment by someone other than a provider or a person who by law may work under a provider's direct supervision;
- Charges incurred for oral hygiene instruction, plaque control program, preventive control programs, including home care times, dietary instruction, X-ray duplications, cancer screening or tobacco counseling;
- Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry, such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment, such as cotton swabs, gauze, bibs, masks or relaxation techniques, such as music;
- Procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation;
- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for benefits provided under this Plan (any taxes are your responsibility and not a covered benefit);
- Deductibles, amounts over plan maximums and/or any service not covered under this Plan;
- Services covered under the Plan that exceed benefit limitations or are not according to processing policies in effect when the claim is processed;
- Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws), except as specifically provided as covered;
- Services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues, except specifically provided as covered;
- Missed and/or cancelled appointments;
- Actions taken to schedule and assure compliance with patient appointments (except part of office operations, but not as a separately payable service);

- Fees for care coordination (except as part of overall patient management, but not as a separately payable service);
- Dental case management motivational interviewing and patient education to improve oral health literacy;
- Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum;
- Extra-oral 2D projection radiographic image and extra-oral posterior dental radiographic image;
- Diabetes testing;
- Corticotomy (specialized oral surgery procedure associated with orthodontics);
- Teledentistry fees; and
- Specialist consultation.

If you have any questions about what expenses are not covered, call Delta Dental at 800-521-2651.

Misstatement

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Dental Plan, all statements made by you or NXP are considered representations and not warranties. No such statement will be used in defense to a claim under the Dental Plan unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement that is material to the acceptance of risk may prevent recovery if, had the true facts been known to the Dental Plan, Delta Dental would not in good faith have issued coverage. If any misstatement would materially affect the Dental Plan, Delta Dental reserves the right to adjust the coverage to reflect actual circumstances enrollment.

If you do not cooperate or provide Delta Dental with notice or your actions result in prejudice to the Dental Plan's rights, this will be considered a material breach of the Dental Plan and will result in you being held personally responsible for repayment. In this event, the Dental Plan may deduct from any pending or subsequent claim made under the Dental Plan any amounts you owe the Dental Plan until your cooperation is provided and the prejudice ceases.

NXP Vision Plan

Routine eye care services are included in the NXP Vision Plan for you and your covered dependents. Services include comprehensive eye examinations, prescription eyeglasses (lenses and frame) or contact lenses. To take advantage of the Vision Plan, you simply enroll yourself, or you and your eligible dependents, pay your contribution, then choose a VSP network doctor or retail chain and pay your share of the cost, as described in the following chart.

If You Are a U.S. Expatriate or U.S. Inpatriate

Medical (including behavioral health and prescription drug), dental and vision coverage for U.S. Expatriates and U.S. Inpatriates on U.S. payroll are provided by separate Global plans that are not described in this SPD. All other benefits described below apply to U.S. Expatriates and U.S. Inpatriates as outlined in the NXP Benefits chart on page v.v

Vision Benefits Summary

Service	Frequency	VSP Network Doctor or Retail Chain*	Out-of-Network
Well Vision			
Vision Examination	Once per calendar year	You pay $20 copayment; Plan pays the rest	Plan reimburses up to $45 after $20 copayment
Prescription Glasses	See Eyeglass Lenses and Eyeglass Frames below	You pay $20 copayment; Plan pays the rest	As outlined in the chart below
Eyeglass Lenses • Single vision • Lined bifocal • Lined trifocal -Impact resistant lenses for children is included at no extra cost	Once per calendar year	Your copayment for Eyeglass Lenses is included in the Prescription Glasses copaymnt	Plan reimburses up to the amounts shown below: • **Single Vision:** Up to $30 • **Lined Bifocal:** Up to $50 • **Lined Trifocal:** Up to $65 • **Progressive:** Up to $50 •
Service	**Frequency**	**VSP Network Doctor or Retail Chain***	**Out-of-Network**

Eyeglass Frames	Once every two calendar years	• Your copayment for Eyeglass Frames is included in the Prescription Glasses copayment • Plan pays up to $250 retail allowance ($270 allowance for featured frame brands**), plus 20% savings on amounts over your allowance • Plan pays up to $135 allowance at Costco • Plan pays up to $250 allowance at Walmart	Plan reimburses up to $70 after your copayment
Lens Enhancements	Once per calendar year	• Standard progressive lenses, covered in full • Premium progressive lenses, $95 – $105 • Custom progressive lenses, $150 – $175 Average savings of 30% on the other lens enhancements	No benefit

Service	Frequency	VSP Network Doctor or Retail Chain*	Out-of-Network
Contacts	Once per calendar year, in lieu of eyeglass lenses and frames	$250 allowance for contacts 15% savings on contact lens exam (fitting and evaluation) and will not exceed $20	$105 allowance for contacts and contact lens exam
Essential Medical Eye Care	As needed	Retinal screening for members with diabetes covered in full $20 copayment for additional exam service and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions, such as dry eye, eye disease, glaucoma and more	No benefit
Computer Vision Care for Employees and Dependents			
Frames	Once every calendar year	After you pay $20 copayment, Plan pays up to $90 allowance Average savings of 20% on amounts over your allowance	Plan reimburses up to $45 after your copayment

Service	Frequency	VSP Network Doctor or Retail Chain*	Out-of-Network
Lenses	Once per calendar year	$10 copayment (includes single vision, lined bifocal, lined trifocal and occupational lenses)	After your copayment, Plan reimburses up to: • $30 for single vision lenses • $50 for bifocal lenses • $65 for trifocal lenses • $50 for progressive lenses • $100 for lenticular lenses
Extra Savings			
Laser Vision Correction	No limits	On average, a 15% discount or 5% off promotional pricing from selected VSP Network Providers	No benefit
Routine Retinal Screening	Not applicable	No more than $39 copayment on routine retinal screening as an enhancement to a Well Vision Exam	Not covered

Service	Frequency	VSP Network Doctor or Retail Chain*	Out-of-Network
Glasses and Sunglasses	Not applicable	• Extra $20 to spend on featured frame brands (go to www.vsp.com/offers for details) • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP providers within 12 months of a Well Vision Exam	Not covered

* *Benefits from a retail chain may be different. Once your coverage begins, visit VSP.com for details.*

** *Visit VSP.com/optical-discounts.html to view VSP featured frames.*

Vision Plan Features

VSP National Network of Doctors and Retail Providers

The Vision Plan offers a national network of doctors (ophthalmologists and optometrists), administered by VSP and retail chains contracted by VSP. Retail chains include Costco Optical and Visionworks (formerly Eye Care Centers of America). This is a different network of providers than the NXP Medical Plan network.

Through VSP, you can receive exclusive contact lens rebates, special offers, such as TruHearing Member Plus Program, and savings up to 50% on hearing aids. To take advantage of these offers, visit **VSP.com/hearing-aid-discounts.html**.

Locating Your Network Doctor or Affiliate Provider

When you obtain services from a VSP network doctor or retail chain you get the most value from your Vision Plan benefits. VSP offers two convenient ways to locate these providers near your home or work or to verify that your doctor is in the network or contracted with VSP as an affiliate provider:

- Visit **VSP.com**. To access this website for the first time, you must register and create a username and password. You can search for a Choice Plan network doctor or retail chain by name or location; or
- Call VSP's Member Services Department at 800-877-7195 and choose either the automated service or talk with a Customer Service Representative.

Scheduling an Appointment

Follow these quick steps to schedule an appointment with a network doctor or retail chain:

- Call a network doctor or retail chain for an appointment and identify yourself as an NXP VSP member. Allow at least 48 hours between your call and your appointment so the provider can verify your eligibility. You will need to provide the NXP employee's name and date of birth or last four digits of his/her Social Security number when you call, as this information is required to make an appointment.
- After you schedule an appointment, the network doctor or retail chain contacts VSP to verify your eligibility and benefit coverage. If you are not eligible for benefits at that time, the provider will let you know.
- Go to your scheduled appointment. You do not need to take any kind of benefit form with you and you do not have to submit a claim form when you use a network doctor or retail chain. At your appointment, you will pay the applicable copayment(s) plus any additional amounts for which you are responsible. As you are choosing among your contact lenses and eyeglasses options, you may ask the provider how much you will have to pay for each item.

If your eligibility for benefits is denied, it may be for one of the following reasons:

- You may not be eligible because you are not an NXP Vision Plan participant or you may be so new to the Vision Plan that your name is not yet in the VSP database. In this case, call VSP Member Services at 800-877-7195 to clarify the situation.
- You may not have waited long enough between provider visits. See the **Vision Benefits Summary** chart 206 to see the allowed frequency of visits. You may also check online at **VSP.com** to see what services you have available now or by what date in the future.

Using an Out-of-Network Provider

If you obtain services from an out-of-network provider, which is a provider who is not a VSP Choice Plan network doctor or retail chain, the level of benefits you receive will be lower than if you use a network doctor or retail chain. You will need to pay in full at the time of services and then submit your itemized bill for reimbursement. You will be reimbursed according to the out-of-network reimbursement amounts (see the "Out-of-Network" column of the **Vision Benefits Summary** 206).

For reimbursement, you can upload images of your receipts when you complete a Member Reimbursement form on **VSP.com**. You are also able to log into your **VSP.com** account to check the status of your reimbursement.

You may also send your itemized receipts to:

VSP

3333 Quality Drive,

Rancho Cordova, CA 95670-7985

Be sure to write the employee's name and birth date, last four digits of his/her Social Security number, services rendered and "paid in full" on each receipt you submit.

What's Covered

The Vision Plan covers the following services and supplies (see **Vision Benefits Summary** 206 for specific information on how each benefit is covered):

- **Eye Examination:** Professional vision exams include a comprehensive analysis of the visual functions and, when necessary, the prescription of corrective lenses.
- **Eyeglass Lenses:** The Vision Plan covers clear glass or plastic single-vision or multifocal (lined bifocal or lined trifocal) lenses up to 65 millimeters in size. Related costs of fitting and adjusting are also covered.
- **Eyeglass Frames:** The Vision Plan covers frames and related costs of fitting and adjustment.
- **Contact Lenses:** You can choose to buy contact lenses instead of prescription eyeglasses (lenses and frame).
- **Essential Medical Eye Care:** Provides fully covered retinal screenings for members with diabetes. These high-resolution images of the inside of the eye area are a non-invasive way to monitor diabetes. In addition, exams and services are available to:

– Treat immediate issues, such as pink eye and sudden changes in vision; and
– Monitor ongoing health conditions, such as dry eye, diabetic eye disease, glaucoma and more.

No benefits are paid for out-of-network care.

- **Medically Necessary Contact Lenses:** Certain eye conditions that cannot be treated with eyeglasses may qualify you for medically necessary contact lenses if specific benefit criteria are met. Eye conditions may include aphakia, anisometropia, high ametropia, nystagmus and keratoconus.
- **Low Vision Benefit:** If you suffer vision loss that prevents you from reading, moving around in unfamiliar surroundings or completing desired tasks, you may be eligible for the Vision Plan's low vision benefit. Your VSP Choice Network Doctor must contact VSP to receive authorization to cover supplemental testing for low vision evaluation, low vision prescription services and optical and non-optical aids. No benefit is paid for treatment by an out-of-network provider.

VSP Choice Plan network doctors and retail chains also offer discounts of 20-25% on all non-covered lens options, such as scratch resistant and anti-reflective coatings and progressive lenses. They also offer 20% off additional glasses and sunglasses, including lens options, from the same network doctor or affiliate provider within 12 months of your last eye examination. If you choose contacts instead of glasses, you receive a 15% discount on professional fees for the contact lens exam (fitting and evaluation).

Laser Vision Surgery

VSP contracts with laser surgery centers to offer discounts of 15% off the regular price or 5% off the promotional price for laser vision surgery. Your VSP Network Doctor will refer qualified candidates to participating laser surgery centers.

Your maximum cost for this surgery is:

- $1,500 per eye for PRK;
- $1,800 per eye for Lasik; and
- $2,300 per eye for custom PRK, custom Lasik (wavefront technology) and bladeless Lasik.

What's Not Covered

There are no benefits for professional services or materials associated with:

- Orthoptics or vision training and any associated supplemental testing;
- Non-prescription eyeglasses or contact lenses (including plano lenses);
- Two pairs of glasses in lieu of bifocals;
- Retinal photographs;
- Eyeglass lenses, frames or contacts provided under the Vision Plan that are lost or broken (except at the normal intervals when services are otherwise available);
- Medical or surgical treatment of the eyes;
- Any eye examination or corrective eyewear, required by an employer as a condition of employment;
- Vision therapy; and
- Any charges over and above reasonable and customary.

Cosmetic Materials

Because the Vision Plan is designed to meet your visual needs, cosmetic materials and enhancements are not covered. But, for an additional fee, you can request the following:

- Blended lenses;
- Oversize lenses (only over 60 mm);
- Progressive multifocal lenses;
- Photochromic or tinted lenses (Pink 1 or 2 tints are covered);
- Coated or laminated lenses;
- A frame that costs more than the Vision Plan allowance;
- Cosmetic lenses;
- Optional cosmetic processes; and
- UV-protected lenses.

Flexible Spending Accounts

The Flexible Spending Account (FSAs) Plan offers a significant tax savings. Both the Health Care/Limited Use Health Care Flexible Spending Account (FSA) 219 and the Dependent Care Flexible Spending Account (DCFSA), as explained beginning on 226, allow you to set aside before-tax dollars into special accounts. When you incur an eligible expense, you file a claim for a tax-free reimbursement of that expense.

Your FSA Participation Agreement

By participating in either the Health Care/Limited Use Health Care FSA or Dependent Care FSA, you certify that any expense paid by the account has not been reimbursed. You also agree not to seek reimbursement from another plan, or claim a tax credit or deduction, for any expenses paid by the account.

If You Are Enrolled in the Medical Plan 1 Coverage Option

By law, if you have a Health Savings Account, you may not contribute to a health care flexible spending account, unless it is a limited use account. Therefore, if you are enrolled in the Medical Plan 1 coverage option, you can only enroll in the Limited Use Health Care FSA.

The amount you contribute to an FSA is deducted from your pay each pay period before federal and most state and local taxes are calculated. This lowers your taxable income and the resulting tax amount you pay.

Summary of Flexible Spending Account Plan Benefits

Plan	Covered Expenses	Maximum Contribution	How Claims Are Paid
Health Care Flexible Spending Account (FSA)	Medical, pharmacy, dental and vision care expenses not reimbursed by another plan	$3,200 per calendar year	Full annual contribution is available on your first day of participation
Limited Use Health Care Flexible Spending Account*	Dental and vision care expenses not reimbursed by another plan	$3,200 per calendar year	Full annual contribution is available on your first day of participation
Plan	**Covered Expenses**	**Maximum Contribution**	**How Claims Are Paid**

Dependent Care Flexible Spending Account (DCFSA)**	Employment-related dependent care expenses not claimed for the federal dependent care income tax credit	$5,000 per calendar year	Only amounts already contributed are available

* *If you enroll in the Medical Plan 1 coverage option and want to contribute to a health care FSA, you must enroll in the Limited Use Health Care FSA.*

** *If you earn over $130,000 annually or are married filing separately, you can contribute up to $2,500.*

How FSAs Reduce Your Taxes

With an FSA, you pay for your health care or dependent care expenses before taxes, so your taxable income is reduced.

> **Example**: Alexandra earns an annual salary of $50,000, is married with one child and she contributes $2,750 a year in a Health Care Flexible Spending Account. Compare the tax savings of using an NXP Health Care Flexible Spending Account and paying health care costs with after-tax dollars.

	Paying Expenses with Health Care Flexible Spending Account	Paying Expenses with After-Tax Dollars
Taxable Income	$50,000	$50,000
Health Care FSA Deposit	- $2,750	- $0
Net Taxable Income	$47,250	$50,000
Estimated Social Security Tax	- $3,615	- $3,825
Federal Income Taxes	- $5,386	- $5,716
Total Estimated Tax*	$9,001	$9,541
Income After Taxes	$38,249	$40,459
After-Tax Payment of Expenses	- $0	- $2,750
Spendable Income	$38,249	$37,709
	Paying Expenses with Health Care Flexible Spending Account	**Paying Expenses with After-Tax Dollars**
Tax Savings		$540

* *This is just an example and makes certain assumptions; your individual situation will be different.*

Plan Your Contributions Carefully

You have until March 31 of the following year to submit claims for expenses *incurred* during a **prior** calendar year. You incur an expense on the day you receive the service or buy the supply; this may be different from the date you actually pay the expense.

You cannot start or stop contributing or change your contribution amount during the year unless you experience a qualified status change.

Beginning January 1, 2025, the plan will no longer roll over unused funds from year to year.

For 2024, the Plan no longer allows you to carry over your entire unused Health Care/Limited Use Health Care FSA and/or Dependent Care FSA balance from year to year.

> If you are changing medical options as of the beginning of the plan year and are enrolled in the Health Care/Limited Use Health Care FSA, any carry over will be credited to the appropriate type of account. For example, if you are changing from Medical Plan 2 to Medical Plan 1, the carryover will automatically be added to a Limited Use Health Care FSA and may only be used to pay for expenses eligible for reimbursement under a Limited Use Health Care FSA.

Special Rules for Eligible Reservists – Health Care Flexible Spending Account Only

If you are an "eligible reservist" and called to active duty for 180 days or more, you may avoid forfeiting money in your Health Care FSA, but not your Dependent Care FSA, by making a taxable withdrawal of the funds in your Health Care FSA. You must make your withdrawal request before December 31 of the year you are called to active duty. For more information, call the NXP Benefits Service Center at 888-375-2367.

Resources from UnitedHealthcare

You have online and telephone access whenever you need information about your FSAs. To access the website, log on to **NXP.com/benefits**. The website allows you to review your account balances, check the status of claims, learn about eligible expenses and more.

If you do not have Internet access, you may speak with a service center representative by calling the NXP Benefits Service Center toll free at 888-375-2367. From the main menu, follow the voice prompts to connect to a representative.

Health Care/Limited Use Health Care Flexible Spending Account (FSA)

The Health Care FSA Plan offers domestic employees and U.S. Expatriates a real financial advantage. It lets you set aside before-tax dollars into an account to pay for eligible health care expenses. The amount you contribute is deducted each pay period before federal and most state and local taxes are calculated. This lowers your taxable income and the resulting tax amount you pay.

Two types of accounts are available:

- **Health Care Flexible Spending Account:** This is the traditional Health Care FSA that can be used to pay for eligible medical, prescription drug, dental and vision care expenses for you and your dependents. You cannot enroll in a traditional Health Care FSA if you are enrolled in a High Deductible Health Plan with a corresponding HSA, such as the Medical Plan 1 coverage option.
- **Limited Use Health Care Flexible Spending Account:** If you enroll in a High Deductible Health Plan with a corresponding HSA, like the Medical Plan 1 coverage option, federal regulations limit reimbursements that can be made before your medical deductible is met. As a result, you cannot participate in a traditional Health Care FSA. However, you may participate in the Limited Use Health Care FSA since this account is only used to pay for eligible dental and vision expenses.

Federal regulations do not allow contributions to an HSA and/or Limited Use Health Care FSA and a standard Health Care FSA during the same year. As a result:

- You are not eligible to contribute to a standard Health Care FSA if you enroll in the Medical Plan 1 coverage option at any time during the year, have a qualifying life event and change your medical coverage option to any other coverage option other than Medical Plan 1.
- You are not eligible to contribute to an HSA or Limited Use Health Care FSA if you contributed to a standard Health Care FSA at any time during the year, have a qualifying life event and enroll in a High Deductible Health Plan, such as the NXP Medical Plan 1 coverage option. In addition, if you enroll in a High Deductible Health Plan, such as the NXP Medical Plan 1, contributions to your standard Health Care FSA will end.

Note: You may not join or make any change to your enrollment or contribution between November 1 and December 31.

Note: If both you and your spouse work at NXP, you are each eligible to contribute to your own Health Care or Limited Use Health Care FSA, up to the annual maximum during the calendar year. Claims may be submitted under either employee's Health Care or Limited Use Health Care FSA.

Eligible Dependents

The Health Care FSA Plan reimburses only eligible expenses incurred by you and your eligible dependents. "Eligible dependents" are those you claim as your dependents on your federal income tax return. If your returns are audited, you may be required to provide proof of dependency for any claim for a dependent's expenses. However, the Health Care/Limited Use Health Care FSA may reimburse the eligible expenses you pay for your child who has not reached age 27 as of the end of the calendar year, even if that child is not your federal income tax dependent.

> **Example**: Tyler's daughter turns 26 on September 12, 2023, so he may claim the eligible expenses she incurs in 2023. Because his daughter will reach age 27 by the end of 2024, Tyler cannot claim expenses his daughter incurs in 2024.

Your Health Care/Limited Use Health Care FSA Contribution

During the enrollment process, you may establish a Health Care or Limited Use Health Care FSA and indicate the annual amount you would like withheld from your paycheck. This amount is spread evenly among your pay periods and automatically withheld from each paycheck and deposited into your own Health Care or Limited Use Health Care FSA. Your taxable income is reduced by the amount you choose to contribute.

The minimum amount you may contribute is $60 annually. The maximum amount is $3,200 annually. The $3,200 annual limit applies only to the amount you elect to contribute to your Health Care FSA; any carryover amount is **in addition to** your contributions for the plan year. **Note:** Reimbursement of eligible expenses will be made from contributions made for the current plan year first, before using any amounts carried over from the previous plan year.

The annual amount you elect to withhold in one year will **not** carry over from year-to-year; you must elect to contribute each year during the enrollment period.

How the Accounts Work

When you have an eligible expense, you can:

- Use the Automatic Claim Submission option (see **Automatic Claim Submission Option** 222). Under this option, you authorize the Plan to automatically reimburse your account for eligible expenses.
- Use an FSA debit card (see **Health Care/Limited Use Health Care FSA Debit Card** on 222. You automatically receive a debit card when you enroll in a Limited Use Health Care FSA. If you enroll in the standard Health Care FSA, you must elect to receive an FSA debit card, after the plan year begins or you enroll in the plan.
- Pay the bill and submit a claim along with your receipts and supporting documentation to the Claims Administrator, as described in **Filing an FSA Claim** on 230.

Automatic Claim Submission Option

When you enroll in a standard Health Care FSA, you are automatically enrolled in the Automatic Claim Submission option. Under the Automatic Claims Submission option, eligible expenses are automatically reimbursed by your Health Care FSA, if you have no other coverage for the eligible expenses. This process saves you both time and paperwork.

When enrolling in the Health Care FSA Plan, you authorize that claims for eligible expenses be submitted directly to your Health Care FSA for payment by our health plan. When these plans pay claims, they automatically send a claim to your Health Care FSA for your share of the covered expense.

Health Care/Limited Use Health Care FSA Debit Card Option

When you enroll in a Limited Use Health Care FSA, you automatically receive an FSA debit card to pay for eligible dental and vision expenses. The same Limited Use FSA debit card is used to pay for eligible medical and prescription expenses from your Health Savings Account. No action is required on your part to coordinate the payment.

When you enroll in a standard Health Care FSA, you may elect to receive an FSA debit card to pay for eligible medical, prescription drug, dental and vision expenses by going directly to **myuhc.com** or via **NXP.com/benefits**.

You can use your FSA debit card at approved merchants to pay for eligible expenses directly from your Health Care or Limited Health Care FSA.

Each time you use your FSA debit card you agree to the terms and conditions of cardholder agreement, including card usage limitations and the Plan's right to withhold and offset for ineligible claims, etc.

You must call the toll-free number included with your card to activate the FSA debit card. You only need to activate one of your cards. Your FSA debit card has an expiration date. This expiration date is on the front of the cards. You will be issued a new FSA debit card when your current card expires (as long as you continue to participate in a Health Care or Limited Use Health Care FSA. If you change from the Health Care FSA to the Health Savings Account, you keep the same debit card for use.

Using your FSA debit card allows you to access your account immediately with no out-of-pocket costs to you. While most expenses will be automatically approved, you must save your receipts; this is an IRS requirement. You may need to provide copies of these receipts to substantiate expenses as eligible for reimbursement.

If you receive a request from the Claims Administrator to substantiate an expense, you will need to provide the requested documentation in a timely manner. If you do not provide proper documentation, your standard Health Care FSA debit card will be suspended and you will have to pay future eligible expenses out of pocket and submit manual claims for reimbursement to the Claims Administrator. If you have a Limited Use Health Care FSA debit card, all future expenses will be paid from your Health Savings Account.

If you would like to take advantage of an FSA debit card for your Health Care FSA, you must change your reimbursement method to pay with an FSA debit card by going directly to **myuhc.com** or via **NXP.com/benefits** after the year begins. You are only allowed one change per year.

Maternity Care and the Health Care FSA

This information does not apply to the Limited Use Health Care FSA.

Most obstetricians submit a single bill to the Medical Plan for all physician services after the child's birth. In these cases, all the physician charges for maternity care, from prenatal care through delivery and discharge, are considered "incurred" when the child is born.

If you use the Health Care FSA to reimburse your share of covered maternity care expenses, plan your contributions for the calendar year in which you expect the child to be born.

Eligible Health Care FSA Expenses

The IRS sets guidelines for eligible and ineligible Health Care FSA expenses. Following are some of the expenses that may be reimbursed through your Health Care FSA:

- Deductibles, copayments and your share of covered expenses under NXP's or another group health plan;
- Expenses beyond the limits of NXP's or another group health plan;
- Expenses over reasonable and customary charges;

- OTC medications, for example, pain relievers, heartburn and allergy relief medicine;
- Feminine care products, including tampons, pads, liners, cups, sponges and other similar products;
- Any deductible health care expense considered under IRS Code Section 213;
- Chiropractic care;
- Smoking cessation programs and products;
- Pre-existing conditions not covered by a spouse's or dependent's plan;
- Expenses for transportation that is essential to and primarily for covered health care;
- Up to $50 per night per person for lodging that is essential to and primarily for covered health care and that meets IRS rules;
- Laser vision surgery; and
- Orthodontia expenses that exceed the Dental Plan's maximum benefit.

For complete details, contact the NXP Benefits Service Center or online at **NXP.com/benefits**.

Over-the-Counter (OTC) Items

The OTC items allowed for reimbursement are those used for "medical care" as defined by the IRS. The IRS defines medical care as the "diagnosis, cure, mitigation, treatment or prevention of disease or for affecting any structure or function of the body." The types of OTC items included under this definition are those used to alleviate or treat personal injuries or sickness. The Claims Administrator, Fidelity Investments, will determine whether an OTC item falls within the reimbursement definition.

Eligible Limited Use Health Care FSA Expenses

The Limited Use Health Care FSA can only be used for eligible dental and vision expenses. Following are some of the expenses that may be reimbursed through your Limited Use Health Care FSA:

- Deductibles, copayments and your share of covered expenses under NXP's or another group dental and/or vision plan;
- Expenses beyond the limits of NXP's or another group dental and/or vision plan;

- Expenses over reasonable and customary charges under NXP's or another group's dental and/or vision plan;
- Laser vision surgery; and
- Orthodontia expenses that exceed the Dental Plan's maximum benefit.

For complete details, contact the NXP Benefits Service Center or online at **NXP.com/benefits**.

Expenses That Are Not Eligible

Following is a list of expenses that are not eligible for reimbursement from a Health Care or Limited Use Health Care FSA. For complete details, contact the NXP Benefits Service Center.

- Premium payments for other health coverage;
- Health club fees, dietary supplements, weight loss programs (unless prescribed by a physician for a health condition);
- Cosmetic surgery, when not medically necessary to improve a deformity arising from a congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease; and
- Any health care expenses not deductible under IRS Code Section 213.

In addition to the above, medical and prescription drug expenses are not eligible for reimbursement from a Limited Use Health Care FSA.

Excluded OTC Items

The following items are not eligible for reimbursement under a Health Care or Limited Use Health Care FSA unless accompanied by an explanation of medical necessity from an eligible provider under the health plans:

- Cosmetics or beauty products (face cream, moisturizers, make-up, etc.);
- Dietary or nutritional supplements (weight loss supplements, vitamins, etc.);
- General use sundries or personal care items not listed;
- Homeopathic or holistic products;
- Lip balms;
- Lotions;
- Shampoos and soaps;
- Toiletries (perfume, body sprays, deodorants, etc.); and
- Toothpaste, toothbrushes, dental floss.

All claims are subject to review and approval by the Claims Administrator.

COBRA Continuation

After your Health Care/Limited Use Health Care FSA coverage ends (including any extension periods described in this section), you may continue Health Care/Limited Use Health Care FSA coverage under COBRA. To continue coverage under COBRA, you are required to pay your previous contribution amount plus 2%. COBRA contributions can only be paid on an after-tax basis. COBRA coverage allows you to continue to be reimbursed for eligible expenses from your previously accumulated before-tax contributions. When you stop paying your COBRA contributions, your participation ends. You may continue coverage under COBRA only until the end of the calendar year in which the COBRA qualifying event occurred.

Eligible Expense Deadline Without COBRA

If you **do not** choose to continue participation in your Health Care/Limited Use Health Care FSA, you may submit only eligible expenses *incurred on or before the day your Health Care/Limited Use Health Care FSA coverage ended*. You must submit these eligible expenses by March 31 of the year following your termination of coverage.

Dependent Care Flexible Spending Account (DCFSA)

The DCFSA offers tax savings for eligible NXP employees. You may direct before-tax dollars into an account to be used to reimburse yourself for eligible dependent care expenses. These are expenses you pay that allow you to work and, if you are married, allow your spouse to work or attend school full-time. You save money because your taxable income amount is decreased.

To use a DCFSA, you must meet one of the following requirements:

- You are a single parent either working or seeking paid employment;
- You are married and must pay dependent care (including child or elder care centers) expenses so you and your spouse can work or look for work;
- You are married, you work and your spouse is a full-time student for at least five months in a plan year;

- You are married, you work and your spouse is disabled and unable to care for himself/herself and has the same principle residence as you do for more than half the year; or
- You are divorced or legally separated and you have custody of your dependent child for more than half of the year (even if the other parent claims the dependent for tax purposes).

Special Note for Leave of Absence: You may not participate in the DCFSA while on a leave of absence. Your participation and contributions will automatically be stopped as of the first day of your leave of absence. To begin participation again on a pro rata basis when you return to active status, contact the NXP Rewards Center at 888-375-2367 within 30 days of your return to work. You may continue to submit claims for reimbursement through the end of the plan year, but only for services received during the dates of your participation.

Special Tax Considerations

Depending on your income, number of children and the amount of dependent care expenses you incur for each child, it may be more advantageous to take child care credits when calculating income taxes. Refer to IRS Publication 503, *Child and Dependent Care Expenses*, for information on the child care credit. You can calculate your exact child care credit amount by following the instructions on IRS Form 2441. You may want to consult a tax advisor to determine whether a DCFSA or child care credit is the best choice for you.

If you or your spouse participates in a DCFSA program outside NXP or if you are both NXP employees, be certain that your combined DCFSA contributions do not exceed the IRS limit.

> The IRS website at **IRS.gov** has additional resources to show how establishing a DCFSA can help you.

Qualified Dependents

Since a DCFSA is for expenses related to the care of your dependents, certain guidelines exist. A qualified dependent must meet one of the following definitions:

- A child (including a child of your domestic partner) under the age of 13 who qualifies as your dependent under Internal Revenue Code 152 (see **Tax Implications and Information** 6 for details) and for whom you may properly claim an exemption on your income tax; or
- A dependent of any age who is physically or mentally incapable of self-care (including your spouse/domestic partner or parent) who qualifies as your dependent under Internal Revenue Code Section 152 and for whom you may properly claim an exemption on your income tax.

> You may want to consult your tax advisor if you need more information on whether your dependent qualifies based on IRS guidelines.

In addition, except with regard to your spouse who is incapable of self-care, you must also provide more than one-half of the qualified dependent's financial support. If you are divorced or legally separated, your child or stepchild may qualify if you satisfy custody requirements specified by the IRS.

For a disabled dependent to qualify, he or she must regularly spend at least eight hours each day in your home. You are not reimbursed for the care of a dependent in an institution.

Your DCFSA Contribution

During the enrollment process, you may establish a DCFSA and indicate the amount you would like withheld from your paycheck on a before-tax basis. That amount is deducted automatically and deposited into your DCFSA. Your taxable income is reduced by the amount you choose to contribute.

Contributions for highly compensated employees, as defined by the IRS, are subject to special contribution limits. Highly compensated employees are generally those whose annual earnings exceed the IRS threshold in the prior year. For 2024, the IRS threshold is $150,000 earned in 2024. If you are affected, you will be notified and your contribution may be refunded or reduced during the plan year to prevent the DCFSA Plan from becoming discriminatory or violating the Internal Revenue Code.

The minimum amount you may contribute is $120 annually. The maximum you may contribute is the lesser of:

- $5,000 ($2,500 if married but not filing a joint return); or
- Your annual earned income*; or
- Your spouse's earned income (special rules apply if your spouse is a student or handicapped).

* *Annual earned income is your total annual compensation (all compensation paid to you during the year, before any amounts you contribute to the 401(k) Retirement Plan, a Health Care FSA, a DCFSA, medical, dental and vision coverage contributions). This compensation level is reviewed annually by the IRS and is subject to change.*

It is important to note that only claims incurred while you are actively employed are eligible for reimbursement.

The amount you elect to contribute will **not** carry over from year -to -year; you must elect to contribute each year during the enrollment period.

If you and your spouse are both eligible for the DCFSA as NXP employees, the sum of your annual contributions is limited to $5,000.

Eligible DCFSA Expenses

Eligible expenses must be incurred while you are actively employed with NXP.

- Qualified child or elder care center, babysitter, nanny or au pair payments;
- Services performed outside the home for the care of dependents;
- Nursery school fees;
- Registration fees;
- Payments to relatives who provide care (except children under the age of 19 and relatives who are your dependents);
- Theme camps such as sports camp, music camp, computer camp, etc., if the primary purpose is to care for your child while you (and your spouse, if married) work or attend school full time;
- After-school care; and
- Out-of-home care for a disabled adult dependent, provided the dependent resides in your home at least eight hours per day and you claim him or her as a personal exemption on your federal income tax.

For an online version of the IRS publications, visit IRS.gov. Refer to IRS Publication 503, Child and Dependent Care Expenses, for a complete list of covered and non-covered expenses.

Expenses That Are Not Eligible

- Expenses incurred on or after your DCFSA has ended;
- Clothing expenses;
- Education expenses for a child in kindergarten or higher;
- Payments for services at a child care center that does not comply with all applicable laws;
- Expenses for which a dependent care tax credit is taken on your annual tax return;
- Expenses for any overnight camp, regardless of purpose;
- Expenses for housekeeping services, unless such services are for the wellbeing and protection of an eligible dependent;
- Deposit fees;
- Supply fees;
- Lesson fees;
- Expenses related to a dependent in a convalescent nursing home; and
- Expenses incurred while you are on a leave of absence.

Filing an FSA Claim

FSA Debit Cards for Health Care/Limited Use Health Care FSAs

An FSA debit card can be used to pay for eligible expenses, which means you do not need to submit claims for reimbursement. See **Health Care/Limited Use Health Care FSA Debit Card** 222for more information.

You may file a claim with the Plan when you incur an eligible expense (see **Eligible Health Care FSA Expenses** 223 and **Eligible DCFSA Expenses** 229). When you file a claim to request reimbursements from your Health Care/Limited Use Health Care FSA or Dependent Care FSA, you must provide a completed corresponding Claim Form and eligible forms of documentation, such as an itemized receipt or Explanation of Benefits (EOB) from your health plan.

- **Health Care/Limited Use Health Care FSA**: When you submit a Health Care FSA claim, you are reimbursed the eligible expense amount that does not exceed the total annual amount you elected to contribute for the year. This applies even if your claim exceeds the amount contributed as of the date you request reimbursement.
- **DCFSA**: When you submit a Dependent Care FSA claim, you are reimbursed the eligible expense amount that does not exceed the balance on the date the claim is processed. If your claim is for more than the balance in your Plan account, the remainder of your claim will be held and processed when your Plan account is credited with sufficient funds.

To submit a claim, go to **myuhc.com** and:

- Use the online claim form submission; or
- Download a claim form.

All forms, documentation and receipts (if you did not upload when using online submission form) should be mailed or faxed, with a signed cover sheet to:

UnitedHealthcare
P.O. Box 981178
El Paso, TX 79998-1178

Fax: 915-781-1085

What to Remember When Filing Your Health Care/Limited Use Health Care Flexible Spending Account Claim

- If you have other group health coverage, include the Explanation of Benefits (EOB) from the other carrier;
- Provide a copy of the medical or dental EOB, if applicable;
- Provide the date of service or purchase;
- Provide name of service provider or retailer;
- Provide purchase amount for each product or service;
- Provide total purchase amount;
- Submit receipts for proof of payment;
- Provide identification of drug or product or description of service;

- For prescriptions, submit the tab from the prescription or a printout from the pharmacy, showing the name of the drug, the pharmacy, the date the prescription was filled and your share of the cost; and
- For OTC medicines prescribed by a physician, submit the physician's written prescription for the medicine (if required).

NXP cannot accept "balance due" statements as sufficient documentation for payment.

What to Remember When Filing Your Dependent Care FSA Claim

- Write the NXP employee's name and the dependent's name on each bill;
- Provide the date (or range of dates) of service;
- Name of service provider;
- Name of dependent receiving services;
- Description of service; and
- Amount paid.

Unlike the Health Care/Limited Use Health Care FSA, claims payments from your DCFSA are limited to the balance in the account on the date the claim is processed.

Avoid Sending Receipts and Documentation with Provider's Signature

You are required to send UnitedHealthcare itemized receipts or other documentation to prove that your expenses are eligible under the Plan.

However, a simpler alternative is for you to get your dependent care provider to sign the "Provider Certification" section of the claim form. This way, you do not need to send receipts or documentation.

By sending the provider-signed claim, you make the reimbursement process easier for yourself and your provider. To have your dependent care claim processed without receipts, follow these three steps:

- Enter your claim information on the **myuhc.com** website;
- Print the claim form and have your provider sign and date it; and
- Upload the form to the **myuhc.com** website or send a copy by fax or mail (after photographing or scanning it).

NXP reserves the right to adjust FSA elections during the year if there is clear and convincing evidence, as determined by NXP in its sole discretion, that the election was a mistake or made in error and that the adjustment is allowed under applicable IRS rules.

Disability Income Benefits

This section includes information on:

- *Short-term disability* Plan *benefits 239;*
- *Short-term disability buy-up benefits 242;*
- *Long-Term Disability* Plan *benefits 244; and*
- *Provisions that relate to disability benefits 252.*

> See **Participation** 1 for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

The NXP Rewards benefits package includes disability plans that provide benefits for you and your family if you have an illness or injury that prevents you from working. Disability plans are offered to U.S. domestic employees and U.S. Expatriates only.

NXP's Short-Term and Long-Term Disability Plan benefits provide you with income even though you are unable to work. The amount of money you receive for short-term and long-term disability is based on your covered pay as of the last day of work before your disability leave begins. NXP provides Short-Term and Long-Term Disability Plan protection at no cost to you.

You may increase your Short-Term Disability Plan coverage through a **Short-Term Disability Buy-Up Option** 242. This extra protection is available to you if you enroll and pay the premiums through before-tax payroll deductions.

This section summarizes your benefits under the disability plans and provides information on how to take full advantage of the tools available to help build security for you and your family.

Summary of Disability Benefits

The chart below lists the various Plans available to NXP employees. To participate in these Plans, you must meet the eligibility requirements as detailed in **Participation** 1. Some of the Plans require you to enroll for participation and others are automatic.

Disability Income Plans Summary		
If you are unable to work at your occupation	*Short-Term Disability*	*Short-Term Disability with Buy-Up*
What it Is	Provides coverage due to illness, pregnancy or a non-work-related accident that prevents you from working for up to 180 calendar days.	Provides additional benefits during your short-term disability.
Who Is Eligible	You (automatic coverage).	You, if you enroll for coverage.
When Coverage Begins	First of the month on or after 90 days of employment.	First of the month after 90 days of employment.
Time Disabled • First seven calendar days • Next 90 calendar days • Next 90 calendar days	• No benefit • 75% of covered pay (weekly benefit) • 60% of covered pay (weekly benefit)	• No benefit • 90% of covered pay (weekly benefit) • 75% of covered pay (weekly benefit
If you are unable to work at your own occupation for 24 months or any reasonable occupation up to your Social Security normal retirement age	*Long-Term Disability*	
What it Is	Extends disability coverage beyond 180 calendar days.	
Who Is Eligible	You (automatic coverage).	
Time Disabled After 180 calendar days (period covered by Short-Term Disability Plan)	60% of covered pay to $10,000 maximum monthly benefit	

Disability Plan Features

- **Short-Term Disability Plan** benefits pay you a portion of your covered pay for up to 180 calendar days when you are unable to perform the essential duties of your regular job because of pregnancy or because of an illness or injury that is not covered under workers' compensation. NXP provides this protection at no cost to you. If you elect to increase your coverage with **Short-Term Disability Buy-Up** , you pay the cost of that additional coverage.
- **Long-Term Disability Plan** benefits pay you a monthly income benefit after you exhaust your Short-Term Disability benefits if you are considered disabled and eligible for Long-Term Disability Plan benefits. NXP provides this protection at no cost to you.

If You Become Disabled

If you become disabled, you will want to return to your personal and work activities as soon as you are medically able. NXP works with New York Life, whose physicians and registered nurses work in conjunction with NXP to effectively manage disability leaves. These physicians and nurses work with your physician, when necessary, to establish a realistic program and timetable for your return to work as soon as possible.

When Disability Coverage Begins

This example shows important dates for this coverage.

Short-Term Disability – Examples of Important Dates			
Eligible Employee	**When Coverage Begins**	**Example: If you are hired on:**	**Example: Your coverage becomes effective on:**
New Hire Eligibility Requirements Met	First of the month on or after 90 days of employment	January 15	May 1

Dates may vary from those shown above. Dates in above example assume a non-leap year.

Pre-Existing Conditions

- The Short-Term Disability and Short-Term Disability Buy-Up Plans do not include any pre-existing condition provisions.

Your Covered Pay Determines Your Benefits

Your Short-Term and Long-Term Disability Plan benefits are a percentage of your basic annual earnings.

Basic Annual Earnings: Your current annualized salary, including lump sum merit, sales incentives and shift differentials looking back on the preceding 12 months (or to date of hire, if shorter) from the first of the pay-date month, as determined by the Company, excluding overtime and other extra pay.

Your annual covered pay is then divided by 26 to determine your biweekly rate of pay for Short-Term Disability Plan benefits and by 12 to determine your monthly rate of pay for Long-Term Disability Plan benefits. If you worked for NXP for less than one year when you become disabled, your covered pay is calculated using figures from your actual period of employment.

The following components of compensation are based on your employee status:

- **Base Salary for Non-Exempt Employees:** Your annual base salary means your annualized base rate of pay.
- **Base Salary for Exempt Employees:** Your annual base salary means your annualized base salary only.
- **Shift Differential:** Any shift premiums you earn are included in determining your benefit. Shift differentials looking back on the preceding 12 months (or to date of hire, if shorter) from the first of the pay-date month.
- **Lump Sum Merit:** If you receive a lump sum merit award instead of an increase to your base salary, your covered pay for disability benefits includes your lump sum merit award.
- **Sales Incentive Plan Employees:** Your coverage includes your current year's earnings plus your prior year's Sales Incentive Plan payments.

- **If You Work Less Than 35 Hours Per Week**: Your coverage is figured at the beginning of each calendar quarter by calculating your highest annualized calendar quarter salary of the previous four quarters. You must work a full calendar quarter before this method applies. If you are a new employee, your coverage is figured according to annualized pay earned during your first 30 days of employment.

Example: Karen, an exempt sales representative, has a monthly covered pay of $2,500. Additionally, in the past year she earned an average sales incentive plan payment of $250 per month. Her covered pay for calculating disability benefits is $2,750 per month.

Short-Term Disability Benefits

When you have been considered disabled for eight calendar days under the Short-Term Disability Plan, you may begin receiving the plan's biweekly benefits. Any disability benefit payable for a period of less than one week is paid on the basis of 1/7 of the weekly benefit for each day you are disabled.

- For the first seven calendar days, no benefit;
- For the next 90 calendar days, your Short-Term Disability Plan benefit is 75% of your covered pay; and
- For the next 90 calendar days, your Short-Term Disability Plan benefit is 60% of your covered pay.

Your Short-Term Disability Plan benefit may be reduced; see **Integration of Benefits** for details.

You are considered disabled under the Short-Term Disability Plan when an illness or injury leaves you continuously unable to perform the essential duties of your regular job in substantially the same manner as you did before incurring your medically determined physical or mental impairment. "Substantially the same manner" takes into account any adjustments that NXP makes to those responsibilities. If you undergo a cesarean section delivery, you are considered disabled for eight weeks following the procedure. After eight weeks, your condition will be treated the same as any other pregnancy-related condition.

When you are considered disabled, you qualify to receive Short-Term Disability Plan benefits only if you are:

- Under the regular care of a physician;
- Unable to perform the regular duties of your job;
- Earning 80% or less of your covered pay solely because of an illness, injury or a disabling pregnancy-related condition; and
- Providing New York Life with documentation from your physician certifying your disability.

You must notify New York Life before engaging in any employment while you are receiving Short-Term Disability Plan benefits.

If You Have Other Income or Disability Benefits

New York Life may require you to provide proof of any income you receive from work while you are disabled. You may also be required to show proof of applying for or receiving any other income benefits that you or your family member or dependent may be eligible to receive due to your disability (such as from Social Security or workers' compensation), as well as proof of an appeal if those benefits are denied. You may not waive any other income benefit without New York Life's consent.

If you do not provide proof required by New York Life, your Short-Term Disability Plan benefits may be suspended or adjusted by the estimated amount of those income benefits.

New York Life requires proof of any other income.

New York Life may require proof:

- That you, your spouse, child or dependent has applied for all other income benefits that you or they are eligible to receive because of your disability and has made a timely appeal of any denial of benefits through the highest administrative level. "Timely appeal" means making the appeal in the time required, but never more than 60 days after the latest denial;
- That the person applying for other income benefits has provided the necessary proof needed for other income benefits, which include, but is not limited to workers' compensation benefits;
- That the person has not waived (given up his or her right to) any other income benefits without New York Life's written consent;
- That the person has sent New York Life copies of documents showing the effective dates and amounts of other income benefits; and
- Of income you receive from any work or pay for profit.

You do not have to apply for:

- Retirement benefits paid only on a reduced basis; or
- Disability benefits under a group life insurance plan, if the disability benefits would reduce your group life insurance amount.

However, if you apply for and receive these benefits, they will be considered as other income benefits and you must provide proof to New York Life, if requested.

If you do not provide the proof that New York Life may require, New York Life has the right to suspend or adjust the Plan's benefits by the estimated amount of the other income benefits.

When Short-Term Disability Benefits End

As long as you are considered disabled and meet the requirements above, your Short-Term Disability Plan benefits continue until the first of these events occurs:

- You have received benefits for 180 calendar days;
- You are no longer considered disabled under the Short-Term Disability Plan;
- You do not provide proof to New York Life that you meet the Short-Term Disability Plan test of disability;
- You do not notify New York Life that you are engaging in employment;
- You are convicted of a felony;
- You do not provide satisfactory evidence of your continuing disability;
- You refuse to be examined or do not cooperate with a request for an examination;
- You do not cooperate with a physician's recommendation for care and treatment;
- The date you refuse to cooperate with or accept changes to your work site or job process designed to suit identified medical limitations or any adaptive equipment or devices designed to suit your identified medical limitations; that would allow you to perform the duties of your regular job (this applies only if a physician agrees that such changes, adaptive equipment or devices suit your particular medical limitation);
- The date you refuse to participate in an approved rehabilitation plan, which may be recommended by NXP, the NXP nurse case manager and/or New York Life;
- The date of your death; or
- The date your condition would allow you to work, increase the hours you work or increase the duties you perform in your regular job, but you refuse to do so.

If you are incarcerated because of your conviction or plea of guilty or no contest to a crime other than a felony, New York Life may suspend your benefits during your period of incarceration.

Short-Term Disability Buy-Up

The Short-Term Disability Buy-Up option allows you to effectively increase your Short-Term Disability Plan benefit. The Short-Term Disability Buy-Up benefit is 15% of your covered pay, and it is paid in addition to the Short-Term Disability Plan benefits you receive biweekly.

When you choose this coverage, here is how you receive benefits for a short-term disability:

- For the first 90 calendar days, your Short-Term Disability and Buy-Up benefits total 90% of your covered pay; and
- For the next 90 calendar days, your Short-Term Disability and Buy-Up benefits total 75% of your covered pay.

All rules governing Short-Term Disability Plan benefits apply to the Short-Term Disability Buy-Up. This means that your Buy-Up benefit is paid only when your Short-Term Disability Plan benefit is paid. If your Short-Term Disability Plan benefit ends, is suspended, or not payable, the same will apply to your Buy-Up benefit.

Leave of Absence

If you are on a leave of absence, you may enroll in Short-Term Disability Buy-Up during annual enrollment. Assuming you are actively at work on the following January 1, your contributions will begin on that date. The period of January 1 – March 31 is your 90-day waiting period, meaning you are not eligible to receive benefits until April 1. But if you are still on leave of absence on that day, your enrollment is retroactively voided for the plan year and you may not enroll again until the next annual enrollment period.

This chart shows these concepts.

Short-Term Disability Buy-Up – Examples of Important Dates				
Eligible Employee	**Enrollment Date**	**When Coverage Begins**	**When Contributions Begin**	**Waiting Period**
New Hire Date: January 16	Within 30 days of hire date	May 1	May 1	None
New Hire Date: September 16	Within 30 days of hire date	January 1 of the following year	January 1 of the following year	None

Short-Term Disability Buy-Up – Examples of Important Dates				
Eligible Employee	**Enrollment Date**	**When Coverage Begins**	**When Contributions Begin**	**Waiting Period**
Active Employee	Annual Enrollment	January 1	January 1	January 1 – March 31*
Employee on Leave of Absence	Annual Enrollment	If actively at work: January 1	January 1	January 1 – March 31*
Employee on Leave of Absence	Annual Enrollment	If on leave of absence on January 1, enrollment is retroactively voided	Not applicable	Not applicable

* *Approximate 90-day period*

Dates may vary from those shown above. Dates in above example assume a non-leap year.

You may not cancel your coverage at any time during a calendar year in which your coverage is in force. All other rules that govern the beginning and ending of Short-Term Disability Plan benefits also apply to the Short-Term Disability Buy-Up; see **When Short-Term Disability Benefits End**..

Long-Term Disability Benefits

If you are eligible, Long-Term Disability Plan benefits begin when your Short-Term Disability Plan benefits end. If after receiving Short-Term Disability Plan benefits for 180 days you are considered disabled under the Long-Term Disability Plan, you may begin receiving the Plan's monthly benefits. Your Long-Term Disability Plan benefit is 60% of your covered pay, to a maximum benefit of $15,000 a month. Any disability benefit payable for a period of less than one month is paid on the basis of 1/30 of the monthly benefit for each day you are disabled. However, the minimum payment the Long-Term Disability Plan will make is $100.

> If the full 180-day Short-Term Disability Plan benefit is not paid for an illness or injury, no Long-Term Disability Plan benefit will be paid for that same illness or injury.
>
> Long-Term Disability is a benefit plan and is not job protected leave. Upon transitioning to long-term disability, employees are provided with a 90-day grace period to return to work. If you are unable to return to work at 90-days post the effective date of your long-term disability, your employment will be subject to termination.

Your Long-Term Disability benefits will not cover a pre-existing condition. You have a pre-existing condition if both of the following are true:

- You received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicines or followed treatment recommendation in the three months just before your effective date of coverage or the date an increase in benefits would otherwise be available; and
- Your disability begins within 12 months of the date your coverage under the plan becomes effective.

Your Long-Term Disability Plan benefit may be reduced; see **Integration of Benefits** for details.

Long-term disability, for the Long-Term Disability Plan, is defined as your ongoing, continuous inability, by reason of a medically determined physical or mental impairment, to work in your *own* or *any* reasonable occupation. For you to remain eligible to receive disability income replacement, you must:

- Be under the regular care of a physician (you will be considered under the care of a physician up to 31 days before you have been seen and treated in person by a physician for the illness, injury or pregnancy-related condition that caused the disability);
- Be unable to engage in your *own* occupation (for the first 24 months) or *any* reasonable occupation (after the first 24 months);
- Have earnings 80% or less of your covered pay during the *own* occupation period (the first 24 months) or 60% or less of your covered pay during the *any* reasonable occupation period;
- Be covered by the Long-Term Disability Plan at the time you became disabled;
- Provide New York Life with documentation from your physician certifying your continuing disability; and
- Provide documentation from the Social Security Administration as the Long-Term Disability Plan requires.

You must notify New York Life before engaging in any employment while you are receiving Long-Term Disability Plan benefits.

The loss of a professional or occupational license or certification that is required by your regular job does not mean you meet the test of disability. You must meet the above requirements to be considered disabled.

Own Occupation and Any Reasonable Occupation

Your own or any reasonable occupation means employment that would afford you earnings potential (which may be determined, in New York Life's discretion, based on evidence of labor market conditions) that equals or exceeds your Long-Term Disability or Short-Term Disability Plan benefits.

Definitions

- **Own Occupation:** The occupation that you are routinely performing when your disability period begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed for your specific employer or at your location or worksite, and without required to your specific reporting relationship.
- **Any Reasonable Occupation:** This is any gainful activity for which you are, or may reasonably become, fitted by education, training or experience that results in, or can be expected to result in, an income of more than 60% of your adjusted pre-disability earnings.

Example: Taylor is eligible for disability benefits, which are paid as follows:

March 27, 2023: First day of disability.
March 27 – April 2, 2023: Seven-day Short-Term Disability Plan elimination period (before benefits begin).
April 3 – September 29, 2023: Period when Short-Term Disability Plan benefits are paid.
September 30, 2023 – October 1, 2025: Long-Term Disability Plan 24-month own occupation benefits period when Long-Term Disability Plan benefits are paid.
October 2, 2025: Long-Term Disability Plan any occupation benefits period begins.

Physician Care Requirements

Your physician or, in certain circumstances, your psychologist or certified addictionologist, must be qualified to treat your disabling condition.

When Long-Term Disability Benefits End

As long as you are considered disabled and meet the requirements above, your Long-Term Disability Plan benefits continue until the first of these events occurs:

- You are no longer considered disabled under the Long-Term Disability Plan;
- The later of the calendar month in which you reach your Social Security normal retirement age or when you reach the maximum benefit period.

– Your Social Security normal retirement age is your full retirement age under Social Security (65 to 67, depending on your year of birth), as shown in this chart:

Year of Birth	Full Social Security Retirement Age
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 – 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

– The maximum benefit period is as follows:

If your age when your disability begins is:	Your maximum benefit period is:
62 or younger	Until your 65th birthday or, if later, the date the 42nd monthly payment is made
63	The date the 36th monthly payment is made
64	The date the 30th monthly payment is made
65	The date the 24th monthly payment is made

66	The date the 21st monthly payment is made
67	The date the 18th monthly payment is made
68	The date the 15th monthly payment is made
60 or older	The date the 12th monthly payment is made

- You fail to meet the Social Security filing requirement applicable to you;
- You commit or attempt to commit fraudulent activity against the Long-Term Disability Plan, NXP or any related company;
- You do not provide proof to New York Life that you meet the Long-Term Disability Plan test of disability, including work or your being able to work at your *own* occupation (for the first 24 months) or *any* reasonable occupation (after the first 24 months) (when required);
- You do not notify New York Life that you are engaging in employment;
- You engage in a felony;
- You do not provide satisfactory evidence of your continuing disability;
- You do not cooperate with a request for an examination or the independent medical examination report or functional capacity evaluation does not, according to New York Life, confirm that you are disabled;
- The date you are not receiving effective treatment for substance use disorder, if your disability is caused (in whole or in part) by alcoholism or drug abuse;
- You do not cooperate with a physician's recommendation for care and treatment or you are no longer under the regular care of a physician;
- The date you refuse or cooperate with or accept changes to your work site or job process designed to suit your identified medical limitations; or adaptive equipment or devices designed to suit your identified medical limitations that would allow you to work at your *own* occupation (for the first 24 months) or *any* reasonable occupation (after the first 24 months) provided that a physician agrees that such changes, adaptive devices or equipment suit your particular limitation;

- The date your condition would allow you to work, increase the hours you work or increase the number or type of duties you perform at your *own* occupation (for the first 24 months) or *any* reasonable occupation (after the first 24 months), but you refuse to do so;
- 90 days after New York Life requests repayment from you or your covered dependent of amounts subject to reimbursement, overpayments or mistaken payments from any NXP welfare plan, if you do not repay or set up an acceptable repayment schedule;
- You die; or
- The day the Long-Term Disability Plan ends or the effective date of an amendment eliminating this coverage.

If you are incarcerated because of your conviction or plea of guilty or no contest to a crime other than a felony, New York Life may suspend your benefits during your period of incarceration.

If You Have a Mental, Nervous, Alcohol or Drug-Related Condition

If your disability is caused primarily by a mental, nervous, alcohol- or drug-related condition, there is a maximum lifetime cap of up to 24 months of Long-Term Disability Plan benefits. These disabilities require the certification of a psychiatrist or physician certified in addictive disorders if they continue for more than 30 days.

Mental, nervous, alcohol- and drug-related conditions subject to the 24-month limitation may include, but are not limited to, the following:

- Alcohol-/substance-related disorders;
- Schizophrenia and other psychotic disorders;
- Mood/depressive disorders; or
- Anxiety disorders.

If You Are a U.S. Expatriate or U.S. Inpatriate

Long-Term Disability Benefits in the U.S.

If you return to the United States before your termination of employment under NXP's Human Resources Leave Policies and if you remain disabled and eligible for Long-Term Disability Plan benefits, you will receive benefits up to the calendar month when you reach your **Social Security full retirement age** if the disability occurs before age 60. If your disability starts at age 60 or older, you are eligible to receive benefits until the later of the calendar month in which you reach your Social Security normal retirement age or when you reach the maximum benefit period, (including the 180 days you received Short-Term Disability Plan benefits). There are exceptions to this length of coverage if your disability is primarily caused by a mental, nervous, alcohol- or drug-related condition (see above).

Long-Term Disability Benefits Abroad

If you remain disabled and eligible for Long-Term Disability Plan benefits and remain abroad, your Long-Term Disability Plan benefits end on the last day of the month in which your employment terminates under NXP's Human Resources Leave Policies.

Filing for Social Security Disability

If your disability continues beyond five months, you may also qualify for Social Security disability benefits. If New York Life determines that you may be eligible for Social Security disability benefits, New York Life will assist you in applying for this benefit.

If you continue to be disabled beyond 180 days of long-term disability, you must provide evidence to New York Life that you have filed for Social Security disability benefits. You are required to exhaust all levels of application and appeal for Social Security benefits. New York Life will help you through this process.

Proof of filing for a Social Security disability award is required no later than the first anniversary of your disability. If you do not file for Social Security disability benefits within one year after becoming disabled, your Long-Term Disability Plan benefits may be terminated. Documentation of a Social Security disability proof of filing, award or denial of Social Security disability benefits must be received by New York Life no later than 90 days after the first anniversary of your disability.

If, at any time, New York Life has a good-faith belief that you are receiving Social Security disability benefits at the same time as you are receiving Long-Term Disability Plan benefits, it may request documentation of your Social Security status. You need to provide the required documentation within 90 days of New York Life's request.

Check with your Social Security Office for more information on filing for Social Security disability benefits. Or go to **SocialSecurity.gov**.

Filing a Claim – Notifying NXP of Your Disability

As soon as you know that you are, or will be, physically unable to work for at least seven calendar days, you must:

- Contact your local Occupational Health nurse first; and
- Call the Claims Administrator (New York Life) at 888-842-4462.

> You must apply for disability benefits within 45 days from the onset of your illness or injury.

Your call initiates the disability process:

- The Claims Administrator needs information about you, your physician and your medical condition. Also, you are asked about the work you do, your location and your supervisor's name.
- The Claims Administrator contacts your physician for detailed clinical information and to jointly reach a conclusion as to the expected outcome of your prognosis and expected return-to-work date. A date is established for your anticipated return to work. When appropriate, you may be eligible to return to work initially on a reduced schedule or in a less physically demanding role.
- The Claims Administrator makes the final decision to approve or deny disability benefits. If the Claims Administrator and your physician cannot reach a joint conclusion as to the expected prognosis of your case and establish when you should return to work, the Claims Administrator's conclusion will govern.

> If you know in advance that you will need Short-Term Disability Plan benefits, such as for childbirth or planned surgery, you can contact the Claims Administrator for approval of disability benefits. Contact the Claims Administrator, your department manager or supervisor and Occupational Health Resources to report which day will be your last day of work.

- The Claims Administrator communicates the decision, along with supporting documentation, to you and your local Occupational Health nurse. If communication with your Human Resources representative is necessary, it does not include your confidential medical information.

- Once approved for disability benefits, you must submit proof of your disability on a regular basis (usually every 30 days) that is consistent with your disability and related care and treatment. NXP has the right to have a physician of its choice examine you (at NXP's expense) during the time of your disability. If you do not cooperate with the physician's recommendation for treatment, your disability benefits will cease.
- During the disability period, a claims or case representative stays in contact with you and your physician. You may be contacted before your anticipated return-to-work date to make sure you are able to return to work. If you are unable to return to work at that time, a representative contacts your physician for additional information and, if you are still disabled, jointly establish a new date when you will return to work.

Taxes and Disability Benefits

Short-Term Disability and Long-Term Disability Plan benefits are taxable income. Applicable tax withholdings are taken from your disability payments. Short-Term Buy-Up benefits are not taxable income since contributions are made on an after-tax basis.

Integration of Benefits

Your disability benefits from NXP are coordinated with certain other payments for which you are eligible. For example, your benefit from the Short-Term and/or Long-Term Disability Plan is reduced by:

- Any payment for which you are eligible under Social Security, including primary disability or old age, widow(er) or dependent awards;
- Any payment made pursuant to occupational disease act or law or any state compulsory disability benefit law;
- Disability or other income benefits from NXP for the same period as the Plan's payment (except benefits under the 401(k) Retirement Plan);
- Any award given under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure;
- Disability, retirement or unemployment benefits required or provided for by government law. This includes (but is not limited to):

– Unemployment compensation benefits;

- Temporary or permanent, partial or total, disability benefits under any workers' compensation law or similar law meant to compensate a worker for:
- Loss of past and future wages;
- Impaired earning capacity;
- Lessened ability to compete for jobs;
- Any permanent impairment; and
- Any loss of bodily function or capacity.

- Benefits under the Federal Social Security Act, Railroad Retirement Act, Canada Pension Plan and Quebec Pension Plan;
- Disability or unemployment benefits payable by either insured and uninsured plans due to employment by or association with your employer or due to your membership in, or association with, any group, association, union or other organization (both insured and uninsured plans);
- Unreduced retirement benefits for which you are (or may become) eligible under a group pension plan at age 62 or the Plan's normal retirement age, whichever comes later, but only to the benefit amount that was paid by the employer;
- Retirement benefits you elect and receive under any group pension plan, but only to the benefit amount that was paid by an employer;
- Disability payments from Under-Insured Motorist (UIM) coverage, uninsured motorist coverage (UM), liability insurance or other sources for a disability caused by a third party (other sources include, but are not limited to, damages or a settlement received through legal action); and
- Disability benefits from an accumulated sick time or salary continuation program, provided they are part of an established group plan maintained by NXP for the benefit of its employees.

Other Income Benefits That Do Not Reduce Benefits

Income from certain sources will not reduce your weekly disability benefits under the Plan. Your benefits under Short-Term Disability Plan coverage will not be reduced by the benefit amounts you were receiving from the following sources, before you became disabled:

- Military and other government service pensions;
- Retirement benefits from a former employer;
- Veteran's benefits for service-related disabilities;

- Individual disability income policies; or
- Retirement benefits from the Federal Social Security Act.

The amount of income or other benefits from the following sources will not reduce your Short-Term Disability Plan benefits:

- Profit sharing plans;
- Thrift or savings plans;
- 401(k) plans;
- Keogh plans;
- Employee stock options plans;
- 403(b) Tax-sheltered annuity plans;
- 457 deferred compensation plans;
- Tax-sheltered annuity plans;
- Individual disability income policies; or
- Individual Retirement Accounts (IRAs).

Other Reductions

Your disability benefits may be reduced as required by a court order, such as a child support order or a garnishment order. Court orders will be recognized if they comply with applicable state law and are not preempted by ERISA.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the coverage(s) described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your group insurance certificate. New York Life has a website that describes these state-specific requirements. You may access the website at **mynylgbs.com**.

What's Not Covered

Your plan does not cover any disabilities caused by, contributed to, by or resulting from your:

- Intentionally self-inflicted injuries;

- Active participation in a riot; or
- Commission of a crime for which you have been convicted under state or federal law.

The Long-Term Disability Plan does not cover a disability or for long-term and short-term disability, due to war, declared or undeclared, or any act of war.

The Short-Term and/or Long-Term Disability Plan does not pay physician or other service provider charges for completion of forms, missed appointments, telephone consultations or examinations (unless the examination is ordered by the Claims Administrator) or for copying and sending your records, including charges for telephone calls. However, New York Life will pay for the cost of medical records when charged by the physician; payment will be made directly to the physician.

Benefits are paid only while you are under the regular care and treatment of a physician. A confirmation from your physician is required for continuation of benefit payments.

If Your Accident or Illness Is Work-Related

If NXP's Workers' Compensation Administrator (or the carrier or appropriate government authority) deems your claim for an injury or illness to be payable under workers' compensation, benefits under the Short-Term are denied and you receive payments from workers' compensation instead. Once a claim for an injury or illness is deemed payable under workers' compensation, that injury or illness is not eligible for any future payments from the Short-Term Plan.

Under the Long-Term Disability Plan, if your claim benefits for an injury or illness is deemed to be payable under workers' compensation, the amount of any workers compensation benefits paid will be deducted from the amount of your LTD benefits.

Recurring Disability

Disability benefits are available more than once during your career with NXP. There is a maximum of 180 calendar days for any one short-term disability period. In most cases, all days you are unable to work because of the same (or a related) cause are considered one "period of disability." If within 30 days after you return to work you have a second period of disability due to the same (or related) cause, this will be considered part of your first period of disability. But:

- If you return to work from a short-term disability for more than 30 days, any later disability will be considered a new period of disability; or
- If you receive Long-Term Disability Plan benefits, return to work and become disabled again within six consecutive months due to the same (or related) cause, your second period of absence will be considered a continuation of your original disability.

Physician's Statement

Benefits are paid only while you are under the regular care and treatment of a physician. A confirmation from your physician is required before benefits start and periodically to confirm your continuing disability. In the Claims Administrator's discretion, a confirmation from a physician of the Claims Administrator's choice may be required for continuation of benefit payments.

Continuation and Conversion Rights

Continuation and conversion rights do not apply to the Short-Term (including Buy-Up option) or Long-Term Disability Plan.

Life, Accidental Death and Dismemberment and Business Travel Accident Benefits

This section includes information on various life and accidental death and dismemberment benefit features, including:

- **Basic life** insurance ;
- **Supplemental life** insurance ;
- Life insurance for **spouses/domestic partners and children** ;
- **Accidental Death and Dismemberment (AD&D)** insurance ; and
- **Business Travel Accident (BTA)** insurance .

See **Participation** 1 for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

The comprehensive NXP Rewards benefits package also includes Life and Accidental Death and Dismemberment (AD&D) Plans that provide benefits for you and your family if you and or a covered family member dies. Coverage is automatic in some cases and optional in others. To participate in these Plans, you must meet the eligibility requirements as detailed in **Participation**. .

This section summarizes your benefits under the Life and Accidental Death and Dismemberment Plans and it provides information on how to take full advantage of the tools available to help build security for you and your family. Refer to this information regularly as your source for building security against what life may bring.

Summary of Life and Accidental Death and Dismemberment Benefits

NXP provides various means to help ensure your family's security. Life insurance benefits are available to help survivors in the event of a death and accidental death and dismemberment benefits are available to help you when you are seriously injured.

The chart below lists the various Plans available to NXP employees. To participate in these Plans, you must meet the eligibility requirements as detailed in **Participation** 1. Some of the Plans require you to enroll for participation and others are automatic.

Life and Accidental Death and Dismemberment Benefits Summary			
Plan	*What It Is*	*Who's Eligible*	*Benefit Amount*
Basic Life Insurance (no cost to you)	Provides a benefit to your survivors if you die.	You (automatic coverage)	• A flat amount of $50,000 or two times your **basic annual earnings** rounded to next higher $100 • **Maximum Benefit:** $1,000,000
Supplemental Life Insurance	Life insurance available in addition to Basic Life Insurance.	You, if you enroll for coverage	• One to eight times your **basic annual earnings** rounded to next higher $100 • **Maximum Benefit:** $1,500,000 • **Non-Medical Issue Amount:** The lesser of three times your **basic annual earnings** or $500,000

Life and Accidental Death and Dismemberment Benefits Summary			
Plan	*What It Is*	*Who's Eligible*	*Benefit Amount*
Spouse/Domestic Partner Life Insurance	Life insurance for your spouse/domestic partner.	Your spouse/domestic partner	• $25,000 • $50,000 • $100,000 • $150,000 • $200,000 • $250,000 • **Maximum Benefit:** The lesser of $250,000 or the level of your combined basic and supplemental life coverage • **Non-Medical Issue Amount:** $25,000
Child(ren) Life Insurance	Life insurance for your child(ren).	All your dependent child(ren)	• $15,000 • $25,000
Accidental Death and Dismemberment Insurance (no cost to you)	Extra protection for you or your survivors if you should die or become disabled due to an accident.	You (automatic coverage)	• A flat amount of $50,000 or two times basic annual earnings rounded to the next higher $100 • **Maximum Benefit:** $1,000,000 • Full amount paid for accidental death • A percentage of benefit paid for accidental injury resulting in a covered loss, depending on extent of injury

Life and Accidental Death and Dismemberment Benefits Summary			
Plan	*What It Is*	*Who's Eligible*	*Benefit Amount*
Business Travel Accident Insurance (no cost to you)	Protection for you or your survivors if something happens while you are traveling on NXP business.	You (automatic coverage)	• Three times **basic annual earnings**, rounded to the next higher $100 • **Minimum Benefit:** $50,000 • **Maximum Benefit:** $1,000,000 • 100% of benefit paid for death while traveling on business for NXP • A percentage of benefit paid for accidental injury resulting in a covered loss while traveling on business for NXP, depending on extent of injury

Your Compensation Determines Your Coverage

Basic annual earnings for Life, Accidental Death and Dismemberment and Business Travel Accident insurance benefits include your annual base salary, prior year Sales Incentive Plan payments, prior quarter shift differential annualized and lump sum merit. As your compensation goes up, so does your protection. When your compensation changes, your coverage for Basic Life, Supplemental Life, Accidental Death and Dismemberment and Business Travel Accident insurance will be adjusted per the policy. Basic annual earnings do not include overtime, incentive pay, bonuses, moving allowances, educational allowances, noncash payments or overseas allowances.

Your basic annual earnings are rounded to the next higher $100. The following components of compensation are calculated according to your employee status:

- **Non-Exempt Employees:** Your annual base salary means your annualized base rate of pay.

- **Exempt Employees:** Your annual base salary means your annualized base salary only.
- **Shift Differential:** Shift differentials looking back on the preceding 12 months (or to date-of-hire, if shorter) from the first of the pay-date month.
- **Lump Sum Merit:** If you receive a lump sum merit award in lieu of an increase to your base salary, **basic annual earnings** includes your lump sum merit award.
- **Sales Incentive Plan Employees:** Your coverage includes your current year's earnings plus prior year's Sales Incentive Plan payments.
- **If You Work Less Than 40 Hours Per Week:** Your coverage is figured at the beginning of each calendar quarter by calculating your highest annualized calendar quarter salary of the previous four quarters. You must work a full calendar quarter before this method applies.

If Your Salary Decreases

Because the amount of your Basic Life, Supplemental Life, Accidental Death and Dismemberment and Business Travel Accident Insurance depends on your salary, the amount decreases if your **basic annual earnings** decreases.

Naming Your Beneficiaries

Life Insurance

It is important for you to name beneficiaries for your Basic Life and Supplemental Life Insurance. You can name one or more primary beneficiaries and one or more contingent beneficiaries and you may name different beneficiaries for each type of coverage.

To change a primary or contingent beneficiary, you can designate them online at **NXP.com/benefits** or you can call the NXP Benefits Service Center at 888-375-2367.

No other type of agreement or document (such as a will or divorce settlement agreement) may be used to change your beneficiary. However, MetLife will recognize a valid Qualified Domestic Relations Order (QDRO) that assigns your benefits. If you do not designate a beneficiary, then the Plan will pay your benefits according to the Life Insurance Policy. This policy provides that if you do not designate a beneficiary, benefits are paid to the first of the following beneficiary classes in which there is a surviving person:

- Your lawful spouse or domestic partner;
- Your children (by birth or adoption);
- Your parents;
- Your siblings; or
- Your estate.

The beneficiary you designate will also receive any death benefit from your Accidental Death and Dismemberment Insurance.

Spouse/Domestic Partner and Child(ren) Life Insurance Beneficiaries

You are the beneficiary of both Spouse/Domestic Partner and Child(ren) Life Insurance covering your family. You receive any benefit payable due to the death of a covered dependent (i.e., spouse/domestic partner and/or child).

Business Travel Accident (BTA) Beneficiaries

It is important for you to name beneficiaries for your BTA Insurance. You can name one or more primary beneficiaries and one or more contingent beneficiaries.

To change a primary or contingent beneficiary, you can designate them online at **NXP.com/benefits** or you can call the NXP Benefits Service Center at 888-375-2367.

No other type of agreement or document (such as a will or divorce settlement agreement) may be used to change your beneficiary. However, MetLife will recognize a valid Qualified Domestic Relations Order that assigns your benefits. If you do not designate a beneficiary, then the Plan will pay your benefits according to the BTA Policy. This policy provides that if you do not designate a beneficiary, benefits will be paid to the first of the following beneficiary classes in which there is a surviving person:

- Your lawful spouse;
- Your children (by birth or adoption);

- Your parents;
- Your siblings; or
- Your estate.

How the Benefit Is Paid

If you die while you are covered by Basic Life, Supplemental Life, Accidental Death and Dismemberment or Business Travel Accident Insurance, the total benefit is paid to your designated beneficiary or beneficiaries. Benefits will be paid in a lump sum or in another mutually agreed form. Your beneficiary or beneficiaries can get more information from the NXP Benefits Team regarding the form in which they may receive benefits.

> A primary beneficiary is a person, trust or estate designated to receive the benefit under your insurance plan.
>
> A contingent beneficiary is designated to receive the benefit if no primary beneficiary is living at the time the benefit becomes payable.

Tax Alert

Company-paid life insurance is tax-free if your coverage does not exceed $50,000. If your Basic Life Insurance coverage exceeds $50,000, the cost of the excess coverage will be imputed and included in your gross income. If enrolled, the cost of your Supplemental and Spouse/Domestic Partner Life Insurance coverage, less your after-tax contributions, will also be included. For this purpose, the cost is computed using a uniform premium table published by the IRS. The taxable amount, if any, is reported to you on your Form W-2 ("C" in Box 12) and on your paycheck ("Group Term Life").

Talk to your accountant or financial advisor for more information regarding taxation of life insurance coverage.

Information for Survivors Filing a Claim

If a covered person dies, the NXP Benefits Service Center provides assistance to survivors. The beneficiary or personal representative should call 888-375-2367 to start the claims process.

Basic Life Insurance

Basic Life Insurance is the foundation of your survivor income benefits. As an eligible NXP employee, you are provided Basic Life Insurance coverage at no cost to you. You are covered under Basic Life Insurance on the first day you are actively at work or on the day you first meet the eligibility requirements for plan participation.

Basic Life Insurance coverage is equal to two times your **basic annual earnings** rounded to the next higher $100. The maximum Basic Life Insurance benefit is $1,000,000.

You do not have to complete any enrollment forms to participate in Basic Life Insurance. However, you must designate a beneficiary as explained in **Naming Your Beneficiaries**

Supplemental Life Insurance

Because everyone's needs are different, you can add more life insurance protection by electing Supplemental Life Insurance. This coverage is in addition to your Basic Life Insurance.

Supplemental Life Insurance Coverage Options

There are eight Supplemental Life Insurance coverage options, from one to eight times your **basic annual earnings**. Supplemental Life Insurance coverage is limited to $1,500,000.

> **Example**: Marcus would like to have additional life insurance benefits paid to his family if he dies. His annual salary is $35,350.
>
> **Marcus's Basic Life Insurance**
> (his basic annual earnings, rounded to the next higher $100) $35,400
> *Plus*
> He chooses the **Two Times Basic Annual Earnings** coverage option
> ($35,350 x 2, rounded to the next higher $100) + $70,800
> *Equals*
> Total Life Insurance Coverage paid if Marcus dies = $106,200

Supplemental Life Insurance Exclusions

If you commit suicide within two years from the date your coverage takes effect, the Supplemental Life Insurance benefit will not be paid. If you commit suicide within two years from the date an increase in your coverage takes effect, the Supplemental Life Insurance benefit in effect on the day before the increase will be paid.

Spouse/Domestic Partner Life Insurance and Child(ren) Life Insurance

You can enroll for Spouse/Domestic Partner Life Insurance for your spouse/domestic partner. You can also enroll for Child(ren) Life Insurance for your eligible children. See **Spouse/Domestic Partner and Child(ren) Life Insurance Eligibility** for the definition of an "eligible child" for life insurance.

Spouse/Domestic Partner Life Insurance Coverage Options

You have six different Spouse/Domestic Partner Life Insurance coverage options from which to choose:

- $25,000;
- $50,000;
- $100,000;
- $150,000;
- $200,000; or
- $250,000.

> The amount of Spouse/Domestic Partner Life Insurance coverage cannot be more than your "total life insurance coverage" amount. Your total life insurance coverage amount includes your Basic and Supplemental Life Insurance coverages combined.

Child(ren) Life Insurance Coverage Option

- You have the option to elect Child(ren) Life Insurance coverage. Child(ren) Life Insurance coverage is $15,000 or $25,000 per eligible child.

Spouse/Domestic Partner and Child(ren) Life Insurance Exclusions

If your spouse/domestic partner or child (as applicable) commits suicide within two years from the date the coverage takes effect, the Life Insurance benefit will not be paid. If your spouse/domestic partner or child (as applicable) commits suicide within two years from the date an increase in coverage takes effect, the Life Insurance benefit in effect on the day before the increase will be paid.

Contribution Amount

Your after-tax contribution, or cost, depends on your choice of coverage options. For Supplemental Life Insurance and Spouse/Domestic Partner Life Insurance, the cost is based on age and tobacco use status. When you enroll each year, you and your spouse/domestic partner complete a certification of tobacco use. The Plan offers discounted rates when you certify that the insured:

- Has not used tobacco products for the past six months; or
- Is enrolled in a smoking cessation program.

For Life Insurance, tobacco use status cannot be changed during the calendar year, even if you have a qualified status change (see **Qualified Status Change**).

For Child(ren) Life Insurance, the cost of coverage is the same regardless of the number of eligible children covered. You may visit **NXP.com/benefits** or call the NXP Benefits Service Center at 888-375-2367 for current contribution amounts.

Evidence of Insurability

In some instances, you may be required to provide evidence of insurability to MetLife. When evidence of insurability is required, coverage begins on the day MetLife approves your application.

> Evidence of insurability must be provided at your own expense.

If you request a coverage increase to your Supplemental, Spouse/Domestic Partner or Child(ren) Life insurance amount that is less than the non-medical issue amount, evidence of insurability is required. If evidence of insurability is not provided or not satisfactory to and accepted by MetLife, your increase will be limited to an increase of one level, not to exceed the non-medical issue amount.

If you request a coverage increase to an amount that is equal to or more than the non-medical issue amount and evidence of insurability is required, but not provided or not satisfactory to and accepted by MetLife, your Supplemental, Spouse/Domestic Partner or Child(ren) Life Insurance amount will not be increased.

If your coverage choice requires evidence of insurability, you must complete an evidence of insurability form online by following the link provided when you elect coverage on the NXP Rewards website. If you do not complete this form online, the NXP Rewards Center will send you the *Statement of Health Form* to complete and return. The coverage requiring evidence of insurability will begin on the day MetLife approves your application.

> **Example**: Brian chooses no Supplemental Life Insurance coverage when he joins NXP. During the following year's annual enrollment, Brian chooses the Supplemental Life coverage option of five times his **basic annual earnings** .

Because this election is more than three times his basic annual earnings, Brian must complete the *Statement of Health Form*. Brian will be enrolled for one times basic annual earnings coverage. If his application is approved, he will be enrolled for five times basic annual earnings coverage.

Basic Life Insurance

For Basic Life insurance, evidence of insurability is required if you make a request to increase your level of coverage at annual enrollment or after a qualifying event. If evidence of insurability is not accepted by MetLife, your coverage will not be increased.

Supplemental Life Insurance

For Supplemental Life Insurance, the non-medical issue amount is the lesser of three times your basic annual earnings or $500,000.

Evidence of insurability is required for Supplemental Life Insurance if you request an amount greater than the non-medical issue amount.

Spouse/Domestic Partner Life Insurance

For Spouse/Domestic Partner Life Insurance, the non-medical issue amount is $25,000.

Evidence of insurability is required for Spouse/Domestic Partner Life Insurance if you request coverage for your Spouse/Domestic Partner of more than $25,000.

Additional Services

Will Preparation Services

Along with your Basic or Supplemental Life insurance coverage, MetLife includes an online will and legal services program. Having an up-to-date will is one of the most important things you can do for your family.

Like life insurance, a carefully prepared will is important. With a will, you can document important decisions, such as who will care for your children or inherit your property. Will Preparation Services also include the preparation of living wills and power of attorney.

You and your dependents may take advantage of these services. This online document preparation service assists you in preparing a will, living will or power of attorney. Visit **WillsCenter.com** for more information.

When you enroll in Supplemental Life coverage, you have access to face-to-face will preparation services. You and your dependents may take advantage of will preparation and legal services available through MetLife Legal Plans' network of more than 13,400 participating attorneys. This service includes face-to-face access to a participating MetLife Legal Plans attorney for preparing or updating a will, living will or power of attorney at no additional cost to you.

Call MetLife Legal Plans at 800-821-6400 and a Client Service Representative will help you find a participating plan attorney in your area.

Grief Counseling

MetLife offers grief counseling, provided by Telus Health, for you, your dependents and your beneficiaries. Facing a loss is never easy and this service provides up to five confidential counseling sessions per event. Assistance is available for any situation you perceive as a major loss, including, but not limited to, death of a loved one, divorce, receiving a serious medical diagnosis or losing a pet. Research specialists can also refer you to services and providers, they can help you locate funeral homes, find specific types of support groups, find estate sale planners and more.
Call 1-888-319-7819 to speak with a licensed professional counselor. You can also log on to **one.telushealth.com** (username: metlifeassist, password: support).

Delivering the Promise

This service helps beneficiaries sort through the details and serious questions regarding claims and financial needs. MetLife representatives are available to provide in person or telephone assistance to beneficiaries and their family members, including:

- Completing and filing life insurance claims;
- Contacting government agencies about benefits;
- Locating grief counseling and support resources;
- Identifying important issues, including updating necessary documents such as titles or deeds; and
- Planning for current and future financial needs.

Call 877-275-6387 to get in touch with a Delivering the Promise specialist in your area.

Estate Resolution Services

MetLife Estate Resolution Services, offered through MetLife Legal Plans, Inc. is part of a robust continuum of services offered as part of MetLife Group Supplemental Life Plans. Estate Resolution Services can be used for your estate as well as your spouse's/domestic partner's estate.

Estate Resolution Services gives estate representatives access to participating attorneys for face-to-face or telephone consultation to get the legal help they need, including:

- Face-to-face consultations: estate representatives can meet with an attorney to discuss matters relating to probating your and your spouse's/domestic partner's estates.
- Preparation and representation: document preparation and representation needed at court proceedings is available to execute the transfer of probate assets from the deceased's estate to the heirs.
- Correspondence and tax filings: any correspondence needed to transfer non-probate assets may be completed by an attorney, as well as any associated filings.
- Coverage for attorney fees: All participating plan attorney fees for included services are covered through the plan. If a non-network attorney is chosen, the individual will be responsible for any attorney's fees that exceed the reimbursed amount.

Beneficiaries can also use this benefit to consult an attorney to discuss general questions about the probate process. Call MetLife Legal Plans at 800-821-6400 and a Client Service Representative will help you find a participating plan attorney in your area.

Living Benefit – Life Insurance Coverage

If you have a life expectancy of 24 months or less, you may request up to 100% of your eligible Basic Life and Supplemental Life Insurance benefits as a "living benefit." The minimum living benefit from all coverage is $20,000 and the maximum is $1,000,000 for Basic Life insurance and $1,000,000 for Supplemental Life insurance. Life expectancy must be certified by your physician. ***This benefit payment may be taxable; consult your tax advisor***. Your death benefit amount is reduced by any living benefit paid.

For details on the Living Benefit, contact the NXP Benefits Service Center at 888-375-2367.

Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment Insurance pays benefits when an accidental bodily injury is the sole cause of your death, dismemberment or another covered loss. Your coverage for Accidental Death and Dismemberment Insurance begins on your first day of work or on the day you first meet the eligibility requirements for Plan participation.

Your Accidental Death and Dismemberment Insurance coverage amount is known as the "principal sum."

Accidental Death and Dismemberment Insurance coverage (principal sum) is equal to your Basic Life Insurance amount. The maximum Accidental Death and Dismemberment Insurance benefit is $1,000,000.

Accidental Death and Dismemberment Insurance pays its principal sum for your accidental death. For other covered losses, Accidental Death and Dismemberment Insurance pays a percentage of its principal sum as your benefit. If a covered accident results in more than one covered loss, only the largest benefit will be paid, and the total amount of Accidental Death and Dismemberment Insurance payable, not including those described in **Special Accidental Death and Dismemberment Insurance Benefits**, cannot be more than your principal sum.

How Accidental Death and Dismemberment Insurance Pays Benefits

Accidental Death and Dismemberment Insurance pays a benefit when an accidental bodily injury is the sole cause of your death, dismemberment or another "covered loss." The covered loss must occur within 365 calendar days after the accident and while Accidental Death and Dismemberment Insurance coverage is in force.

Benefits for accidental death are paid to the beneficiary you named as your Basic Life beneficiary as described above. Benefits for all other covered losses are paid to you.

This chart shows the Accidental Death and Dismemberment Insurance benefit paid for each covered loss.

Accidental Death and Dismemberment Insurance Benefit Schedule

Covered Loss	Benefit Amount	Important Definitions
Life	Principal sum	N/A
Both Hands	Principal sum	Permanently severed at or above the wrist but below the elbow or at or above the ankle but below the knee.
Both Feet	Principal sum	
One Hand and One Foot	Principal sum	
One Hand or One Foot	One-half principal sum	
One Arm or One Leg	Three-fourths principal sum	Permanently severed at or above the elbow or at or above the knee.
Sight in Both Eyes	Principal sum	Permanent and uncorrectable loss of sight. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
Sight in One Eye	One-half principal sum	
Any Combination of Hand, Foot or Sight in One Eye	Principal sum	See above.
Speech and Hearing	Principal sum	Entire and irrecoverable loss of speech or hearing in both ears that continues for six consecutive months following an accidental injury.
Speech or Hearing	One-half principal sum	
Thumb and Index Finger of Same Hand	One-fourth principal sum	Permanent severance of the thumb and index finger through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
Paralysis of Both Arms and Both Legs	Principal sum	Permanent, complete and irreversible loss of use of a limb, without severance.
Paralysis of Both Legs	One-half principal sum	
Paralysis of the Arm and Leg on Either Side of Body	One-half principal sum	
Paralysis of One Arm or Leg	One-fourth principal sum	

Covered Loss	Benefit Amount	Important Definitions
Brain Damage	Principal sum	Permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. The damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least five days and persist for 12 consecutive months after the date of the accidental injury.

Special Accidental Death and Dismemberment Insurance Benefits

Your Accidental Death and Dismemberment Insurance includes these special benefits that are paid *in addition* to the benefit shown in the chart above.

- **Seatbelt Benefit:** If you die in an accident while traveling in a passenger vehicle *and* you were properly wearing your seatbelt, your accidental death and dismemberment insurance will pay its seatbelt benefit equal to 10% of your principal sum, with a minimum benefit of $1,000, up to a maximum benefit of $25,000. A police officer investigating the accident must certify that the seat belt was properly fastened and a copy of the certification must be provided to MetLife with the claim.
- **Air Bag Benefit:** If you die in an accident while traveling in a passenger vehicle *and* you were properly wearing your seatbelt *and* your seat was equipped with an air bag, your accidental death and dismemberment insurance will pay its air bag benefit equal to 5% of your principal sum, with a minimum benefit of $1,000, up to a maximum benefit of $10,000. A police officer investigating the accident must certify that the seat belt was properly fastened and that the passenger vehicle in which the deceased was traveling was equipped with air bags; a copy of the certification must be provided to MetLife with the claim.

Neither the seatbelt nor air bag benefit are payable if you are the driver of the vehicle and are intoxicated, impaired or under the influence of alcohol or drugs or not a licensed driver.

- **Coma Benefit:** If you are in a coma for at least seven consecutive days as the result of an accidental injury and the coma began within 30 days of the injury, your accidental death and dismemberment insurance will pay its coma benefit. Coma means a state of deep and total unconsciousness from which the person cannot be aroused. This benefit is paid monthly and is 1% of the principal sum. This benefit begins on the seventh day of the coma for the duration of the coma, up to a maximum of 60 months.
- **Common Carrier Benefit:** If you die due to an accidental injury while traveling in a common carrier, accidental death and dismemberment insurance will pay a benefit equal to 100% of your principal sum. A common carrier is a government-regulated entity that is in the business of transporting fare-paying passengers. This does not include chartered or other privately arranged transportation, taxis or limousines.

Exclusions

Accidental Death and Dismemberment Insurance benefits **are not** payable for loss resulting directly or indirectly from:

- Intentionally self-inflicted injury;
- Suicide or attempted suicide;
- Committing or attempting to commit a felony;
- Physical or mental illness or infirmity or diagnosis or treatment of the illness or infirmity;
- The voluntary intake or use, by any means of:

– Any drug, medication or sedative, unless it is taken or used as prescribed by a physician or an OTC drug, medication or sedative taken as directed;

– Alcohol in combination with any drug, medication or sedative; or

– Poison, gas or fumes;

- Any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level meets or exceeds the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurs;
- Infection, other than infection occurring in an accidental external wound;
- Any incident related to:

– Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;

- Travel in an aircraft for parachuting purposes or otherwise exiting from the aircraft while it is in flight;
- Parachuting or otherwise exiting from an aircraft while the aircraft is in flight, except for self-preservation; or
- Travel in an aircraft or devised used for testing or experimental purposes, by or for any military authority or for travel or designed for travel beyond the earth's atmosphere;

- War or any act of war, whether declared or undeclared;
- Participation in an insurrection, rebellion or riot; or
- Service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless when in connection with reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. Reserve forces here means as reserve forces of any branch of the military of the United States or of any other country or international authority, including, but not limited to, the National Guard of the United States or the national guard of any other country.

Business Travel Accident Insurance

Business Travel Accident Insurance

Business Travel Accident (BTA) Insurance pays benefits if an accidental injury results in your death, dismemberment or another covered loss, ***but only if the accident occurs while you are traveling on NXP business***. BTA Insurance begins on your first day of work or on the day you first meet the eligibility requirements for plan participation. Your BTA Insurance coverage amount is also known as your "principal sum." BTA Insurance coverage (principal sum) is equal to three times your **basic annual earnings** .

BTA pays its principal sum for your accidental death. For other covered losses, BTA pays a percentage of its principal sum as your benefit. If multiple losses occur, only one benefit amount, the largest, will be paid for all losses due to the same covered accident.

BTA insurance coverage is provided by a contract written in the Netherlands. Benefit amounts are listed in Euros.

How BTA Insurance Pays Benefits

BTA Insurance pays a benefit when you have a "covered loss" while you are traveling on NXP business. Covered business trips begin when you leave your home, regular place of employment or other location to travel to another location to work on NXP business. The trip ends when you return to your home, regular place of employment or you deviate for personal reasons for more than seven days, whichever occurs first. Unless noted otherwise, the covered loss must occur within 365 calendar days of the accident.

BTA Insurance also pays a benefit when you have a covered loss:

- During a bomb scare, bomb search or bomb explosion directed at NXP or its property;
- During a felonious assault on NXP property;
- Due to a terrorist act on NXP property; or
- Resulting from a hijacking of an aircraft during a business trip.

Benefits for accidental death are paid to the beneficiary(ies) you named for BTA Insurance but benefits for other covered losses are paid to you.

Detailed Insured Amounts and Benefits (per Insured)

Covered Loss	Benefit Amount
Personal Accident Per Event	
Accidental Death	
Per Person (three times annual salary)	Up to 1.000.000,00 EUR
Accompanying Children	Up to 15.000 EUR
Accompanying Partner	Up to 50.000 EUR
Permanent Disablement as a Result of an Accident	
Per Person (three times annual salary)	Up to 1.000.000,00 EUR
Accompanying Children	Up to 15.000 EUR
Accompanying Partner	Up to 50.000 EUR
Additional Covers	
Paraplegia	25.000,00 EUR
Quadriplegia	50.000,00 EUR
Dependent Children	5.000,00 EUR
Retraining Costs	Up to 10.000,00 EUR
Hospitalization	Per day 50,00 EUR
Coma	Per day 50,00 EUR
Cosmetic Surgery	Up to 5.000,00 EUR
Psychological Counselling	Up to 5.000,00 EUR
Personal Belongings	Up to 5.000,00 EUR
Funeral Expenses	Up to 7.500,00 EUR
Whiplash, % of the Insured Amount	Up to 8%
Seatbelt	5.000,00 EUR
Life Saver	25.000,00 EUR
Home Modifications	Up to 5.000,00 EUR
Partner/Child	25.000,00 EUR
Scars	5 or 10%
Medical Expenses and Assistance	
Medical Expenses Abroad (secondary)	Real expenses

Covered Loss	Benefit Amount
Medical Expenses in the Place of Residence	Up to 25.000,00 EUR
Medical Assistance	At costs
Direct Payment of Medical Expenses	At costs
Medical Referral	At costs
Medical Transport	Real expenses
Supervising the Clinical Condition	At costs
Sending a Physician	At costs
Sending Medication	Shipping costs
Repatriation to Hospital or Place of Residence	Real expenses
Accommodation	Real expenses
Presence of Relative	Real expenses
Search and Rescue	Up to 25.000,00 EUR
Repatriation of the Body	Real expenses
Funeral Expenses	Up to 7.500,00 EUR
Travel Assistance	
Premature Return	Real expenses
Message Relay	Dispatching costs
Travel Advice	Real expenses
Referral	Real expenses
Lost Documents or Luggage	Real expenses
Cash Advance	Real expenses
Unforeseen Delay	Real expenses
Cancellation and Interruption of the Business Trip up to 10,000.00 EUR (per trip)	
Cancellation	Service included
Interruption	Service included
Change of Travel	Service included
Travel Delay	Up to 1.500,00 EUR
Travel Extension	Service included
Personal Belongings and business equipment	

Covered Loss	**Benefit Amount**
Loss, Theft or Damage	Up to 7.500,00 EUR
Luggage Delay	Up to 1.500,00 EUR
Travel and Identity Documents	Up to 2.500,00 EUR
Cash, Valuable Documents and SIM Cards	Up to 2.500,00 EUR
Personal Liability	
Bodily and Material Damage (per policy per year)	Up to 5.000.000,00 EUR
Legal Assistance	
Legal Assistance	Up to 15.000,00 EUR
Detention	Up to 5.000,00 EUR
Bail Bond	Up to 50.000,00 EUR
Kidnap, Hijack and Unlawful Detention	
Daily Cover, 400,00 EUR per day	Up to 20.000,00 EUR
Advisory Fee	Up to 125.000,00 EUR
Political Evacuation and Crisis Containment	
Costs of Evacuation	Up to 50.000,00 EUR
Crisis Containment and Disaster Evacuation	Up to 50.000,00 EUR
Limits (Cumulation limit (Article 1.32))	
In Case of Using Any Airplane	30.000.000,00 EUR
In All Other Events	50.000.000,00 EUR

Work/Life Programs and Life Events

This section provides information on how to take advantage of your benefits as your situation changes. Specific sections include:

- *Work/Life Programs, including:*
  - *Adoption Assistance Program*
  - *Backup Care*
  - *Identity Theft Protection*
  - *Live and Work Well Program*
  - *Pet Insurance*
  - *Travel Assistance*
  - Tutoring
- *Life events* (some of which are qualified status changes) *and how these events affect your benefits.*

See **Participation** for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

The NXP Rewards package is designed to support you through the different stages and events of your life. The charts and other information in this section highlight the information you need to take full advantage of your health and wellness benefits as your situation changes.

Note: If your work schedule changes (for example, you begin working less than 20 hours per week), this change may affect the benefits for which you are eligible. Contact the NXP Benefits Service Center at 888-375-2367 to find out exactly how your benefits may be affected.

Balancing Your Work and Your Personal Life

From time to time, we can all use a little assistance in balancing our work and personal responsibilities. NXP's Work/Life benefits provide you with information, resources, financial assistance and benefit programs that can ease some of the challenges you face in managing your daily life.

NXP offers a range of solutions and resources to help meet your needs, regardless of your stage of life, whether you need a child care center, a nursing home facility for a loved one or scholarship resources for your college-bound child. The chart below gives an overview of the various Work/Life programs offered to NXP employees and a description of who may be eligible for them.

To participate in these programs, you must meet the eligibility requirements as detailed in this SPD. Some of the programs require you to enroll for participation, while others are automatic.

Work/Life Program	What It Is	Who Is Eligible
Adoption Assistance Program	Offers financial assistance to help with some of the expenses associated with adopting a child.	You
Backup Care	Offers alternative childcare, senior care or self-care when needed due to an emergency, unexpected event, or disruption in regular care.	You
Identity Theft Protection	Offers identity theft protection for when your personal information is stolen or to help protect yourself, and your family, from identity fraud.	You and your family
Live and Work Well Program	A resource and referral program that offers a range of tools and information to help you manage your work and personal life, such as child care, elder care and convenience services, like landscaping, home maintenance, car repair, etc. It also offers a variety of discounted products and services.	You, members of your household and your adult children up to the age of 26
Work/Life Program	**What It Is**	**Who Is Eligible**

Pet Insurance	Optional coverage that helps ensure you can care for your pets.	You
International SOS Travel Assistance Program	Travel assistance program that provides a comprehensive resource for domestic and international travel information services including medical and security assistance.	You (and family members if you are on a U.S. Expatriate or U.S. Inpatriate assignment)
Tutoring provided by Bright Horizons	Offers in-person and virtual tutoring. Tutoring can assist children and teens with reading, math, and more than 300 other subjects.	You and your family

To Find Out More

Use the following resources when looking for more details on your Work/Life programs:

- NXP Intranet under the *Benefits* section; or
- **NXP.com/benefits**; or
- NXP Benefits Service Center by calling 888-375-2367.

Adoption Assistance Program

If you are adopting a child, NXP can help. The Adoption Assistance Program offers you financial assistance for some of the expenses associated with domestic and international adoptions. You may be reimbursed up to $10,000 per child for eligible adoption expenses. If both you and your spouse/domestic partner are NXP employees, your family is only eligible for up to $10,000 per child.

How the Program Works

You may receive reimbursement for many eligible expenses associated with adopting or attempting to adopt a child, such as legal and medical fees. You simply submit the appropriate documentation and paid receipts to the NXP Benefits Service Center.

> ***Adoption Assistance***
>
> NXP reimburses up to $10,000 in eligible adoption expenses. You can file for reimbursement once a child is placed in your home for adoption, once the adoption becomes finalized or when your attempts to adopt a child end unsuccessfully.

Filing for Reimbursement

Once a child has been placed in your home for adoption, the adoption is finalized or your attempts to adopt a child end unsuccessfully, you can file for reimbursement of eligible expenses.

Expenses must be:

- Incurred while you are an eligible NXP employee; and
- Submitted for reimbursement by the earlier of the date you terminate or the following applicable date:
  - For eligible expenses incurred on or before the date of the initial placement of the child in your home, one year from the date of the initial placement.
  - During the period after the initial placement of the child in your home but before the final (or failed) adoption, you may submit one or more requests for reimbursement for eligible expenses incurred following the initial placement of the child in your home but before the date of the final (or failed) adoption; or
  - For all eligible expenses associated with a final (or failed) adoption, one year from the later of the date of the final (or failed) adoption or the date the eligible expense was incurred.

For reimbursement, use the Adoption Assistance Reimbursement Request form, available online at **NXP.com/benefits** under Adoption Assistance Program. Complete the form and send all relevant documents (translated to English, if they are originated in a non-English language) including:

- A copy of the adoption court order or a notarized letter from an attorney or agency granting preliminary placement or documenting a failed adoption attempt; and
- Paid itemized receipts for eligible adoption expenses, sent to the address listed on the form.

Be sure to sign and include your NXP Workday identification number on each document, including receipts (in case any paperwork gets separated).

Email all documentation to:

NXP Benefits Team at usbenefits.office@nxp.com

-

Documents Needing Translation

More parents are adopting children from locations around the world. In many of these cases, adoption documents or receipts will not be in English. Therefore, you must have these documents translated to English.

For a smooth adoption reimbursement process:

- Locate someone who is proficient in the language of the documents and in English to translate the documents;
- Submit a signed, notarized letter or affidavit from the translator that:

– Attests that they are proficient in the English language and the language they have translated;
– Attests that their translation is accurate as to what the original documents contain;
– Provides a list of each document translated;
– Provides the native currency amount of each receipt and the translated dollar equivalent; and
– Contains the legible, printed name of translator.

Documents that have been translated to English should be accompanied by a notarized letter or affidavit from the translator, noting each of the documents he or she has translated.

Adoption Assistance Eligible Expenses

- Public or private adoption agency fees (includes home study fees where required);
- Foreign and international adoption fees;
- Legal fees associated with surrogacy, adoption or with a legal guardianship, if the legal guardianship is an integral part of a final (or failed) adoption, except for legal retainer fees;
  - Court fees associated with the adoption;
  - Medical expenses (adopting parent(s)' physical exam and, in the case of a private adoption, the medical and professional counseling expenses of the biological mother and child);
  - Agency or legal fees associated with temporary foster care charges;
  - Reasonable travel expenses, including auto, airfare, hotel and meals, if such expenses are directly related to and necessary for an adoption or a bona fide attempt to adopt; and
  - Fees associated with the translation of documents written in a language other than English.

If you have any questions about the Adoption Assistance program, email the NXP Benefits Team at **usbenefits.office@nxp.com.**

Expenses Not Eligible

- Donations to adoption organizations;
- Legal fees for legal guardianship unless legal guardianship is an integral part of a final (or failed) adoption;
- Cost of adoption when you, your spouse/domestic partner is the biological parent of the child;
- Costs to have a child through a surrogate parent or adopt a child born to a surrogate parent;
- Expenses covered by any other plan, policy or program offered by NXP or otherwise;
- Legal retainer fees paid to an attorney;
- Independent adoption networking fees and associated services;
- Advertisement and soliciting fees;
- Any service or expenses incurred before the date you became eligible to participate in the Program;

- Expenses incurred or submitted for reimbursement after your Program participation ends; and
- Any expenses not listed as eligible.

Key Terms

- **Eligible expenses** are those costs that are associated with the placement or adoption of a child, such as adoption agency fees, legal fees, court fees and in some circumstances, medical and travel expenses.
- **Failed adoption expenses** are eligible costs incurred in the legal attempt to adopt a child when the adoption has been terminated due to unforeseen circumstances.
- **Temporary foster care expenses** are agency and legal fees associated with temporary foster care that results in a final (or failed) adoption.

Some Things to Consider

Before Adopting: NXP's Live and Work Well Program, managed by UnitedHealthcare, can assist you if you need help with additional resources or information about adoption. Call 866-248-4094, 24 hours a day, or visit **liveandworkwell.com** (access code: NXP) for more information on this.

> Certain expenses may have special tax advantages. Please consult your tax advisor for details.

- **After Adopting:** As soon as the placement or adoption of the child is complete, you will want to consider the following options:

File for any remaining Adoption Assistance program reimbursement: complete an Adoption Assistance Reimbursement Request form and send it to the NXP Benefits Team (see **Filing for Reimbursement** for details);

- Add your child to your medical, dental and/or vision coverage within 30 days of adoption by calling the NXP Benefits Service Center at 888-375-2367;
- Enroll your new child, if eligible, in Child(ren) Life Insurance;
- Establish or change a Health Care Flexible Spending Account;
- Establish or change a Dependent Care Flexible Spending Account;
- Change your beneficiary designations for your life insurance and/or your 401(k) Retirement Plan; and
- Find out about child care options in your area by contacting NXP's Live and Work Well Program at **liveandworkwell.com** (access code: NXP) or by calling 866-248-4094.

When Adoption Assistance Program Coverage Ends

Your coverage under the Adoption Assistance Program ends on the earliest of the following events:

- The date on which your NXP employment ends;
- The date you no longer meet the Adoption Assistance Program eligibility requirements other than due to a leave of absence under the NXP Parental Leave Policy or a paid leave of absence;
- The last day of the month in which you receive military service pay under the NXP Military Service Pay Policy, provided that your coverage as a participant who returns to active employment within 31 days of ending military service as described in the Uniformed Services Employment and Reemployment Rights Act is not terminated due to the absence;
- 90 days after the Adoption Assistance Program requests repayment from you or your covered dependent of amounts subject to reimbursement, overpayments or mistaken payments from any NXP welfare plan, if you fail to repay or set up an acceptable repayment schedule; or
- The day the Adoption Assistance Program ends or the effective date of an amendment eliminating such coverage.

Important Tax Information

The Adoption Assistance Program's reimbursements are considered taxable income. Any reimbursements you receive are paid directly to you with applicable tax withholding already deducted. Reimbursements are not eligible for the adoption assistance income exclusion under Internal Revenue Code Section 137. Therefore, any reimbursements you receive are reported as wages in Box 1 of your Form W-2.

You may be able to take a tax credit, allowed by Section 23 of the Internal Revenue Code, for qualified adoption expenses that are not reimbursed under this Plan. Depending on your financial situation, it may be to your advantage to have only certain eligible expenses reimbursed by the Adoption Assistance Program or to use the Program only after you have received the full tax credit. For information on the adoption tax credit, talk to your accountant or financial advisor or review information online at **IRS.gov**.

Backup Care

Offered through Bright Horizons, Backup Care Helps you secure and pay for temporary child, self, pet, or senior care when your regular care plans are disrupted.

Backup Care provides you with up to ten visits per year. These visits are provided on a first come, first served basis. You choose the care provider that's right for your needs. Options range from center or facility-based care to in-home providers. . For each visit, you pay a $15 copayment per child or $25 per family for facility based care or $6/hour for in-home care.

Backup Care provides flexible scheduling. You can arrange care up to 90 days in advance for planned events or at the last minute for something unexpected.

Backup Care also provides flexible access. You can access Backup Care 24/7:
By phone, call --Bright Horizons at 877-242-2737 ;

- Online, go to **member.lifecare.com** (use registration code: NXP); or

Using the Bright Horizons Backup Care mobile app.

Once enrolled, you can use the Backup Care Connection mobile app to:

- Request new care;
- Update scheduled care;
- View your account history;
- Submit for reimbursement;
- Add dependents;
- Access personalized, live support.

Identity Theft Protection

NXP offers you the opportunity to purchase identity theft protection through ID Watchdog. ID Watchdog helps warn you when your personal information is stolen and helps you better protect yourself, and your family, from identity fraud—when stolen information is used for illicit gain. This coverage can give you peace of mind knowing you don't have to face the complexities of identity theft alone.

The ID Watchdog program' protection and control provides:

- Advanced identity theft detection; and
- Fully managed identity restoration.

NXP offers you the option to select the coverage that's right for you. You may elect to enroll in one of two options, with individual or family coverage:

- Essentials plan option; or
- Platinum Plus plan option.

Regardless of the option you chose, the program:

- Gives you control; you manage the program features you want to use, such as:
  - Monitoring your financial accounts;
  - Monitoring your social accounts*;
  - Receiving reports on registered sex offenders in your area*;
  - Customizable alert options, including:
    - Equifax blocked inquiry alerts;
    - National provider ID alerts; and
    - Integrated fraud alerts (with fraud alerts, potential lenders are encouraged to take extra steps to verify your identity before extending credit); and
- Monitors your data and detects any changes, services provided include:
  - Monitoring the dark web for your information*;
  - Notifying you of any data breaches;
  - Monitoring high-risk transactions*;
  - Monitoring subprime loan*;
  - Monitoring public records*;
  - Monitoring USPS changes of address*;
  - Providing identity profile reports; and
  - Tracking your credit score; and
- Supports you and helps restore your data by offering:
  - Fully managed resolution services, including pre-existing conditions*;
  - Online resolution tracking;
  - Lost wallet vault and assistance;
  - Deceased family member fraud remediation; and
  - Credit freeze assistance.

* *More services are available for families, such as adult family members receive full-featured, customizable accounts, protection for children with Equifax Child Credit Lock and Equifax Child Credit Monitoring Plus.*

Here's an overview of the services available to you under both options:

Specific Feature	Essentials Option	Platinum Plus Option
Credit Report Monitoring	Equifax	Equifax, Experian and TransUnion
Credit Report(s) and VantageScore Credit Score(s)	• Equifax, monthly	• Equifax, daily • Equifax, Experian and TransUnion, annually
Credit Report Lock	Equifax	Equifax and TransUnion
Identity Theft Insurance	Up to $1,000,000	Up to $1,000,000
401(k)/HSA Stolen Fund Reimbursement		X
Sub-Prime Loan Block (with the monitored lending network)		X
Social Account Takeover Alerts		X
Personal VPN and Safe Browsing		X
Password Manager		X

ID Watchdog services are available 24 hours a day, 7 days a week, every day of the year. For more information or to enroll, call ID Watchdog at 866-513-1518 or go online to **nxp.bswift.com**.

Legal Services Plan

MetLife Legal Plans provides the Legal Services Plan. Services are provided through a panel of carefully selected participating law firms. Lawyers in the network are called Services Plan attorneys.

You also have the option to add coverage for your parents under the MetLife Legal plan. If you choose to elect the Parents Buy-Up option, your parents will also have access to some of the services covered under this Plan.

How to Get Legal Services

Website

To access legal services, visit the MetLife Legal Plans' member website at **members.legalplans.com**. To login enter the last four digits of your Social Security Number and zip code. After you login, you will jump to a page that is specific for member services. On this page, you can choose the following options:

- How Do I Use the Plan?
- Covered Services
- Attorney Locator
- Obtain Case Number
- Life Guide
- Self-Help Documents/Forms

Client Service Center

You can also contact MetLife by calling their Client Service Center at 800-821-6400, Monday-Friday, 7 a.m. to 7 p.m., Central Time. Be prepared to give the last four digits of your Social Security Number and zip code. If your spouse/domestic partner or eligible dependent child calls, he or she will need the last four digits of your Social Security Number and zip code. The Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Services Plan attorney will make the final determination of coverage);
- Give you a case number, which is similar to a claim number (you will need a new case number for each new case you have);
- Give you the telephone number of the Services Plan attorney most convenient to you; and
- Answer any questions you have about the Legal Services Plan.

You then call the Services Plan attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available.

If you choose, you may select your own attorney. If there are no participating law firms near you, you will be asked to select your own attorney. In both of these circumstances, MetLife Legal Plans will reimburse you for these non-Services Plan attorneys' fees according to a set fee schedule.

For services to be covered, you or your eligible dependents must obtain a case number, retain a Services Plan attorney and the Services Plan attorney must begin work on the covered legal matter while you are an eligible member of the Legal Services Plan.

What's Covered

The Legal Services Plan allows you and your eligible dependents to receive certain personal legal services, as described in this section. The benefits available are comprehensive, but there are limitations and other conditions that must be met.

> All benefits are available to you and your spouse/domestic partner and dependents, unless otherwise noted.

Advice and Consultation

Advice and consultation services cover:

- **Office Consultation:** You have the opportunity to discuss with a Services Plan attorney any personal legal problems that are not specifically excluded. A Services Plan attorney will explain your rights, point out your options and recommend a course of action. The Services Plan attorney will identify any further coverage available under the Plan and represent you if you request. If representation is covered by the Plan, you are not charged for the Services Plan attorney's services. If representation is recommended, but is not covered by the Plan, the Services Plan attorney will provide a written fee statement in advance. You may choose whether to retain the Services Plan attorney at your own expense, seek outside counsel or do nothing. There are no restrictions on the number of times per year that you may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a Services Plan attorney to seek advice that would allow you to undertake your own representation;

- **Telephone Advice:** You have the opportunity to discuss with a Services Plan attorney any personal legal problems that are not specifically excluded. The Services Plan attorney will explain your rights, point out your options and recommend a course of action. The Services Plan attorney will identify any further coverage available under the Plan and represent you if you request. If representation is covered by the Plan, are not charged for the Services Plan attorney's services. If representation is recommended, but is not covered by the Plan, the Services Plan attorney will provide a written fee statement in advance. You may choose whether to retain the Services Plan attorney at your own expense, seek outside counsel or do nothing. There are no restrictions on the number of times per year that you may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a Services Plan attorney to seek advice that would allow you to undertake your own representation

Consumer Protection

Consumer protection services include:

- **Consumer Protection Matters:** Coverage for you as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This does not include disputes over real estate, construction, insurance or collection activities after a judgment.
- **Small Claims Assistance:** Counseling on prosecuting a small claims action, helping you prepare documents, advising on evidence, documentation and witnesses and preparing for trial. The does not include the Services Plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.
- **Personal Property Protection:** Counseling over the phone or in the office on any personal property issue, such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. This includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

Debt Matters

Debt matter services include:

- **Debt Collection Defense:** Services Plan attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial, if necessary. Services include a motion to vacate a default judgment. It does not include counter, cross or third party claims, bankruptcy, any action arising out of family law matters, including support and post decree issues or any matter where the creditor is affiliated with NXP or MetLife.
- **Identity Management Services:** Access to LifeStages Identity Management Services provided by IDT911. These services include both proactive services when you believe your personal data has been compromised as well as resolution services to assist you in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications and provides victims with credit and fraud monitoring. Theft support, fraud support, recovery and replacement services are covered by this service.
- **Identity Theft Defense:** Consultations with a Services Plan attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. Defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft, such as foreclosure, repossession or garnishment, up to and including trial, if necessary. The service also provides you with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters or any matter where the creditor is affiliated with NXP or MetLife.
- **Personal Bankruptcy or Wage Earner Plan:** Service for you and your spouse/domestic partner in pre-bankruptcy planning, preparation and filing of a personal bankruptcy or wage earner petition and representation at all court hearings and trials. This service is not available if a creditor is affiliated with NXP, even if you or your spouse/domestic partner chooses to reaffirm that specific debt.

- **Tax Audits:** Reviewing tax returns and answering questions the IRS or a state or local taxing authority has about your tax return, negotiating with the agency, advising you on necessary documentation and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

Defense of Civil Lawsuits

Civil lawsuit defense includes:

- **Administrative Hearing Representation:** Provides defense in civil proceedings before a municipal, county, state or federal administrative board, agency or commission. Services include the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by an insurance policy and does not include family law matters, post judgment matters or litigation of a job-related incident.
- **Civil Litigation Defense:** Provides defense for an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by an insurance policy and does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.
- **Incompetency Defense:** Defense of any incompetency action, including court hearings when there is a proceeding to find you incompetent.

Document Preparation

Document preparation services include:

- **Affidavits:** Preparation of any affidavit in which you are the person making the statement.
- **Deeds:** Preparation of any deed for which you are either the grantor or grantee.

- **Demand Letters:** Preparation of letters that demand money, property or some other property interest, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to you. Negotiations and representation in litigation are not included.
- **Mortgages:** Preparation of any mortgage or deed of trust for which you are the mortgagor. This does not include documents pertaining to business, commercial or rental property.
- **Promissory Notes:** Preparation of any promissory note for which you are the payor or payee.
- **Document Review:** Review of any personal legal document, such as letters, leases or purchase agreements.
- **Elder Law Matters:** Counseling for you over the phone or in the office on any personal issues relating to your parents as they affect you. This includes reviewing documents of the parents to advise you on the effect on you. Documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. This also includes preparing deeds involving parents when you are either the grantor or grantee and preparing promissory notes involving parents when you are the payor or payee.

Family Law

Family law services cover:

- **Name Changes:** Necessary pleadings and court hearings for a legal name change.
- **Prenuptial Agreement:** Your representation and includes the negotiation, preparation, review and execution of a prenuptial agreement between you and your fiancé/partner before your marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse/domestic partner. Representation is provided only to you, the employee. Your fiancé/partner must have separate counsel or must waive his or her right to representation. This does not include subsequent litigation arising out of a prenuptial agreement.

- **Protection from Domestic Violence:** This applies to you only; not your spouse/domestic partner or dependents, as the victim of domestic violence. It includes representation for you to obtain a protective order, including all required paperwork and attendance at all court appearances. This does not include representation in suits for damages, defense of any action or representation for the offender.
- **Adoption and Legitimization (Contested and Uncontested):** Legal services and court work in a state or federal court for an adoption by you and your spouse/domestic partner. Legitimization of your or your spouse's/domestic partner's child, including reformation of a birth certificate, is also covered.
- **Guardianship or Conservatorship (Contested or Uncontested):** Establishing a guardianship or conservatorship over a person and his or her estate when you or your spouse/domestic partner are appointed as guardian or conservator. This includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing paperwork, attending the hearing and preparing the initial accounting. This does not include representation of the person over whom guardianship or conservatorship is sought or any annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

Immigration

Immigration assistance covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping you prepare for hearings.

Personal Injury

Personal injury (25% network maximum), subject to applicable law and court rules, Services Plan attorneys will handle personal injury matters (where you are the plaintiff) at a maximum fee of 25% of the gross award. It is your responsibility to pay this fee and all costs.

Real Estate Matters

Real estate matter services include:

- **Boundary or Title Disputes (Primary Residence):** Negotiations and litigation arising from boundary or real property title disputes involving your primary residence, where coverage is not available under you homeowner or title insurance policies. This includes filing to remove a mechanic's lien.
- **Eviction and Tenant Problems (Primary Residence – Tenant Only):** For you as a tenant, matters involving leases, security deposits or disputes with a residential landlord. This includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.
- **Security Deposit Assistance (Primary Residence – Tenant Only):** For you as a tenant, counseling you in recovering a security deposit from your residential landlord for your primary residence, reviewing the lease and other relevant documents and preparing a demand letter to the landlord for the return of the deposit. This also covers assisting you in prosecuting a small claims action, helping prepare documents, advising on evidence, documentation and witnesses and preparing you for the small claims trial. This does not include the Services Plan attorney's attendance or representation at small claims trial, collection activities after a judgment or any services relating to post-judgment actions.
- **Home Equity Loans (Primary Residence):** Review or preparation of a home equity loan on your primary residence.
- **Home Equity Loans (Second or Vacation Home):** Review or preparation of a home equity loan on your second or vacation home.
- **Property Tax Assessment (Primary Residence):** Review and advice on a property tax assessment on your primary residence, including filing the paperwork, gathering the evidence, negotiating a settlement and attending the hearing necessary to seek a reduction of the assessment.

- **Refinancing of Home (Primary Residence):** Review or preparation, by a Services Plan attorney representing you, of all relevant documents (including the refinance agreement, mortgage and deed and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on your primary residence. This also includes attendance of a Services Plan attorney at closing. This includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.
- **Refinancing of Home (Second or Vacation Home):** Review or preparation, by a Services Plan attorney representing you, of all relevant documents (including the refinance agreement, mortgage and deed and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on your second home or vacation home. This also includes attendance of a Services Plan attorney at closing. This includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.
- **Sale or Purchase of Home (Primary Residence):** Review or preparation, by a Services Plan attorney representing you, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of your primary residence or of a vacant property to be used for building a primary residence. This also includes attendance of a Services Plan attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

- **Sale or Purchase of Home (Second or Vacation Home):** Review or preparation, by a Services Plan attorney representing you, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of your second home or vacation home or of a vacant property to be used for building a second home or vacation home. This also includes attendance of a Services Plan attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.
- **Zoning Applications:** Services of a lawyer to help get a zoning change or variance for your primary residence. Services include reviewing the law, reviewing the surveys, advising you, preparing applications and preparing for and attending the hearing to change zoning.

Traffic and Criminal Matters

Traffic and criminal matter services cover:

- **Juvenile Court Defense:** Your or your dependent child's defense in any juvenile court matter, provided there is no conflict of interest between you and the dependent child. When a conflict exists or where the court requires separate counsel for the child, this service provides a Services Plan attorney for you only, including services for parental responsibility.
- **Traffic Ticket Defense (No DUI):** Representation in defense of any traffic ticket including traffic misdemeanor offenses, except driving under the influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.
- **Restoration of Driving Privileges:** Representation in proceedings to restore your driving license.

Wills and Estate Planning

Will and estate planning services cover:

- **Trusts:** Preparation of revocable and irrevocable living trusts for you. It does not include tax planning or services associated with funding the trust after it is created.
- **Living Wills:** Preparation of a living will for you.

- **Powers of Attorney:** Preparation of any power of attorney when you are granting the power.
- **Probate:** Subject to applicable law and court rules, Services Plan attorneys will handle probate matters at a fee 10% less than the Services Plan attorney's normal fee. It is your responsibility to pay this reduced fee and all costs.
- **Wills and Codicils:** Preparation of a simple or complex will for you. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Attorney Services for Non-Covered Matters

Up to four hours of attorney time and services per year for non-covered matters that are not otherwise excluded. You are responsible for any fees beyond four hours.

> **Note:** Attorney services for non-covered matters is only available if you choose to elect the Short-Term Disability Buy-Up Plan option.

Plus Parents Covered Services

- **Identity Restoration Services:** Identity restoration services are provided by IdentityForce, a TransUnion brand. Services includes identity restoration services from U.S.-based certified protection specialists. Specialists assist with more than identity restoration, they help in recovery if wallets and information are ever lost or stolen and can save you hundreds of hours by completing all the paperwork, making calls and doing all the heavy lifting to make sure your identity is restored.
- **Promissory Notes:** Preparation of any promissory note for which you are the payor or payee.
- **Deeds:** Preparation of a deed for which you are either the grantor or grantee.
- **Mortgages:** Preparation of any mortgage or deed of trust for which you are the mortgagor. This does not include documents pertaining to business, commercial or rental property.
- **Living Wills:** Preparation of a living will for you.
- **Powers of Attorney:** Preparation of power of attorney when you are granting the power.

- **Wills and Codicils:** Preparation of a simple or complex will for you. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.
- **Affidavits:** Preparation of any affidavit in which you are the person making the statement.
- **Demand Letters:** Preparation of letters that demand money, property or some other property interest, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to you. Negotiations and representation in litigation are not included.
- **Document Review:** Review of any personal legal document, such as letters, leases or purchase agreements.

Note: You have the option to add coverage for your parents under the MetLife Legal plan. If you choose to elect the Parents Buy Up option, your parents will also have access to the above covered services.

Exclusions

Excluded services are those legal services that **are not** provided under the Plan. No services, not even a consultation, is provided for the following matters:

- Employment-related matters, including company or statutory benefits;
- Matters involving the NXP, MetLife ® and affiliates and Services Plan attorneys;
- Matters in which there is a conflict of interest between you and your spouse/domestic partner or dependents in which case services are excluded for your spouse/domestic partner and dependents;
- Appeals and class actions;
- Farm, business or investment matters and matters involving property held for investment or rental or issues when you are the landlord;
- Patent, trademark and copyright matters;
- Costs or fines;
- Frivolous or unethical matters; and
- Matters for which a Services Plan attorney-client relationship exists before you became eligible for benefits.

Limitations

- **If Other Coverage Is Available to You:** If you are entitled to receive legal representation provided by any other organization, such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Plan. However, if you are eligible for legal aid or Public Defender services, you are still eligible for benefits under this Plan as long as you meet the eligibility requirements.
- **Legal Disputes with Your Dependents:** You may need legal help with a problem involving your spouse/domestic partner or your children. In some cases, each of you may need an attorney. If it would be improper for one attorney to represent you, only you will be entitled to representation by a Services Plan attorney. Your spouse/domestic partner or dependent will not be covered under the Plan.
- **Legal Disputes with Another Employee:** If you, your spouse/domestic partner or your dependents are involved in a dispute with another eligible employee or that employee's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.
- **Court Awards of Attorneys' Fees as Part of a Settlement:** If you are awarded attorneys' fees as a part of a court settlement, the Plan must be repaid from this award to the extent that it paid the fee for your attorney.

Claims and Appeals Procedures

Eligibility

MetLife verifies eligibility using information provided by NXP. When you call for services, you will be advised if you are ineligible and MetLife Legal Plans will contact NXP for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you believe you are eligible to:

NXP USA, Inc.
Human Resources Department, OE 331
6501 William Cannon Drive West
Austin, TX 78735

Within 30 days, you will be provided with a written explanation.

Appeals

If you are denied coverage by MetLife Legal Plans or by any Services Plan attorney, you may appeal by sending a letter to:

MetLife **Legal Plans**
Director of Administration
Eaton Center
1111 Superior Avenue
Cleveland, OH 44114-2507

The Director will issue MetLife Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause MetLife Legal Plans to reconsider the decision, an explanation of the review procedure and notice of the right to bring a civil action under ERISA Section 502(a).

Confidentiality, Ethics and Independent Judgment

Your use of the Plan and the legal services is confidential. Your Services Plan attorney will maintain strict confidentiality of the traditional lawyer-client relationship. NXP will know nothing about your legal problems or the services you use under the Plan. Plan administrators will have access only to limited statistical information needed for administration of the Plan.

No one will interfere with your Services Plan attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The Services Plan attorney will adhere to the rules of the Plan and he or she will not receive any further instructions, direction or interference from anyone else connected with the Plan. The Services Plan attorney's obligations are exclusively to you. The Services Plan attorney's relationship is exclusively with you. MetLife Legal Plans or the law firm providing services under the Plan is responsible for all services provided by their Services Plan attorneys.

The Plan has no liability for the conduct of any Services Plan attorney. You have the right to file a complaint with the state bar concerning Services Plan attorney conduct under the Plan. You have the right to retain at your own expense any attorney authorized to practice law in this state.

Services Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous or to harass another person. If you have a complaint about the legal services received or the conduct of a Services Plan attorney, call MetLife Legal Plans at 800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

You have the right to retain at your own expense any attorney authorized to practice law in the state. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan.

Live and Work Well Program

Live and Work Well is your Employee Assistance Program (EAP). It is managed by UnitedHealthcare and offers you a wide range of tools, resources and information to help you better manage your work and personal life. A simple toll-free call connects you with a trained specialist who can assist with services such as counseling referrals, legal and financial assistance, child care and elder care, convenience services like finding a landscaper or plumber – and other resources and referrals. NXP members have access to four sessions per issue, per year with a counselor at no cost through this Program.

> To contact Live and Work Well, call 866-248-4094 or visit **liveandworkwell.com** (access code: NXP).

This program is available to you, members of your household and your adult children up to the age of 26 at no cost. However, you are responsible for any costs associated with any services or products you may purchase.

By calling Live and Work Well at 866-248-4094 or visiting **liveandworkwell.com** (access code: NXP), you can get practical advice, useful materials and referrals to address a wide range of work or personal issues, such as those listed in the chart below.

Family	Health and Wellness	Education	Legal/Financial / Identity Theft	Daily Life
• Adoption • Aging Loved Ones • Child Care • Funeral Planning • Grandparenting • Parenting • Prenatal • Special Needs • Summer Programs • Work and Family	• Children's Health • Diet and Nutrition • Emotional Health • Fitness/ Exercise • General Health • Men's Health • Safety • Women's Health • Senior Health	• College • Elementary Education • Financial Aid • Gifted and Talented • Middle/High School • Pre-K/ Kindergarten • Preschool/ Nursery School • Special Education	• Will Development • Legal Support and Representation • Identity Theft Breach or Prevention • Credit and Debt • Insurance • Medicare/ Medicaid • Personal Finance • Real Estate and Loans • Retirement Planning • Social Security	• Automotive Services • Consumer Information • Home Improvement • Moving/ Relocation • Pet Care • Travel • Utilities/Home Services

Program Resources

You can access program services for information and materials through a variety of formats, all of which are easy to use.

- Trained specialists offer supportive, individualized consultation, referrals and educational materials to identify programs and services that best meet your needs. One specialist works with you from start to finish.
- Even if you don't have a need for a specialist, you can request educational materials on an array of family and personal issues supported by the program. Resources include:

– Educational Guides;
– Helpful articles and checklists; and
– Online tools, including health encyclopedias, online workshops, a Discount Center and more.

To access services, go to **liveandworkwell.com** (access code: NXP). If you need help, you can call a trained Live and Work Well Program specialist any time, day or night, at 866-248-4094.

Child Care Assistance

NXP offers assistance with identifying and screening a network of national child care providers as well as helping you with tips on how to evaluate the quality of the programs you may be considering. Call Live and Work Well at 866-248-4094 and speak with a work/life consultant for more information. The participating child care centers or programs are not endorsed or recommended by NXP. It's up to you to visit participating centers and decide which is best for your child.

You are responsible for any fees and child care costs at the service provider you choose. A participating child care center does not automatically guarantee a space for your child or any priority in enrollment.

> Live and Work Well, your EAP, can also help you find before- and after-school programs, summer camps and other local programs for school-age children. Call 866-248-4094 or visit **liveandworkwell.com** (access code: NXP).

School's Out Program

One of the toughest problems faced by many working parents is what to do when their children's schools are closed for vacations, holidays and other events. NXP offers programs at several locations to provide care for children ages 6 through 12 at times when schools are closed. Call Live and Work Well at 866-248-4094 for a referral to a program near you.

> To learn more about programs for school-age children that are available in your area, call Live and Work Well at 866-248-4094 or visit **liveandworkwell.com** (access code: NXP).

Pet Insurance

Pet insurance, offered through PetFirst Healthcare, is a program that helps ensure you can care for your pets.

With pet insurance, a small monthly payment can help you prepare for unexpected vet expenses down the road. Pet insurance covers:

- Accidental injuries;

- Illnesses;
- Exam fees
- Surgeries
- Medications;
- Ultrasounds;
- Hospital stays;
- X-rays and other diagnostics and diagnostic tests;
- Hip dysplasia;
- Alternative therapies;
- Holistic care; and
- Hereditary, congenital and chronic conditions.

PetFirst offers flexible products with straightforward pricing options, premium discounts, customizable limits, deductible savings and a hassle-free claims process.

You have the option to select the coverage that's best for you when you enroll. To enroll or get a quote, call a Pet Advocate at 800-438-6388 and provide referral code 11010. You may also go online to **metlife.com/mybenefits** (use "NXP" for the employer's name and register using your employee ID).

> **Note:** If you leave NXP, you can decide to port your insurance. This means that you can take the coverage with you, but you are responsible for paying all premiums. Premiums may change; and any discounts arising from the PetFirst program with NXP may no longer be available. In addition, any insurance you purchase will be continued and renewed according to the terms of MetLife's underwriting and administrative guidelines.

Travel Assistance

The Travel Assistance Program is administered by AIG and it is available to you 24 hours a day. Travel Assistance is a program that provides you a comprehensive source for domestic and international travel information and services. One phone call connects you to a network of multilingual specialists for immediate help in an emergency. These services are designed to help you with medical, personal, travel, security and legal problems when away from home. Contact the Travel Assistance Program at any time to speak with a physician or security specialist about simple or critical matters.

Other travel assistance benefits, covering both international and domestic travel, are available with Basic Life Insurance coverage (see **Travel Services** for details).

AIG® Business Travel Accident Insurance Policy: GTP-0009152759-B

AIG Travel Guard – Travel Medical Assistance:

- ***U.S.:*** 877-244-6871
- ***International:*** Collect +1-715-346-0859

Initiate a claim online by visiting **Travel Guard** and then select the "Create an Account" button.

Who Is Eligible

The Travel Assistance Program is available to all NXP employees who are traveling domestically and abroad on NXP business, including those on an assignment as determined by NXP Global Mobility.

Benefit Summary

This is not a health insurance program; however, this program offers you a wide array of pre-trip and in-transit travel services while you are traveling abroad on NXP business, including:

Medical Services

- Immunization information;
- 24-hour emergency and routine medical advice;
- Medical and dental referrals;
- Access to International SOS medical clinics;
- Emergency medical care;
- Emergency evacuation or medically-supervised repatriation and companion ticket;
- Additional travel and accommodation arrangements after medical evacuation;
- Pre-trip information on travel health issues (Country Guides);
- Claims assistance; and
- Dispatch of medication and medical supplies.

Travel Services

- Travel advice;
- Legal referrals;
- Emergency message transmission;
- Translations and interpreters;
- Lost document advice; and
- Emergency personal cash advances.

Security Services

- Up-to-date travel security alerts;
- Security evacuation assistance;
- Online travel security information; and
- Access to security crisis center.

This means that when traveling on NXP business anywhere in the world, you have the assurance, security and convenience of a "one stop shop" for any and all health, safety and travel concerns.

Emergency Assistance and Your AIG Card

Tutoring

Bright Horizons provides access to tutoring for your child, including instant homework help in reading, math, science, social studies, and 3,000+ other subjects. There are additional options available for adult and college-aged learners, including yourself.

Employees who are working 20+ hours have access to:

- In-person tutoring through Sylvan Learning for K-12 learners
- Virtual tutoring options through Varsity Tutors, Revolution Prep, and Sylvan Learning
- Tutoring can assist children and teens with reading, math, and more than 300 other subjects.
- 1:1 tutoring for college students + adults
- Adult Learning: Spanish, Microsoft Excel, Public Speaking, ESL
- Support for a variety of admissions tests, including the SAT, ACT, PSAT, AP, SSAT, and ISEE
- Professional Certifications: SIE, CPA, SHRM-CP
- Technical: AutoCAD, Python, PMP, Java, Adobe Illustrator

Exchange one Back-Up Care use for 4-hours of Virtual Tutoring.

Exchange one Back-Up Care use for 3-hours of In-Person Tutoring with Sylvan Learning.

For more information, call 877-242-2737 or visit Bright Horizons to learn more.

Life Events

> ***HSA Note***
>
> Since HSAs are not subject to ERISA, your HSA is not considered a plan established or maintained by NXP and is therefore not subject to provisions relating life events as described in this section. See the **Health Savings Account (HSA)** section, for information about HSAs.

During your employment with NXP, you may experience life events such as the birth of a child, marriage, or divorce. While these types of events may be demanding times in your life, they are also times when you need to consider how your benefits are affected. This section includes charts summarizing the actions you can take and some considerations when the following events occur:

- **When you are a new employee**;
- **If you marry or establish a domestic partnership**;
- **Adding an eligible dependent child**;
- **If you divorce or end a domestic partnership**;
- **If your child no longer qualifies as a dependent**;
- **If you take a leave of absence**;
- **If you retire**;
- **If you die**;
- **If your spouse/domestic partner or child dies**;
- **If you terminate employment**; and
- **When you reach age 65**.

> This list is not all inclusive and other qualified status changes may apply due to other events. For example, if your work schedule changes (such as you begin working less than 20 hours per week), this change may affect the benefits for which you are eligible. Contact the NXP Benefits Service Center for more information.

Most events require that you make changes **within 30 days** of the event. However, if you are making a change due to the loss of CHIP or Medicaid coverage or because you became eligible for contribution subsidies from Medicaid or CHIP, you may make changes within **60 days** of the event.

Any change you make must be consistent with the event allowing the change. For example, if a dependent child is no longer eligible due to reaching age 26, you may drop that child from coverage; you may not enroll yourself in coverage.

No Flexible Spending Account changes are allowed for any reason between November 1 and December 31.

We recommend you carefully review any changes to your Health Savings Account before processing them since they can significantly impact your paycheck, especially large HSA elections or changes late in the plan year.

Any change will be implemented as soon as administratively possible. If you do not take action when allowed within the time required (30 days), you must wait until the next annual enrollment, unless you experience another qualified status change that is reported within the time required (30 days).

When You Are a New Employee

See **Participation** for more detailed information.

Benefit Program	Action and/or Consideration
Medical, including pharmacy and behavioral health	• Enroll and choose coverage option for yourself, your spouse/domestic partner and/or eligible children **If no action is taken,** you will be automatically enrolled with employee -only coverage in the Medical Plan 1 coverage option and the applicable contributions will be deducted from your pre-tax earnings • If you enroll in the Medical Plan 1 coverage option, a Health Savings Account will be established in your name and you will receive a pro-rated amount of NXP's annual contribution based on when you are hired
Dental	• Enroll and choose coverage option for yourself, your spouse/domestic partner and/or eligible children
Vision	• Enroll and choose coverage option for yourself, your spouse/domestic partner and/or eligible children
Health Care/Limited Use Health Care Flexible Spending Account	• Enroll and consider the pay amount you want to contribute • If you enroll in the Medical Plan 1 coverage option, you can only enroll in the Limited Use Health Care Flexible Spending Account • **If hired after November 1,** participation begins January 1
Benefit Program	**Action and/or Consideration**

Dependent Care Flexible Spending Account	• Enroll and consider the pay amount you want to contribute • **If hired after November 1,** participation begins January 1
Short-Term Disability	• No enrollment required; coverage is automatic • Coverage begins on the first day of the month after 90 days of continuous service
Short-Term Disability Buy-Up	• Enroll and elect coverage • **If enrolled within 30 days of hire,** coverage begins on the first day of the month following 90 days of continuous service
Long-Term Disability	• No enrollment required; coverage is automatic • Coverage begins on the first day of the month after 90 days of continuous service
Basic Life Insurance	• No enrollment required; coverage is automatic • Designate beneficiary(ies)
Supplemental Life Insurance	• Enroll and choose level of coverage • Designate beneficiary(ies)
Dependent Life Insurance (Spouse/Domestic Partner and/or Children)	• Enroll and choose level of coverage for spouse/domestic partner and/or eligible children
Accidental Death and Dismemberment Insurance*	• No enrollment required; coverage is automatic
Business Travel Accident Insurance	• No enrollment required; coverage is automatic
Work/Life Programs	• Available on your first day of active employment • **Identity Theft Protection, Legal Services Plan, Pet Insurance:** Must enroll and choose level of coverage

If You Marry or Establish a Domestic Partnership

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• Enroll your spouse/domestic partner (and your spouse's/domestic partner's eligible children) • **HSA:** If you are enrolled in the Medical Plan 1 coverage option and are changing to family coverage, the amount you may contribute to your HSA may increase (no additional contribution will be made by NXP)
Dental	• Enroll your spouse/domestic partner (and your spouse's/domestic partner's eligible children)
Vision	• Enroll your spouse/domestic partner (and your spouse's/domestic partner's eligible children)
Health Care/Limited Use Health Care Flexible Spending Account	• Consider your contribution amount
Dependent Care Flexible Spending Account	• Enroll or consider your contribution amount
Short-Term Disability	• No action necessary
Short-Term Disability Buy-Up	• No action necessary
Long-Term Disability	• No action necessary
Basic Life Insurance	• Consider updating your beneficiary designation
Supplemental Life Insurance	• Consider amount of coverage and updating your beneficiary designation
Spouse/Domestic Partner and Child(ren) Life Insurance	• Enroll your spouse/domestic partner
Accidental Death and Dismemberment Insurance	• No action necessary
Business Travel Accident Insurance	• Consider updating your beneficiary designation

Benefit Program	Allowed Action and/or Consideration
Work/Life Programs	• **Adoption Assistance, Identity Theft Program, Legal Services Plan, Travel Assistance, Tutoring:** No action necessary/allowed • **Backup Care:** Consider adding dependents, if applicable • **Live and Work Well Program:** Available immediately to spouse/domestic partner • **Pet Insurance:** Consider enrolling or updating coverage

Adding an Eligible Dependent Child

Newborns (or any new dependents) are not automatically enrolled in coverage. You must report the birth of the child and add the child to coverage by calling the NXP Benefits Service Center at 888-375-2367. If you do not add the child within 30 days, he or she cannot be enrolled for coverage until the next annual enrollment, unless you experience another qualified status change that is reported within 30 days.

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• If you already have medical coverage, enroll child in coverage • **HSA:** If you are enrolled in the Medical Plan 1 coverage option and are changing to family coverage, the amount you may contribute to your HSA may increase (no additional contribution will be made by NXP)
Dental	• If you already have dental coverage, enroll child in coverage
Vision	• If you already have vision coverage, enroll child in coverage
Health Care/Limited Use Health Care Flexible Spending Account	• Consider contribution amount
Dependent Care Flexible Spending Account	• Enroll or consider contribution amount
Short-Term Disability	• Contact Occupational Health Resources and New York Life before childbirth
Short-Term Disability Buy-Up	• Contact Occupational Health Resources and New York Life before childbirth

Benefit Program	Allowed Action and/or Consideration
Long-Term Disability	• No action necessary
Basic Life Insurance	• Consider updating beneficiary designation
Supplemental Life Insurance	• Consider amount of coverage and updating beneficiary designation
Spouse/Domestic Partner and Child(ren) Life Insurance	• Enroll child for coverage
Accidental Death and Dismemberment Insurance	• No action necessary
Business Travel Accident Insurance	• Consider updating your beneficiary designation
Work/Life Programs	• **Adoption Assistance:** Benefit is available when child is placed in your home for adoption, the adoption is finalized or your attempt to adopt ends unsuccessfully • **Backup Care:** Consider adding dependent information • **All Other Programs:** No action necessary/allowed

If You Divorce or End a Domestic Partnership

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• Drop spouse/domestic partner and any ineligible children from coverage • **HSA:** If you are enrolled in the Medical Plan 1 coverage option and are changing to employee-only coverage, the amount NXP contributed to your HSA will not change; however, this may mean the amount you may contribute to your Health Savings Account may be less • **HSA:** If you have an HSA, money in your HSA may be considered part of your assets when going through divorce proceedings. Therefore, these accounts may be subject to division under the terms of the divorce or a Qualified Domestic Relations Order • **COBRA:** Spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions

Benefit Program	Allowed Action and/or Consideration
Dental	• Drop spouse/domestic partner and any ineligible children from coverage • **COBRA:** Spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions
Vision	• Drop spouse/domestic partner and any ineligible children from coverage • **COBRA:** Spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions
Health Care/Limited Use Health Care Flexible Spending Account	• Consider contribution amount • **COBRA:** Health Care Flexible Spending Account coverage may be extended to the end of the calendar year
Dependent Care Flexible Spending Account	• Enroll or consider contribution amount
Short-Term Disability	• No action necessary
Short-Term Disability Buy-Up	• No action necessary
Long-Term Disability	• No action necessary
Basic Life Insurance	• Consider updating beneficiary designation
Supplemental Life Insurance	• Consider updating beneficiary designation
Spouse/Domestic Partner and Child(ren) Life Insurance	• Drop spouse/domestic partner and any ineligible children from coverage • Your spouse/domestic partner may elect to convert or port coverage
Accidental Death and Dismemberment Insurance	• No action necessary
Business Travel Accident Insurance	• Consider updating your beneficiary designation

Benefit Program	Allowed Action and/or Consideration
Work/Life Programs	• **Adoption Assistance, Travel Assistance, Tutoring:** No action necessary/allowed • **Backup Care, Identity Theft Protection:** Consider updating dependents, if applicable • **Life and Work Well Program:** Spouse's/domestic partner's eligibility ends on date of divorce or termination of domestic partnership • **Pet Insurance:** Drop pet insurance, if applicable

If Your Covered Child No Longer Qualifies as a Dependent

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• Coverage ends on the last day of the month • **HSA:** Only the child's eligible expenses incurred before the date the child no longer qualifies are eligible • **COBRA:** Child is eligible for COBRA for up to 36 months with paid contributions
Dental	• Coverage ends on the last day of the month • **COBRA:** Child is eligible for COBRA for up to 36 months with paid contributions
Vision	• Coverage ends on the last day of the month • **COBRA:** Child is eligible for COBRA for up to 36 months with paid contributions
Health Care/Limited Use Health Care Flexible Spending Account	• Only the child's eligible expenses incurred before the date the child no longer qualifies will be reimbursed • **COBRA:** Health Care Flexible Spending Account coverage may be extended to the end of the calendar year
Dependent Care Flexible Spending Account	• Consider contribution amount • Only the child's eligible expenses incurred before the child no longer qualifies will be reimbursed
Short-Term Disability	• No action necessary
Short-Term Disability Buy-Up	• No action necessary
Long-Term Disability	• No action necessary
Basic Life Insurance	• No action necessary

Benefit Program	Allowed Action and/or Consideration
Supplemental Life Insurance	• No action necessary
Spouse/Domestic Partner and Child(ren) Life Insurance	• Dependent can apply to convert or port coverage
Accidental Death and Dismemberment Insurance	• No action necessary
Business Travel Accident Insurance	• No action necessary
Work/Life Programs	• **Adoption Assistance, Legal Services Plan, Life and Work Well Program, Pet Insurance, Travel Assistance, Tutoring:** No action necessary/allowed • **Backup Care, Identity Theft Protection:** Consider updating dependent information

If You Take a Leave of Absence

Under certain conditions, you can continue your NXP health care coverage and life insurance coverage (and dependent coverage), if you are on an approved leave of absence. You must continue to pay the monthly contributions required for each type of coverage.

In addition to a paid leave due to disability (as detailed in **Disability Income Benefits**), NXP provides various types of leaves of absence:

- **Medical Leave:** For your own serious health condition or due to a workplace injury or illness or for the illness or qualifying serious health condition of a family member;
- **Paid Maternity/Parental Leaves:** For a child's birth or the placement of a child with you for adoption or foster care:

Maternity Leave: Maternity leave provides you with 100% of your pay for the approved period of your short-term disability; Note:

  - This leave must be taken continuously and completed within the first six months after the birth or placement;

You must have been with NXP for at least three months ; and
This leave runs concurrent with NXP's Short-Term Disability program and state leave laws;

For babies bore on January 1 or later, maternity leave is provided at 100% of your pay during your approved short-term disability for six weeks, with an additional six weeks paid at 100% of your pay through parental leave for a total of 12 weeks of paid leave.

- ***Parental Leave:*** Parental leave provides you with up to six weeks at 100% of your pay; Note:
  - This leave must be taken continuously and completed within the first 12 months after the birth or within the first three months of placement for adoption of foster care;

You must have been with NXP for at least three months to be eligible for this leave; and
This leave runs concurrent with state leave laws;

Paid maternity/parental leaves combined are limited to a total of 12 weeks of 100% paid leave.

- **Leave under the Family and Medical Leave Act (FMLA):**

- For the birth of a son or daughter and to care for such son or daughter;
- For the placement of a child with you for adoption or foster care;
- To care for a spouse, child or parent with a serious health condition;
- For your own serious health condition that makes you unable to perform the functions of your position;
- To attend to qualifying exigencies that have arisen from the fact that your spouse, child or parent who is a covered military member is on or has been notified of an impending call to covered active duty in the armed forces; or
- To care for a covered service member with a serious injury or illness and you are the spouse, child, parent or next of kin of the covered service member.

- **ADA Leave:** For your own serious health condition when you are not yet or no longer eligible for FMLA leave.
- **Personal Leave**: To attend to personal matters; and
- **Military Service Leave**: If you are called to active duty or temporary active duty by the U.S. armed forces or you are on temporary training duty with the U.S. armed services.

If You Are on a Non-Disability Leave of Absence

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• **If you have less than six months of service,** your coverage ends on the last day of the month in which the leave occurs • **If you have six or more months of service,** your coverage may continue for up to six months if monthly contributions are paid • **If you are on a military service leave,** your coverage will continue until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy • **HSA:** You may continue to use your HSA; you can make contributions until coverage under an eligible HDHP ends • **COBRA:** You may continue coverage under COBRA for up to 18 months with paid contributions
Dental	• **If you have less than six months of service,** your coverage ends on the last day of the month in which the leave occurs • **If you have six or more months of service,** your coverage may continue for up to six months if monthly contributions are paid • **If you are on a military service leave,** your coverage will continue until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy • **COBRA:** You may continue coverage under COBRA for up to 18 months with paid contributions
Vision	• **If you have less than six months of service,** your coverage ends on the last day of the month in which the leave occurs • **If you have six or more months of service,** your coverage may continue for up to six months if monthly contributions are paid • **If you are on a military service leave,** your coverage will continue until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy • **COBRA:** You may continue coverage under COBRA for up to 18 months with paid contributions

Benefit Program	Allowed Action and/or Consideration
Health Care/Limited Use Health Care Flexible Spending Account	• **If you have less than six months of service,** your participation ends on the last day of the month in which your leave begins • **If you have six or more months of service,** your participation may continue for up to six months if monthly contributions are paid (contributions will be paid on an after-tax basis); you may stop contributions at the end of the month in which your leave occurs • You have until March 31 of the following year to submit claims for eligible expenses incurred through the date your contributions ended • **COBRA:** You may extend coverage under COBRA to the end of the calendar year
Dependent Care Flexible Spending Account	• **If you are on an unpaid leave of absence,** your participation ends on the last day of active employment before your leave • **If you are on a paid leave of absence,** you may continue contributions or change or stop contributions within 30 days of beginning your leave • You can request reimbursement from any remaining account balance through March 31 for the following year for expenses incurred through the end of the calendar year
Short-Term Disability	• Your coverage ends on date your leave begins • If you are on an approved leave of absence before the start of Short-Term Disability, you will be eligible for coverage • If your leave is due to a medical condition and within the first six months of your leave you are determined to be disabled under the Disability Income Plan, you will be reinstated to the Plan, retroactive to the date the leave began
Short-Term Disability Buy-Up	• Your coverage ends on date your leave begins • If your leave is due to a medical condition and within the first six months of your leave you are determined to be disabled under the Disability Income Plan, you will be reinstated to the Plan, retroactive to the date the leave began

Benefit Program	Allowed Action and/or Consideration
Long-Term Disability	• Your coverage ends on date your leave begins • If you are on an approved leave of absence, you will be covered to the end of the month following the month in which your leave of absence begins • If your leave is due to a medical condition and within the first six months of your leave you are determined to be disabled under the Disability Income Plan, you will be reinstated to the Plan, retroactive to the date the leave began
Basic Life Insurance	• **If you have less than six months of service,** your coverage ends on the last day of the month in which your leave begins • **If you have six or more months of service,** your coverage continues at no cost to you for up to six months from the last day of the month in which your leave began • **If you are on a military service leave,** your coverage continues until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy • When your coverage ends, you may elect to convert or port coverage
Supplemental Life Insurance	• **If you have less than six months of service,** your coverage ends on the last day of the month in which your leave begins • **If you have six or more months of service,** your coverage may continue for up to six months from the last day of the month in which your leave began if contributions are paid • **If you are on a military service leave,** your coverage continues until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy • When your coverage ends, you may elect to convert or port coverage

Benefit Program	Allowed Action and/or Consideration
Spouse/Domestic Partner and Child(ren) Life Insurance	• **If you have less than six months of service,** coverage ends on the last day of the month in which your leave begins • **If you have six or more months of service,** coverage may continue for up to six months from the last day of the month in which your leave began if contributions are paid • **If you are on a military service leave,** coverage continues until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy • When coverage ends, your dependents may elect to convert or port coverage
Accidental Death and Dismemberment Insurance	• **If you have less than six months of service,** your coverage ends on the last day of the month in which your leave begins • **If you have six or more months of service,** your coverage continues at no cost to you for up to six months from the last day of the month in which your leave began • **If you are on a military service leave,** your coverage continues until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy
Business Travel Accident Insurance	• Your coverage ends on date your leave begins
Work/Life Programs	• **Adoption Assistance, Travel Assistance:** Benefit is only available when you are actively at work • **Backup Care, Live and Work Well Program, Tutoring:** Benefit is available during your leave • **Identity Theft Protection, Legal Services Plan, Pet Insurance:** Benefit is available during your leave, provided you continue to pay premium

If You Are on a Disability Leave of Absence

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• Your coverage continues as long as you remain employed and eligible for Long-Term Disability Plan benefits if monthly contributions are paid • **HSA:** You may continue to use your HSA; you can make contributions until coverage under an eligible HDHP ends • **COBRA:** COBRA continuation coverage is not available during long-term disability leave
Dental	• Your coverage continues as long as you remain employed and eligible for Long-Term Disability Plan benefits if monthly contributions are paid • **COBRA:** COBRA continuation coverage is not available during long-term disability leave
Vision	• Your coverage continues as long as you remain employed and eligible for Long-Term Disability Plan benefits if monthly contributions are paid • **COBRA:** COBRA continuation coverage is not available during long-term disability leave
Health Care/Limited Use Health Care Flexible Spending Account	• Your participation continues as long as you remain employed and disabled if monthly contributions are paid • You may change or stop your contributions at the end of the month in which your leave occurs • You have until March 31 of the following year to submit claims for eligible expenses incurred through the date your contributions ended • Your participation ends on the day you become eligible for the Post-Employment Benefits Plan • **COBRA:** COBRA continuation coverage is not available during long-term disability leave
Dependent Care Flexible Spending Account	• You may continue contributions or change or stop contributions within 30 days of beginning your leave • Your participation may continue until termination of employment under the Medical Leave Policy if monthly contributions are paid • You can request reimbursement from your remaining account balance through March 31 for the following year for expenses incurred through the end of the calendar year

Benefit Program	Allowed Action and/or Consideration
Short-Term Disability	• Benefits are paid for up to 180 days • Contact Occupational Health Resources and New York Life
Short-Term Disability Buy-Up	• Your contributions are waived while you are receiving benefits
Long-Term Disability	• Benefits begin after 180 days of short-term disability
Basic Life Insurance	• **If you have six or more months of service,** your coverage continues for up to 12 months. • **If you remain totally disabled at 12 months,** your coverage may continue for the duration of your disability, up to age 65 if you were disabled before age 60 or up to the earlier of age 70 or five years from onset of disability if you were disabled after age 60.
Supplemental Life Insurance	• **If you have six or more months of service,** your coverage may continue for up to 12 months if contributions are paid. • **If you remain totally disabled at 12 months,** your coverage may continue for duration of your approved disability, up to age 65 if you were disabled before age 60 or up to the earlier of age 70 or five years from the onset of disability if you were disabled after age 60.
Spouse/Domestic Partner and Child(ren) Life Insurance	• Coverage may continue if contributions are paid
Accidental Death and Dismemberment Insurance	• **If you have less than six months of service,** your coverage ends on the last day of the month in which your disability leave of absence begins • **If you have six or more months of service,** your coverage continues for up to 12 months
Business Travel Accident Insurance	• Coverage ends on the date your leave begins
Work/Life Programs	• **Adoption Assistance, Travel Assistance:** Benefit is only available when you are actively at work • **Backup Care, Live and Work Well Program, Tutoring:** Benefit is available during your leave • **Identity Theft Protection, Legal Services Plan, Pet Insurance:** Benefit is available during your leave, provided you continue to pay premium

When You Return from a Leave of Absence

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• If you were previously covered, your coverage resumes on first day of reinstatement • **HSA:** There is no change
Dental	• If you were previously covered, your coverage resumes on first day of reinstatement
Vision	• If you were previously covered, your coverage resumes on first day of reinstatement
Health Care/Limited Use Health Care Flexible Spending Account	• If you were previously participating, your participation is reinstated at your last election choice • You may elect to make up missed contributions
Dependent Care Flexible Spending Account	• If you were previously participating, your participation is reinstated at your last election choice • You may change your contribution amount if you had a qualified status change
Short-Term Disability	• Your coverage resumes on your first day of reinstatement
Short-Term Disability Buy-Up	• If you were previously enrolled, your coverage resumes on your first day of reinstatement
Long-Term Disability	• Your coverage resumes on your first day of reinstatement
Basic Life Insurance	• Your coverage resumes on your first day of reinstatement
Supplemental Life Insurance	• If you were previously enrolled, your coverage resumes on your first day of reinstatement
Spouse/Domestic Partner and Child(ren) Life Insurance	• If previously enrolled, coverage resumes on your first day of reinstatement
Accidental Death and Dismemberment Insurance	• Your coverage resumes on your first day of reinstatement
Business Travel Accident Insurance	• Your coverage resumes on your first day of reinstatement

Benefit Program	Allowed Action and/or Consideration
Work/Life Programs	• **Adoption Assistance, Travel Assistance:** Available on your first day of reinstatement • **Backup Care, Live and Work Well Program, Tutoring:** Benefit is available during leave and remains available upon your reinstatement • **Identity Theft Protection, Legal Services Plan, Pet Insurance:** If you were previously covered, your coverage resumes on first day of reinstatement

If You Retire

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• Coverage for you and your dependents ends on the last day of the month in which your employment ends • **If eligible,** coverage may be provided under the Post-Employment Benefits Plan (see the Post-Employment Benefits Plan SPD) • **HSA:** NXP contributions are only made while you are an active employee covered under the Plan. However, since you own the account, you may continue to use your account for eligible expenses; if your account is with the HSA bank, the HSA bank will send you a new card and account numbers • **COBRA:** You and your dependents are eligible for COBRA for up to 18 months with paid contributions
Dental	• Coverage for you and your dependents ends on the last day of the month in which your employment ends • **If eligible,** coverage may be provided under the Post-Employment Benefits Plan (see the Post-Employment Benefits Plan SPD) • **COBRA:** You and your dependents are eligible for COBRA for up to 18 months with paid contributions
Vision	• Coverage for you and your dependents ends on the last day of the month in which your employment ends • **If eligible,** coverage may be provided under the Post-Employment Benefits Plan (see the Post-Employment Benefits Plan SPD) • **COBRA:** You and your dependents are eligible for COBRA for up to 18 months with paid contributions

Benefit Program	Allowed Action and/or Consideration
Health Care/Limited Use Health Care Flexible Spending Account	• Your contributions end on the last day of the month in which your employment ends • **COBRA:** Your Health Care Flexible Spending Account participation may be extended to the end of the calendar year
Dependent Care Flexible Spending Account	• Your contributions end with the last pay period before your last day of employment • You can request reimbursement from your remaining account balance through March 31 of the following year for expenses incurred through the end of the calendar year
Short-Term Disability	• Your coverage ends on the date your employment ends
Short-Term Disability Buy-Up	• Your coverage ends on the date your employment ends
Long-Term Disability	• Your coverage ends on the date your employment ends
Basic Life Insurance	• Your coverage ends on the last day of the month in which your employment ends • You may apply to convert or port coverage
Supplemental Life Insurance	• Your coverage ends on the last day of the month in which your employment ends • You may apply to convert or port coverage
Spouse/Domestic Partner and Child(ren) Life Insurance	• Coverage ends on the last day of the month in which your employment ends • Dependents may apply to convert or port coverage
Accidental Death and Dismemberment Insurance	• Your coverage ends on the last day of the month in which your employment ends • You may apply to port coverage
Business Travel Accident Insurance	• Your coverage ends on the date your employment ends

Benefit Program	Allowed Action and/or Consideration
Work/Life Programs	• **Adoption Assistance, Backup Care, Live and Work Well Program, Travel Assistance, Tutoring:** Benefits end when your employment ends • **Identity Theft Protection:** Coverage ends on the last day of the period for which premiums were paid; you may continue coverage on your own (premiums are your responsibility) • **Legal Services Plan:** Benefit ends when your employment ends, but the Plan will cover legal fees for covered services that were opened and pending during your employment • **Pet Insurance:** Your coverage ends on the last day of the month in which your employment ends; you may continue coverage on your own (premiums are your responsibility)

If You Die

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• Your dependent's coverage ends on the last day of the month in which you die • **HSA:** If you have an HSA when you die, the account may be transferred to your designated beneficiary. The account will continue to be considered an HSA for your spouse. However, if you designate another beneficiary (other than your spouse), it will no longer be considered an HSA and your beneficiary will be required to pay taxes on the account • **COBRA:** Your spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions
Dental	• Your dependent's coverage ends on the last day of the month in which you die • **COBRA:** Your spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions
Vision	• Your dependent's coverage ends on the last day of the month in which you die • **COBRA:** Your spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions
Health Care/Limited Use Health Care Flexible Spending Account	• Participation ends on the last day of the month in which you die • **COBRA:** Your Health Care Flexible Spending Account participation may be extended to the end of the calendar year
Dependent Care Flexible Spending Account	• Contributions end with your last pay period before your last day of employment • Survivors can request reimbursement from your remaining account balance through the end of the calendar year
Short-Term Disability	• Your coverage ends on date of your death
Short-Term Disability Buy-Up	• Your coverage ends on date of your death
Long-Term Disability	• Your coverage ends on date of your death
Basic Life Insurance	• Full benefit is payable to your beneficiary(ies)

Benefit Program	Allowed Action and/or Consideration
Supplemental Life Insurance	• If enrolled, full benefit is payable to your beneficiary(ies)
Spouse/Domestic Partner and Child(ren) Life Insurance	• Coverage ends on the last day of the month in which you die • Dependents may apply to convert or port coverage
Accidental Death and Dismemberment Insurance	• If applicable, full benefit is payable to your beneficiary(ies)
Business Travel Accident Insurance	• If applicable, full benefit is payable to your beneficiary(ies)
Work/Life Programs	**Adoption Assistance, Backup Care, Legal Services Plan, Live and Work Well Program, Pet Insurance, Travel Assistance, Tutoring:** Benefits end on the date of your death • **Identity Theft Protection, Pet Insurance:** Coverage ends on the last day of the period for which premiums were paid

If Your Covered Spouse/Domestic Partner or Child Dies

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• Coverage for that person ends on the date of his or her death • **HSA:** If you are enrolled in the Medical Plan 1 coverage option and are changing to individual coverage, the amount NXP contributed will not change; however, this may mean the amount you are eligible to contribute to your Health Savings Account may be less
Dental	• Coverage for that person ends on the date of his or her death
Vision	• Coverage for that person ends on the date of his or her death
Health Care/Limited Use Health Care Flexible Spending Account	• Consider contribution amount
Dependent Care Flexible Spending Account	• Consider contribution amount
Short-Term Disability	• No action necessary
Short-Term Disability Buy-Up	• No action necessary
Long-Term Disability	• No action necessary
Basic Life Insurance	• Consider updating your beneficiary designation
Supplemental Life Insurance	• Consider amount of coverage and updating your beneficiary designation
Spouse/Domestic Partner and Child(ren) Life Insurance	• If dependent was enrolled for coverage, full benefit is payable to you
Accidental Death and Dismemberment Insurance	• No action necessary
Business Travel Accident Insurance	• Consider updating your beneficiary designation

Benefit Program	Allowed Action and/or Consideration
Work/Life Programs	• No action necessary/allowed • **Backup Care, Identity Theft Program:** Update dependent information, if applicable

If You Terminate Employment

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	• Coverage for you and your dependents ends on the last day of the month in which your employment ends • **HSA:** NXP contributes will end; however, you own this account, so you may continue to use the account for eligible expenses • **COBRA:** You and your dependents may be eligible for COBRA for up to 18 months with paid contributions
Dental	• Coverage for you and your dependents ends on the last day of the month in which your employment ends • **COBRA:** You and your dependents may be eligible for COBRA for up to 18 months with paid contributions
Vision	• Coverage for you and your dependents ends on the last day of the month in which your employment ends • **COBRA:** You and your dependents may be eligible for COBRA for up to 18 months with paid contributions
Health Care/Limited Use Health Care Flexible Spending Account	• Your contributions end on the last day of the month in which your employment ends • **COBRA:** Your Health Care Flexible Spending Account participation may be extended to the end of the calendar year
Dependent Care Flexible Spending Account	• Your contributions end with the last pay period before your last day of employment • You can request reimbursement from your remaining account balance through March 31 for the following year for expenses incurred through the date your employment ended
Short-Term Disability	• Your coverage ends on the date your employment ends
Short-Term Disability Buy-Up	• Your coverage ends on the date your employment ends
Long-Term Disability	• Your coverage ends on the date your employment ends unless you are disabled and terminated under the Medical Leave Policy and your coverage continues as a Terminated Disabled Participant (TDP)
Basic Life Insurance	• Your coverage ends on the last day of the month in which your employment ends • You may apply to convert or port coverage

Benefit Program	Allowed Action and/or Consideration
Supplemental Life Insurance	• If enrolled, your coverage ends on the last day of the month in which your employment ends • You may apply to convert or port coverage
Spouse/Domestic Partner and Child(ren) Life Insurance	• If enrolled, your dependent's coverage ends on the last day of the month in which your employment ends • Your dependents may apply to convert or port coverage
Accidental Death and Dismemberment Insurance	• Your coverage ends on the last day of the month in which your employment ends • You may apply to port coverage
Business Travel Accident Insurance	• Your coverage ends on the date your employment ends
Work/Life Programs	• **Adoption Assistance, Backup Care, Travel Assistance, Tutoring:** Benefit ends when your employment ends • **Identity Theft Program:** Coverage ends on the last day of the period for which premiums were paid; you may continue coverage on your own (premiums are your responsibility) • **Legal Services Plan:** Benefit ends when your employment ends, but the Plan will cover legal fees for covered services that were opened and pending during your employment • **Life and Work Well Program:** Benefit ends 90 days after your employment ends • **Pet Insurance:** Coverage ends on the last day of the month in which your employment ends; you may continue coverage on your own (premiums are your responsibility)

When You Reach Age 65

Many Americans become eligible for Medicare at age 65. If you continue working at NXP when you reach age 65, the Social Security Administration may allow you to defer your Medicare coverage without penalty until you retire. This section includes information about the Medicare enrollment process.

> If you continue to work beyond age 65, are enrolled in the Medical Plan 1 coverage option and do not enroll in Medicare, NXP will continue to make contributions to your HSA. If you enroll in Medicare, no contributions are allowed to your HSA; however, you may use your HSA for eligible expenses.

Medicare and Social Security

During the 3-4 months before your 65th birthday, you should contact your local Social Security Administration office. You will have to provide proof of your eligibility for both Medicare and Social Security (though it is not necessary to actually receive Social Security retirement benefits to qualify for Medicare). Documents you may need include:

- Your Social Security card (or a record of your number);
- Your birth certificate;
- Proof of U.S. citizenship or lawful alien status if you were not born in the U.S.;
- Military discharge papers; and/or
- Last year's Form W-2 or tax return.

Original Medicare, Medicare Parts A and B, is a fee-for-service medical plan offered by the federal government. Medicare Part A is provided at no cost to most people who are eligible for Medicare (known as Medicare beneficiaries). Medicare Part B requires a monthly premium. When you enroll, you have a number of options for making payment, including automatic withdrawal from your Social Security benefits.

For many, Original Medicare coverage may begin on the first day of the month before their 65th birthday. If your birthday falls on the first day of the month, your Medicare coverage may begin on the first day of the month before your birthday. For example:

- If your 65th birthday is May 10, your Medicare coverage may begin on May 1; or
- If your 65th birthday is August 1, your Medicare coverage may begin on July 1.

You may start the Medicare enrollment process up to 120 days before the date you want your Medicare coverage to begin. If you are already age 65 or older when you enroll, you may arrange to start your Original Medicare coverage on the day that your NXP active plan coverage ends.

> If you need help completing any Social Security Administration (SSA) Form, contact the NXP Benefits Service Center at 888-375-2367.

Contact the nearest Social Security Administration office or visit **SocialSecurity.gov** or **Medicare.gov** for more information.

Claims and Appeals

This section provides information on:

- How to **file claims**
- The **appeals** process
- How your benefits are **coordinated** with other plans and
- Your **privacy** rights .

Filing Claims

Note: All claims except for urgent care claims must be submitted in writing to the applicable Claims Administrator. Under some plans, you start the claims process by contacting the NXP Benefits Service Center, as shown in this chart. If you wait any longer than the indicated deadlines, you are not eligible for Plan benefits relating to those expenses.

> Since the Health Savings Account belongs to you; you do not need to submit claims, therefore there are no claims or appeals procedures relating to your Health Savings Account.

Filing for Your Benefits			
Plan/Program	**Information Needed and Deadline**	**Claims Administrator**	**Initial Decision**
NXP Medical Plan (including Behavioral Health Program)	*Network Care:* You are not required to file a claim when using a network provider *Out-of-Network Care*:* If your provider does not submit the claim for you, you must submit an itemized bill that includes: • Date of service • Description of service, with CPT code if applicable • Dollar amount • Diagnosis • Name and address of provider • Patient's name Write the NXP employee's identification number on the statement **Deadline:** One year from date service is provided	**NXP Medical Plan** **UnitedHealthcare** P.O. Box 30555 Salt Lake City, UT 84130-0555	**Urgent Care Claim:** Within 72 hours after claim is received **Concurrent Care Claim:** Within 72 hours after claim is received **Pre-Service Claim (not urgent):** Within 15 days** after claim is received **Post-Service Claim:** Within 30 days** after claim is received

Filing for Your Benefits			
Plan/Program	**Information Needed and Deadline**	**Claims Administrator**	**Initial Decision**
Prescription Drug	If your provider does not submit the claim for you, you must submit an itemized bill that includes: • Date of service • Description of service • Dollar amount • Name and address of provider • Patient's name Write the NXP employee's identification number on the statement **Deadline:** One year from date service is provided	**NXP Medical Plan** **CVS Caremark** P.O. Box 52136 Phoenix, AZ 85072-2136	Within 30 days** after claim is received
Dental Plan	Claims for benefits must be submitted on a standard Delta Dental claim form. If your provider does not submit a claim for you, you can request a claim form from Delta Dental. The form must be completed and signed by the provider and patient (or the parent or guardian if the patient is a minor) **Deadline:** One year from date the service is provided	**Delta Dental Insurance Company** P.O. Box 1809 Alpharetta, GA 30023-1809	Within 30 days after claim is received

Filing for Your Benefits			
Plan/Program	**Information Needed and Deadline**	**Claims Administrator**	**Initial Decision**
Vision Plan	If your provider does not submit the claim for you, you must submit an itemized bill that includes: • Date of service • Description of service • Dollar amount • Name and address of provider • Patient's name On the statement, write the NXP employee's name and either birth date or the last four digits of his/her Social Security number **Deadline:** One year from date service is provided	**VSP** P.O. Box 997105 Sacramento, CA 95899-7105	Within 30 days** after claim is received
Flexible Spending Accounts	Completed Health Care Flexible Spending Account/Dependent Care Flexible Spending Account claim either by mail or online and all supporting documentation, such as receipts or Explanation of Benefits **Deadline:** By March 31 of the following year	**UnitedHealthcare** P.O. Box 981178 El Paso, TX 79998-1178	Within 30 days** after the claim is received
Disability Income Plan	See **Filing a Claim – Notifying NXP of Your Disability**		

Filing for Your Benefits			
Plan/Program	**Information Needed and Deadline**	**Claims Administrator**	**Initial Decision**
Life and Accidental Death and Dismemberment Insurance	Contact the NXP Benefits Service Center An original death certificate for death claims (photocopies cannot be accepted) **Deadline:** Within 90 days after the covered loss (180 days for disability claims)	**NXP Benefits Service Center** P.O. Box 617907 Chicago, IL 60661	Within 90 days after claim is filed (45 days for disability claims) Plus, extension of up to 90 days (30 for disability claims) in special circumstances

* *Includes care received abroad by eligible plan members.*

** *Plus, extension of up to 15 days in special circumstances.*

Group Health Plans

As identified in the preceding charts, the following special rules apply to expedite claims under the NXP group health plans (i.e., the Medical Plan, Dental Plan, Vision Plan and Health Care Flexible Spending Accounts), depending on the type of claim involved. Any reference in this section to "you" includes your authorized representative . The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

Urgent Care Claim

An urgent care claim is any claim for medical care for which the applicable periods for the Plan to make non-urgent care determinations could:

- Seriously jeopardize your life or health or your ability to regain maximum function;
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus; or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment.

If you provide insufficient information for the Plan to decide an urgent care claim, the Plan will notify you of the deficiency and the necessary information to complete the claim within 24 hours after its receipt of your claim. You must provide the requested information within a reasonable period, but not more than 48 hours after the Plan notifies you of the deficiency. The Plan will then notify you of its decision within 48 hours of the earlier of its receipt of the requested information or the end of the period within which you were to provide the requested information.

Pre-Service Claim

A pre-service claim is any claim for a Plan benefit where the Plan requires you to get approval of the benefit in advance of receiving the care. If your claim is incomplete, the Plan will notify you of the Plan's procedures for a pre-service claim and your failure to follow them within five days after its receipt of your deficient claim if your attempt at filing:

- Is communicated by you or your authorized representative to the NXP Benefits Service Center; and
- Names your specific medical condition or symptom and a specific treatment, service or product for which approval is requested.

If your claim is incomplete but does not meet to the above, you will be treated as not having filed the required claim for benefits.

Post-Service Claim

A post-service claim is any claim for a benefit for care already provided.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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Payment of Benefits

Except as required by the *No Surprises Act*, you may not assign, transfer or in any way convey your Plan benefits or any cause of action related to your Plan benefits to a provider or to any other third party. Nothing in this Plan will be construed to make the Plan, Plan Sponsor or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for benefits.

The Plan does not recognize claims for benefits brought by a third party. Also, any third party will not have standing to bring any claim independently, as a covered person or beneficiary, or derivatively, as an assignee of a covered person or beneficiary.

References third parties include providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a convenience to you, the Claims Administrator may, where practicable and as determined in their sole discretion, pay benefits directly to a provider. Any such payment to a provider:

- Is **not** an assignment of your Plan benefits or of any legal or equitable right to institute any proceeding relating to your benefits;

- Is **not** a waiver of the prohibition on assignment of Plan benefits; and
- Will **not** estop the Plan, Plan Sponsor or Claims Administrator from asserting that any purported assignment of Plan benefits is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you relating to the benefits is extinguished by the payment. If any payment of your benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your benefits claim, and the Plan reserves the right to offset any benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan).

Claim Decision

You will receive a decision in writing. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific Plan provisions upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

For disability and health benefits, the written denial notice also informs you of:

- Any specific rule, guideline or protocol that was relied upon or a statement that the rule, guideline or protocol was relied upon and that you may request a copy of it free of charge;
- If the adverse determination is based on a medical necessity or experimental treatment exclusion, an explanation of the scientific or clinical judgment or a statement that you may request such explanation free of charge; and
- For an urgent care claim, a description of the expedited review process.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in NXP's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination;
- Demonstrate compliance with the Plan's administrative processes or safeguards; or
- For disability and health benefits, constitute a statement of the Plan's policy or guideline regarding the benefit for your diagnosis, whether relied upon or not.

Overpayment and Underpayment – For UnitedHealthcare Medical Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that this Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan overpays a provider, UnitedHealthcare reserves the right to recover the excess amount from the provider. A covered person or any other person or organization that was overpaid, must make a refund to the Plan if:

- The Plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you;
- All or some of the payment this Plan made exceeded the benefits under this Plan; or
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested. If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Plan benefits. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Plan benefits payable for services provided to other covered persons or future Plan benefits for services provided to persons under other plans for which UnitedHealthcare processes payments, according to a transaction in which the Plan's overpayment recovery rights are assigned to the other plans in exchange for the plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Dental Plan Claim Provisions

- **Clinical Examination:** Before approving a claim, Delta Dental is entitled to receive from any attending or examining provider, or from hospitals in which a provider's care is provided, information and records relating to attendance to or examination of, or treatment provided to, you as may be required to administer the claim, or have you examined by a dental consultant retained by Delta Dental at Delta Dental's expense, in or near your community or residence. Delta Dental will keep the information and records confidential.
- **Notice of Claim Form:** Delta Dental will give you or your provider, on request, a claim form to make claim for benefits. The form should be completed and signed by the provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to Delta Dental at the address provided. If the form is not provided by Delta Dental within 15 days after requested by you or your provider, you will be considered to have timely filed a claim. You or your provider may download a claim form from the Delta Dental website.

- **Written Notice of Claim/Proof of Loss:** Delta Dental must be given written proof of loss within 12 months after the date of the loss unless the claimant is legally incapacitated. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible.

Your Right to Appeal

NXP wants to be sure that you and your covered dependents and beneficiaries receive the full benefits for which you or they are eligible under each of the NXP Plans.

If an initial claim for Plan benefits is denied, in whole or in part, in an Explanation of Benefits form, a letter from the NXP Benefits Service Center or otherwise, you may appeal the denial. Your appeal must be in writing and should contain the reasons you believe you are entitled to benefits and any additional information or documentation to support your claim for benefits. You must send written appeals to different locations, depending on the plan. For an urgent care claim, you may submit your request for review orally or in writing. For an eligibility or enrollment claim, you must call the NXP Benefits Service Center at 888-375-2367 to request a *Claim Initiation Notice*.

For all claims (excluding disability claims and health benefit claims), the applicable decision makers consider your request for review and notify you in writing of their decision within 60 days of receiving your request. If, because of special circumstances, they cannot make a decision within the initial review period, the review period may be extended up to an additional 60 days. If an extension be necessary, you are notified before the end of the initial review period.

For a disability claim, the applicable decision makers consider your appeal and notify you in writing of their decision within 45 days of receiving your request. If, because of special circumstances, they cannot make a decision within the initial review period, the review period may be extended up to an additional 45 days. If an extension is necessary, you are notified before the end of the initial review period.

For health benefit claims, the applicable decision makers consider your request for review and notify you of their decision within the following periods:

- **Urgent Care Claims:** 36 hours of receipt of your appeal (30 days of receipt of your appeal for dental claims);
- **Pre-Service Claims:** 15 days of receipt of your appeal (30 days of receipt of your appeal for dental claims); or
- **Post-Service Claims:** 30 days of receipt of your appeal (30 days of receipt of your appeal for dental claims).

For a Life Insurance Plan claim, the applicable decision makers consider your request for review and notify you in writing of their decision within 60 days of receiving your request. If, because of special circumstances, they cannot make a decision within the initial review period, the review period may be extended up to an additional 60 days. If an extension is necessary, you are notified before the end of the initial review period.

You will receive a decision on appeal in writing as detailed in **Claim Decision**.

Where to Send Appeals		
Type of Appeal	**Send Written Appeals to:**	**Deadline for Submitting Written Appeals**
Eligibility and Enrollment (all Plans and Programs, including any rescission or retroactive termination of coverage)	**NXP Benefits Determination Review Team** NXP Semiconductors Attention: Benefits 6501 West William Cannon Drive, OE 331 Austin, TX 78735	180 days from notification of denial
Medical Plan (including Behavioral Health Program)	**UnitedHealthcare Appeals** P.O. Box 30432 Salt Lake City, UT 84130-0432	180 days from notification of denial **Urgent Care:** 72 hours from receipt of denial
Prescription Drug Program	**CVS Caremark Appeals Department** Mail Code 109 P.O. Box 52084 Phoenix, AZ 85072-2084	180 days from notification of denial **Urgent Care:** 72 hours from receipt of denial
Aetna Global Medical Plan For U.S. Inpatriates and U.S. Expatriates	**Aetna Global Benefits/Aetna** P.O. Box 981543 El Paso, TX 79998-1543 USA **Fax:** 800-475-8751	180 days from notification of denial **Urgent Care:** 72 hours from receipt of denial
GeoBlue Global Medical Plan For U.S. Inpatriates and U.S. Expatriates	**Worldwide Insurance Services, LLC** **Attn: Appeals Department** **933 First Avenue** **King of Prussia, PA 19406**	180 days from notification of denial
Where to Send Appeals		

Type of Appeal	Send Written Appeals to:	Deadline for Submitting Written Appeals
Dental Plan	**Delta Dental Insurance Company** P.O. Box 1809 Alpharetta, GA 30023-1809	180 days from notification of denial
Vision Plan	**VSP** 3333 Quality Drive, Rancho Cordova, CA 95670-7985	180 days from notification of denial
Flexible Spending Account Plan	**UnitedHealthcare Appeals** Attention: Appeals P.O. Box 981512 El Paso, TX 79998-1512	180 days from notification of denial
Disability Income Plan	**New York Life Appeals** 80 Livingston Avenue Roseland, NJ 07068	180 days from notification of denial
Life and Accidental Death and Dismemberment Insurance Plans	**MetLife Group Life Claims** P.O. Box 6100 Scranton, PA 18505-6100	60 days from notification of denial
Business Travel Accident Insurance Plan	**AIG Accident and Health Claims Department** Accident & Health P.O. Box 25987, Shawnee Mission, KS 66225	180 days from notification of denial
Adoption Assistance Program	**NXP Benefits** -6501 W. William Cannon Dr. OE 331, Austin, TX 78735	60 days from notification of denial

Second Level Appeals

Under the **Medical Plan** (including behavioral health and prescription drug) and the **Disability Income Plans**, if your appeal is denied, you may submit a second level appeal of that denial. *Note that this second level of review does not apply to claims for any other benefits*. Your written second level appeal, issues and comments should be sent to different locations, depending on the plan/program. There is no second level review for any claim for benefits other than what is listed below.

Second Level Appeals			
Type of Appeal	**Send Written Appeals to:**	**Deadline for Submitting Written Request for Review**	**Decision on Appeal**
Medical Plan (including Behavioral Health Program)	**UnitedHealthcare Appeals** P.O. Box 30432 Salt Lake City UT 84130-0432	60 days from notification of denial	**Urgent Care:** 36 hours of receipt of your appeal **Pre-Service Care:** 15 days of receipt of your appeal **Post-Service Care:** 30 days of receipt of your appeal
Prescription Drug Program (included in Medical Plan)	**CVS Caremark Prescription Drug Appeals** Mail Code 109 P.O. Box 52084 Phoenix, AZ 85072-2084	180 days from notification of denial	**Urgent Care:** 72 hours from receipt of your appeal **All Others:** 15 days from receipt of your appeal
Disability Income Plan	**New York Life Appeals** 80 Livingston Avenue Roseland, NJ 07068	60 days from notification of denial	45 days of receipt of your written appeal (plus extension of up to 45 days in special circumstances)

Special Rule When Decision Is Based on Medical Judgment

When a denial on appeal is based on a medical judgment, the Plan consults with a health care professional with appropriate training, who will be identified upon request. Such health care professional will be someone who was neither consulted in connection with the initial denial of a claim that is the subject of the appeal, nor the subordinate of any such individual.

The final decision on appeal is sent to you in writing and will inform you of the specific reasons for the decision and the specific Plan provision upon which the decision is based. Except as required by law, the decisions are final and binding on all parties. You or your covered dependents must exhaust all the internal administrative remedies described above before bringing an action for Plan benefits under Section 502(a) of ERISA.

External Reviews – Medical Claims

You must complete all of the levels of standard appeal process described in the previous sections before you can request an external review. Your authorized representative may act on your behalf for an external review.

The notice of adverse benefit determination you receive from UnitedHealthcare (for medical claims) or CVS Caremark (for prescription drug claims) will describe the process to follow if you want to request an external review and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to UnitedHealthcare (or CVS Caremark, as applicable) within 123 calendar days of the date you received the adverse benefit determination notice from UnitedHealthcare (or CVS Caremark, as applicable). If the last filing date falls on a Saturday, Sunday or federal holiday, the date is extended to the next day that is not a Saturday, Sunday or federal holiday. You must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary external review request, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other Plan benefits. However, the appeal is voluntary and you are not required to file a request before pursuing legal action.

Request for External Review

You are eligible to request an external review if the claim decision involves medical judgment and:

- UnitedHealthcare, CVS Caremark, the Plan or its designee does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations);
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An adverse benefit determination based on eligibility is not eligible for external review.

If a coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, UnitedHealthcare (or CVS Caremark, as applicable) and the Plan unless otherwise allowed by law.

Preliminary Review

Within five business days after the date of receipt of the request, UnitedHealthcare (or CVS Caremark, as applicable) will provide a preliminary review determining if you are eligible for an external review, which will evaluate if:

- You were covered under the Plan at the time the service was requested or provided;
- The determination does not relate to eligibility;
- You have exhausted the internal appeals process; and
- You have provided all paperwork necessary to complete the external review.

Within one business day after completion of the preliminary review, UnitedHealthcare (or CVS Caremark, as applicable) will issue written notification. If you request is complete but not eligible for an external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete and UnitedHealthcare (or CVS Caremark, as applicable) will allow you to perfect the request for an external review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to External Review Organization (ERO)

UnitedHealthcare (or CVS Caremark, as applicable) will assign an ERO accredited as required under federal law, to conduct the external review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for external review and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information for the ERO to consider when conducting the external review. Within one business day after making the decision, the ERO will notify you, UnitedHealthcare (or CVS Caremark, as applicable) and the Plan of the decision.

The ERO will review all information and documents timely received. In reaching a decision, the assigned ERO will review the claim and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you or your treating provider;
- Plan terms to ensure that the ERO's decision is not contrary to Plan terms, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by UnitedHealthcare (or CVS Caremark, as applicable), unless the criteria are inconsistent with Plan terms or applicable law; and
- The opinion of the ERO's clinical reviewer(s) after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The assigned ERO will provide written notice of the external review decision within 45 days after the ERO receives the request for an external review. The ERO will deliver the notice to you, UnitedHealthcare (or CVS Caremark, as applicable) and the Plan.

After a final external review decision, the ERO will maintain records of all claims and notices associated with the external review process for six years. The ERO will make the records available for examination by you, the Plan or state or federal oversight agencies upon request, except where disclosure would violate state or federal privacy laws.

Upon receipt of a decision reversing the adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan allows you to request an expedited external review if you receive and adverse benefit determination:

- That involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- If you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or it concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, UnitedHealthcare (or CVS Caremark, as applicable) will determine if the request meets the reviewability requirements described above for standard external review. UnitedHealthcare (or CVS Caremark, as applicable) will immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for external review following preliminary review, UnitedHealthcare (or CVS Caremark, as applicable) will assign an ERO. The ERO will decide as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO will provide written confirmation of the decision to you, UnitedHealthcare (or CVS Caremark, as applicable) and the Plan.

Dental Plan Appeals

The Delta Dental will notify you and your provider if benefits are denied, in whole or in part; the notice will include the reason(s) for the denial. You have up to 180 days after receiving a notice of denial to request an appeal or submit a grievance by writing to Delta Dental. Your request should include the reasons you believe the denial is incorrect. You and your provider may also ask Delta Dental to examine any additional information provided that may support the appeal or grievance.

Send your appeal or grievance to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

Delta Dental will send you a written acknowledgment within five days of receipt of your appeal or grievance. Delta Dental will make a full and fair review and may ask for more documents during this review, if needed. The review will take into account all comments, documents, records and other information, regardless of whether the information was submitted or considered initially. If the review is of a denial based, in whole or in part, on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Plan, Delta Dental will consult with a dentist who has appropriate training and experience. The review will be conducted by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of that individual. Delta Dental will send you a decision within 30 days after receipt of the appeal or grievance.

Coordination of Benefits

This COB section describes how benefits under the NXP Plan are coordinated with those of any other plan that provides benefits to you.

COB provisions apply to you if you are covered by more than one health benefit plan, which may include:

- Another employer sponsored health plan;
- A medical component of a group long-term care plan, such as skilled nursing care;
- No-fault or traditional fault type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- Medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this plan reimburses, if anything, will also depend in part on the allowable expense (as defined in this section).

Order of Benefit Determination Rules

The order of benefit determination rules determine if this plan is a primary plan or secondary plan when someone has health care coverage under more than one plan. When this plan is primary, it determines payment for benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expenses.

The order of benefit determination rules below govern the order in which each plan will pay:

- **Primary Plan:** The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses.

- **Secondary Plan:** The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expenses.

When an individual is covered by two or more plans, the first of the following rules that applies is used to determine the order of benefit payments:

- **Medical Payment or Personal Injury Protection Rule:** This plan is always secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- **No COB Provision Under Other Plan Rule:** When you have coverage under two or more plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- **Non-Dependent or Dependent Rule:** The plan that covers an individual other than as a dependent (e.g., as an employee, former employee under COBRA, policyholder, subscriber or retiree) is the primary plan and the plan that covers an individual as a dependent is the secondary plan. However, if an individual is a Medicare beneficiary and due to federal law Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the individual as an employee, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.
- **Dependent Child Covered Under More Than One Plan Rules:** Unless there is a court decree stating otherwise:

– ***Birthday Rule:*** For a dependent child whose parents are married or are living together, whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the year is the primary plan; if both parents have the same birthday, the plan that covered the parent longest is the primary plan.

- For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married, if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
- For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married, if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, then the ***Birthday Rule*** applies.
- For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married, if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, then the ***Birthday Rule*** applies.
- For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married, if there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child is as follows:
  - The plan covering the custodial parent;
  - The plan covering the custodial parent's spouse;
  - The plan covering the non-custodial parent; and
  - The plan covering the non-custodial parent's spouse.

  The custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides for more than one-half of the calendar year, excluding any temporary visitation.

  For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is the same as described above as if those individuals were parents of the child.

– For a dependent child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan, the ***Longer or Shorter Length of Coverage Rule*** below applies. If a dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the ***Birthday Rule*** applies to the dependent child's parent(s) and the dependent's spouse.

- **Active Employee, Retired Employee or Laid-off Employee Rule:** The plan that covers an individual as an active employee, that is, an employee who is neither laid off nor retired is the primary plan. The same would hold true if the individual is a dependent of an active employee and that same individual is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply for a dependent child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan.
- **COBRA or State Continuation Coverage Rule:** If an individual whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the individual as an employee, member, subscriber or retiree or covering the individual as a dependent of an employee, member, subscriber or retiree is the primary plan, and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply for a dependent child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan.
- **Longer or Shorter Length of Coverage Rule:** The plan that covered the individual the longer period is the primary plan and the plan that covered the individual the shorter period is the secondary plan.
- **No Other Rule:** If the preceding rules do not determine the order of benefits, allowable expenses are shared equally between the plans meeting the definition of plan for COB purposes.

Note: This plan will not pay more than it would have paid had it been the primary plan.

How Benefits Are Paid When this Plan Is Secondary

When this plan is secondary, the plan determines the amount it would have paid based on the allowable expense. If this plan determines the amount, it would have paid based on the allowable expense is:

- The same or less than the primary plan paid, then this plan pays no benefits; or
- More than the primary plan paid, then this plan will pay the difference.

You are responsible for any applicable copayment, deductible, or coinsurance amounts as part of any COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense When this Plan Is Secondary

For COB purposes, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

- When the provider is a network provider for both the primary plan and this plan, the allowable expense is the primary plan's network rate.
- When the provider is a network provider for the primary plan and a non-network provider for this plan, the allowable expense is the primary plan's network rate.
- When the provider is a non-network provider for the primary plan and a network provider for this plan, the allowable expense is the reasonable and customary charges allowed by the primary plan.
- When the provider is a non-network provider for both the primary plan and this plan, the allowable expense is the greater of the two plans' reasonable and customary charge.

If this plan is secondary to Medicare, refer to the **Determining the Allowable Expense When this Plan Is Secondary to Medicare** section.

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this plan pays benefits secondary to Medicare when you become eligible for Medicare, even if you do not elect Medicare. However, this plan pays benefits first and Medicare pays benefits second for:

- Active current employees age 65 or older and their spouses age 65 or older (domestic partners are excluded as provided by Medicare);
- Individuals with end-stage renal disease, for a limited period; and
- Active current disabled employees younger than age 65 and their dependents younger than age 65.

Determining the Allowable Expense When this Plan Is Secondary to Medicare

If this plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined it will recognize and that it reports on an Explanation of Medicare Benefits (EOMB) issued by Medicare for a given service. Medicare typically reimburses such providers a percentage of its approved charge (often 80%).

If the provider does not accept assignment of Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they do not accept Medicare, typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with plan benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), benefits under this plan will be paid on a secondary basis and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the plan's benefits in these situations, and when Medicare does not issue an EOMB, the Claims Administrator will use the Medicare approved amount or Medicare limiting charge as the limiting charge.

When this plan is secondary to Medicare, the plan determines the amount it would have paid based on the primary plan's allowable expense. If this plan determines the amount it would have paid is:

- Less than the primary plan paid, this plan pays no benefits; or
- More than the primary plan paid, this plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The applicable Claims Administrator may get the facts needed from, or give them to, other organizations or persons to apply these rules and determined benefits payable under this plan and other plans covering the individual claiming benefits.

The applicable Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the applicable Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the applicable Claims Administrator the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

COB Overpayment and Underpayment of Benefits

If you are covered under more than one plan, there is a possibility that one plan will pay a benefit that the other plan should have paid. If this occurs, the plan may pay the other plan the amount owed.

If the plan pays you more than it owes under COB provisions, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages or benefits payable under any Plan Sponsor-funded benefit plans, including this plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the plan overpays a provider, the applicable Claims Administrator reserves the right to recover the excess amount from the provider; see the **COB Refund of Overpayments** section.

COB Refund of Overpayments

If the plan pays for benefits for expenses incurred for a covered individual, that covered individual or any other person or organization that was paid, must make a refund to the plan if:

- The plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the individual, but all or some of the expenses were not paid by or did not legally have to be paid by the individual;
- All or some of the payment the plan made exceeded the benefits under the plan; and
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the plan paid in excess of the amount that should have been paid under the plan. If the refund is due from another person or organization, the individual must agree to help the plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for you that are payable under the plan. If the refund is due from a person or organization other than you, the plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits that are:

- Payable in connection with services provided to other individuals covered under this plan; or
- Payment in connection with services provided to persons under other plans for which the applicable Claims Administrator processes payments, according to a transaction in which the plan's overpayment recovery rights are assigned to the other plans in exchange for the plans' remittance of the amount of the reallocated payment.

The reallocated payment amount will either:

- Equal the amount of the required refund; or
- Be deducted from the amount of refund owed to the plan if less than the full amount of the required refund.

The plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

NXP HIPAA Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The NXP Health Plans are required by federal law (specifically, the Health Insurance Portability and Accountability Act, known as HIPAA) to protect the privacy of your personal health information.

This notice explains:

- How your personal health information (called Protected Health Information) may be used; and
- What rights you have regarding this information.

How the Group Health Plans May Use Your Information

We are permitted by law to use and disclose your Protected Health Information in certain ways without your authorization:

- **For treatment.** We may use and disclose your Protected Health Information to coordinate or manage health care services you receive from providers.
- **For payment.** We may use and disclose your Protected Health Information to determine plan eligibility and responsibility for coverage and benefits. For example, to make sure that you receive the correct benefits and claims are paid accurately, we may use your information when we confer with other health plans to resolve a coordination of benefits issue. We may also use your Protected Health Information for utilization review activities.
- **For health care operations.** We may use your Protected Health Information in several ways, including Plan administration, quality assessment and improvement and vendor review. Your information could be used to ensure quality and efficient plan operations, for example, to assist in the evaluation of a vendor who supports us. We also may contact you to provide information about treatment alternatives or other health-related benefits and services available under the Plan.

We may also disclose your Protected Health Information to NXP (the plan sponsor) in connection with these activities or for purposes related to your enrollment or disenrollment in the Plan.

Other Permitted Uses and Disclosures

Federal regulations allow us to use and disclose your Protected Health Information, without your authorization, for several additional purposes, in accordance with law:

- Public health – We may disclose your Protected Health Information to public health authorities that need the information to prevent or control disease, injury or disability.
- Reporting and notification of abuse, neglect or domestic violence – We may disclose Protected Health Information to appropriate authorities if we have reason to believe that a person has been a victim of abuse, neglect or domestic violence.
- Oversight activities of a health oversight agency – We may disclose Protected Health Information so that government agencies can monitor or oversee the health care system and government benefit programs and be sure that certain health care entities are following regulatory programs or civil rights laws like they should.
- Judicial and administrative proceedings – We may disclose Protected Health Information in a court or other type of legal proceeding if it is requested through a legal process, such as a court order or a subpoena.
- To law enforcement officials – We may disclose Protected Health Information to law enforcement if it is required by law; if needed to help identify or locate a suspect, fugitive, material witness or missing person; if it is about an individual who is or is suspected to be the victim of a crime; or if we think that a death may have resulted from criminal conduct.
- To a coroner or medical examiner – We may disclose Protected Health Information to coroners, medical examiners or funeral directors so that they can carry out their responsibilities.
- To certain organ, eye or tissue donation programs – We may disclose Protected Health Information to organizations involved in organ donation or organ transplants.
- To avert a serious threat to health or safety – We may use or disclose your Protected Health Information to appropriate persons or authorities if we have reason to believe it is needed to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- Specialized government functions (e.g., military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations). We may use or disclose Protected Health Information to the federal government for military purposes and activities, national security and intelligence or so it can provide protective services to the U.S. President or other official persons.
- Research, as long as certain privacy-related standards are satisfied – We may use or disclose Protected Health Information for research purposes if the privacy of the information will be protected in the research.
- Workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness – We may use or disclose Protected Health Information to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.
- Other purposes required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law – We may use or disclose Protected Health Information as may be required by and as may be enforceable in a court of law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.

In Special Situations

We may disclose your Protected Health Information to a family member, relative, close personal friend or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care.

We also may use your Protected Health Information to notify a family member, your personal representative, another person responsible for your care or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, there is an emergency or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.

For uses and disclosures beyond treatment, payment and operations purposes and for reasons not included in one of the exceptions described above, we are required to have your written authorization. We must obtain your authorization for all treatment and health care operations communications where we receive financial remuneration for making communications from a third party whose product or service is being marketed. We must obtain an authorization for any disclosure which is a sale of protected health information. Such authorization must state that the disclosure will result in remuneration to the Plan. Finally, communications of Protected Health Information containing psychotherapy notes generally require your authorization, except for use by the originator of the psychotherapy notes for treatment or for use or disclosure by the Plan for defense against a legal action or other proceeding brought by an individual who is the subject of that information.

We will make other uses and disclosures only after you authorize them in writing. You may revoke your authorization in writing at any time.

Disclosure of Genetic Information

We are prohibited from using or disclosing your Protected Health Information that is considered genetic information for underwriting purposes. However, to the extent that the Plan is an issuer of long-term care policies, the Plan may use your genetic information for such purposes.

Your Rights Regarding Protected Health Information

You have the right to:

- Inspect and copy your Protected Health Information – You have the right to inspect and/or obtain a copy of the Protected Health Information that we have about you, except for information that we are allowed to withhold by law. You have the right to request a readily- producible form in which your Protected Health Information may be delivered. You may also request a summary or an explanation of your health information. Requests for access or a summary or explanation of your Protected Health Information must be made in writing to the address below. The request should indicate the form or format in which you would like to see your health information. We may charge you a fee to copy and mail the information to you or to prepare a summary or explanation. In certain situations, we may deny your request to see your health information, but you may be entitled to have a licensed health care professional review that denial.
- Request that inaccurate information be amended or corrected – You have the right to request changes to the Protected Health Information we have about you. Requests for changes must be made in writing to the address below and must explain why you think the change is needed. We may decide that the change you request does not need to be made, for example, if the Protected Health Information is already correct and complete.
- Receive a paper copy of this notice, even if you agreed to receive it electronically.
- Receive an accounting of certain disclosures of your Protected Health Information made by us. The Plan will provide you an accounting of disclosures of Protected Health Information made by us for the six years before the date on which the accounting is requested.
- However, you are not entitled to an accounting of several types of disclosures including, but not limited to:

– Disclosures made for payment, treatment or health care operations
– Disclosures we make to you about your own health information or that you authorized in writing

Right to Request Restrictions

You may ask us to restrict how we use and disclose your Protected Health Information as the Plan carries out payment, treatment or health care operations. You may also ask the Plan to restrict disclosures to your family members, relatives, friends or other persons you identify who are involved in your care or payment for your care. However, we are not required to agree to these requests, except that we must agree to a request to restrict disclosure of Protected Health Information if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law and the Protected Health Information pertains solely to a health care item or service for which you, or someone on your behalf, has paid in full.

Right to Request Confidential Communications

You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have Protected Health Information sent by mail or to an address other than your home.

For more information about exercising these rights, contact the office below.

Right to Notice of Breach of Unsecured Protected Health Information

You have the right to receive notice in the event that unsecured Protected Health Information identifying you has been or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner.

Complaints

If you believe that your privacy rights have been violated, you may file a written complaint without fear of reprisal. Direct your complaint to the office listed below under “Contacting Us” or to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201.

About this Notice

We are required to provide you this notice regarding our privacy policies and procedures and to abide by the terms of this notice, as it may be updated from time to time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information we maintain. If we materially change this notice, you will receive a new notice by e-mail or hard-copy mail.

Contacting Us

You may exercise the rights described in this notice and get additional information by submitting a written request to the address provided below:

- **usbenefits.office@NXP.com**; or
- **NXP USA, Inc.**
  Human Resources Department **–** HIPAA Privacy Inquiries
  6501 William Cannon Drive West, OE 331
  Austin, TX 78735

Subrogation and Right of Recovery Provisions

This section has important information that you need to know and understand if you or your covered dependent may be eligible to recover from any other source an expense that is or may be paid as a benefit by any NXP Rewards Plan. Before you take legal action or accept a settlement due to any injury, illness or condition, you should contact the NXP Benefits Service Center at 888-375-2367 to understand your responsibilities. If you are considering a lawsuit for damages, you should also share this section with your attorney.

Note: For subrogation and right of recovery information specific to medical programs administered by UHC, see the **Subrogation and Reimbursement – For UHC Medical Plans** section.

The Plan's subrogation and right of recovery provisions apply to all current and former Plan participants, including parents, guardians and other representatives of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) applies to the personal representative of your estate, your decedents, minors and incompetent or disabled persons. You or your includes anyone on whose behalf the Plan pays benefits. No adult may assign any rights he or she may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of that adult without the prior express written Plan consent.

Throughout this Subrogation and Right of Recovery Provisions section, "you" or "your" refers to you and/or your covered dependent(s).

The Plan's right of subrogation or reimbursement extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims, including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no fault automobile coverage or any first party insurance coverage.

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage and medical payments coverage.

No disbursement, including but not limited to the payment of attorney's fees, of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interests are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you or your covered dependent(s) may have to recover benefits paid by the Plan. Immediately upon paying or providing any Plan benefit, the Plan is subrogated to (stands in the place of) all rights of recovery for any claim or potential claim against any party due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your or your dependent's name and take appropriate action to assert its subrogation claim, with or without your or your dependent's consent. The Plan is not required to pay you or your covered dependent part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment due to an injury, illness or condition, you agree to reimburse the Plan first from that payment for all amounts the Plan has paid and will pay due to that injury, illness or condition, from such payment, up to and including the full amount of the recovery.

Constructive Trust

By accepting benefits (whether payment is made to you or made on your behalf to any provider), you agree that if you receive any payment due to an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold the funds in trust will be deemed a breach of your fiduciary duty to NXP or the Plan. No disbursement, including but not limited to the payment of attorney's fees, of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interests are fully satisfied.

Lien Rights

The Plan automatically has a lien to the extent of benefits paid by NXP or the Plan for treatment of an illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which NXP or the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by NXP or the Plan including, but not limited to, you, your representative or agent and/or any other source possessing funds representing benefit amounts paid by NXP or the Plan.

Assignment

To secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be paid to the Plan before you and your attorney receive any recovery for your damages. The Plan is entitled to full reimbursement on a first-dollar basis from any payments, even if the payment to the Plan results in a recovery that is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The Plan's subrogation and right of recovery provision terms apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of the settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and

suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or receive compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representatives with notice of any recovery you or your agents obtain before receipt of the recovery funds or within five days if no notice was given before receipt. Further, you and your agents agree to provide notice before any disbursement of settlement or any other recovery funds obtained. You and your agents must provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, to assist the Plan in pursuit of its subrogation rights or to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Plan benefits or the institution of court proceedings against you.

You must do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery before fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that NXP and the Plan have the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. NXP and the Plan reserve the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right, according to the Health Insurance Portability and Accountability Act (HIPAA) to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

If any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan's Claims Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding about this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting benefits, you hereby submit to each jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this provision.

Plan Information

This section includes important administrative information, as well as your ERISA rights.

Administrative Information

Employer and Plan Sponsor	NXP USA, Inc. 6501 William Cannon Drive West Austin, TX 78735
Employer Identification Number	20-0443182
Agent for Legal Service	NXP USA, Inc. c/o Corporation Service Company 251 Little Falls Drive Wilmington, DE 19808
Plan Year	January 1 through December 31

Plan Name and Type	Number	Funding Administration	Plan Administrator	Effective Date
NXP Employee Medical Plan* (including pharmacy and behavioral health)	501	Self-insured by NXP and claims administered by: **UnitedHealthcare** P.O. Box 30555 Salt Lake UT 84130-0555	NXP USA, Inc.	January 1, 2024
NXP Employee Dental Plan	501	Self-insured by NXP and claims administered by: **Delta Dental Insurance Company** P.O. Box 1809 Alpharetta GA 30023-1809	NXP USA, Inc.	January 1, 2024
NXP Employee Vision Plan	501	Fully-insured and claims administered by: **VSP** 3333 Quality Drive Rancho Cordova, CA 95670	NXP USA, Inc.	January 1, 2024

Plan Name and Type	Number	Funding Administration	Plan Administrator	Effective Date
NXP Health Care Flexible Spending Account Plan	501	Self-insured by NXP and claims administered by: **UnitedHealthcare** P.O. Box 30555 Salt Lake UT 84130-0555	NXP USA, Inc.	January 1, 2024
NXP Dependent Care Flexible Spending Account Plan	501	Self-insured by NXP and claims administered by: **UnitedHealthcare** P.O. Box 30555 Salt Lake UT 84130-0555	NXP USA, Inc.	January 1, 2024
NXP Disability Income Plan	501	The Short-Term Disability Plan is self-insured by NXP and the Long-Term Disability Plan is fully-insured Claims administered by: **New York Life** 80 Livingston Avenue Roseland, NJ 07068	NXP USA, Inc.	January 1, 2024
NXP Group Life Insurance Benefit Plan (Life, Accidental Death and Dismemberment)	501	Insurance contract with Claims Administrator: **MetLife** P.O. Box 6100 Scranton, PA 18505-6100	NXP USA, Inc.	January 1, 2024
NXP Business Travel Accident Insurance Plan	501	Insurance contract with Claims Administrator: **AIG** P.O. Box 25987 Shawnee Mission, KS 66225	NXP USA, Inc.	January 1, 2024

Plan Name and Type	Number	Funding Administration	Plan Administrator	Effective Date
NXP Adoption Assistance Program	501	Self-insured by NXP and claims administered by: **NXP Benefits Team** 6501 W. William Cannon Dr. OE 331, Austin, TX 78735 -	NXP USA, Inc.	January 1, 2024
MetLife Legal Plan	926/0025	Contract with MetLife Legal Plans and administered by: **MetLife Legal Plans** 1111 Superior Avenue Cleveland, OH 44114-2407	NXP USA, Inc.	January 1, 2023
Identity Theft Protection	Not applicable	This plan is not subject to ERISA	NXP USA, Inc.	January 1, 2023
Health Savings Account	Not applicable	Assets are held in individual accounts with Fidelity Investments (or as otherwise established)	Fidelity Investments	January 1, 2023

* *The NXP Employee Medical Plan includes an HMO option, administered by Kaiser Permanente. The Kaiser medical option is fully-insured and is not described in this SPD.*

Plan Administration

The Plan Administrator has the sole and complete discretionary authority to determine eligibility for Plan benefits and to construe Plan terms, including the making of factual determinations. The Plan Administrator has the discretionary authority to grant or deny Plan benefits. Plan benefits will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The Plan Administrator's decisions are final and conclusive for all questions relating to the Plans.

No final action, finding, interpretation, ruling or decision is subject to de novo review in any judicial proceeding. No Plan Administrator's final action, finding, interpretation, ruling or decision may be set aside unless it is held to have been arbitrary and capricious by a final judgment of a court having jurisdiction over the issue.

The Plan Administrator may delegate to other persons responsibilities for performing certain Plan Administrator duties under Plan terms and may seek expert advice as the Plan Administrator deems reasonably necessary under the Plans. The Plan Administrator is entitled to rely upon the information and advice provided by the delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator may adopt uniform rules for Plan administration from time to time, as it deems necessary or appropriate.

Amendment and Termination

NXP reserves the sole discretionary right to modify, amend or terminate any of the NXP benefit plans, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or its designee.

If a Plan is modified, amended or terminated, you will be notified of the effect of such change to your Plan benefits or coverage. However, the modification, amendment or termination may be effective before you are notified. No consent of any employee or any other person will be necessary for NXP to modify, amend or terminate any of the Plans described in this SPD.

Representations Contrary to the Plans

No employee, director or officer of NXP has the authority to alter, vary or modify the terms of any Plan except by means of a duly authorized written amendment to the Plan. No verbal or written representations contrary to Plan terms are binding upon the Plan, the Plan Administrator or NXP.

Plan Funding

The welfare plans (i.e., medical, pharmacy, dental, short-term disability) are primarily funded by NXP and paid from NXP's general assets. Other portions of the Plan (e.g., vision, long-term disability, life insurance) is funded through insurance contracts.

No Assignment

To the extent allowed by law, and except as specified under Plan terms, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind and any attempt to do so will be void. However, some Plan benefits may be subject to a Qualified Medical Child Support Order or a Qualified Domestic Relations Order and you may assign your benefits under the NXP Group Life Insurance Plan.

Recovery of Payments Made by Mistake

You are required to return to NXP any benefits, or portion thereof, paid under any of the Plans by a mistake of fact or law.

No Contract of Employment

Your participation in the Plans does not assure you of continued employment with NXP or rights to benefits except as specified under Plan terms. Nothing in the Plans or in this SPD confers any right of continued employment to any employee.

Severability

If a court of competent jurisdiction finds, holds or deems any provision of a Plan described in this SPD to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan continues in full force and effect.

Applicable Law

The Plans described in this SPD are governed and construed according to the laws of the State of Texas, to the extent not pre-empted by the laws of the United States.

Statement of ERISA Rights

As an NXP Rewards Program participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to:

Receive Information about Your Plan and Benefits

- Examine without charge, at the NXP Corporate Offices, 6501 William Cannon Drive West, Austin, TX 78735, and major Human Resources Offices of NXP, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA), such as annual financial reports (Form 5500 Series);
- Get copies of documents governing Plan operations, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies; and
- Receive summaries of the Plan's annual financial reports. These reports are prepared and distributed to Plan participants each year. The Plan Administrator is required by law to provide each participant a copy of the summary annual report.

Continue Group Health Plan Coverage

Under a group health plan, continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the group health plan due to a qualifying event. You or your dependents may have to pay for such coverage.

Review this Summary Plan Description and the documents governing the Plan regarding the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for Plan operations. The people who operate the Plans, called fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from getting a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to know why this was done, to get copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials about a Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the Plan Administrator to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plans, you should contact the NXP Benefits Service Center. If you have any questions about this Statement or about your rights under ERISA or if you need assistance in getting documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or you may write:

Employee Benefits Security Administration
Division of Technical Assistance and Inquiries
200 Constitution Avenue, N.W.
Washington, DC 20210
866-444-3272
DOL.gov/EBSA

You may also get certain publications about your rights and responsibilities under ERISA by contacting the Employee Benefits Security Administration.

Definitions

This section includes definitions of terms and phrases used throughout this SPD that have special meanings for the Plans described in this SPD.

Accepted Fee

The amount the attending Delta Dental provider agrees to accept as payment in full for services rendered.

Accident

An unexpected, unintentional and unforeseen traumatic experience that is caused by an outside force and that happens at a specific time and place.

For the Disability Income Plan, "accident" further means that such experience results in your inability to return to work with NXP for a period of at least eight consecutive calendar days beginning within 30 days of the experience and does not include a strain or injury caused by over-exertion of the body or pregnancy.

For Accidental Death and Dismemberment Insurance, "accident" means a sudden, unexpected and unintended event, independent of sickness and all other causes. Accident does not include sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. Accident does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

Accidental Injury

For the Dental Plan, accidental injury means damage to the mouth, teeth and supporting tissue, due directly to an accident and independent of all other causes. Accidental injury does not include damage to the teeth appliances or prosthetic devices that results from chewing or biting food or other substances.

Accidental Death and Dismemberment (AD&D) Insurance

Insurance coverage that provides benefits due to loss of life, limb(s), eyesight, speech or hearing as the result of an accident.

Actively at Work

You currently perform the essential functions of your job at your assigned place of employment during assigned working hours.

Adoption Assistance

A benefit program that reimburses employees up to $10,000 (on a taxable basis) for eligible expenses related to adoption.

GeoBlue Global Benefits

Medical, behavioral health, prescription drug and dental benefits administrator responsible for claims processing, customer service and appeals. This Plan is for U.S. Inpatriates and U.S. Expatriates. Benefit details for Global Benefits are not included in this SPD.

Aggregate Lifetime Maximum Benefit

The sum of all benefits a plan pays over a person's lifetime. For example, if during your employment with NXP and Motorola you participated in the NXP Medical Plan and the former Basic Medical Plan, the sum of benefits paid under the NXP Medical Plan and the former Basic Medical Plan is your aggregate lifetime maximum benefit under any NXP health plan. The NXP Medical Plan does not have an aggregate lifetime maximum benefit.

Air Ambulance

Medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane (as defined in *42 CFR 414.605*).

Allowable Medical Expense

Expenses for medical care provided to a participant for which the Claims Administrator has determined a benefit is payable under the Employee Medical Plan.

Allowed Amounts

Allowed amounts for covered health care services incurred while covered under the Plan are determined by UnitedHealthcare, as the Claims Administrator, according to the UnitedHealthcare's reimbursement policy guidelines, or as otherwise required by law. UnitedHealthcare develops these guidelines, in its discretion, after review of all providing billings according to one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association and/or the Centers for Medicare and Medicaid Services (CMS);
- As reported by generally recognized professionals or publications;
- As used for Medicare; and/or
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

Ancillary Services

The following services performed by out-of-network physicians at a network facility:

- Emergency medicine, anesthesiology, pathology, radiology or neonatology;
- Assistant surgeon, hospitalist and intensivist services;
- Diagnostic services, including radiology and laboratory services (unless specifically excluded by UnitedHealthcare's definition ancillary services);
- Specialty practitioner services as defined by the Plan; and
- Out-of-network physician services provided when no other network physician is available.

Annual Deductible

The total allowed amount you must pay for covered health services each year before the Plan begins paying benefits. The deductible does not include any amounts that exceed the allowed or recognized amount, as applicable.

Annual Enrollment

Period each year in which eligible participants may enroll themselves and their eligible dependents in medical, dental and/or vision coverage and enroll in the Short-Term Disability Buy-Up option. Eligible participants may also establish a Health Care Flexible Spending Account and a Dependent Care Flexible Spending Account for the next calendar year. Eligible participants may make enrollment changes during annual enrollment without a qualified status change.

Annual Out-of-Pocket Maximum

The maximum amount of eligible expenses (including any deductibles) that you have to pay in a calendar year. Once you or your family members meet the annual out-of-pocket maximum, covered services for you or all covered family members, as applicable, are paid at 100% coinsurance for the remainder of the calendar year.

Any Reasonable Occupation

For Short-Term and Long-Term Disability Plan benefits, this is any gainful activity for which you are, or may reasonably become, fitted by education, training or experience that results in, or can be expected to result in, an income of more than 60% of your adjusted pre-disability earnings.

Assisted Reproductive Technology (ART)

Procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve pregnancy. Examples include:

- In Vitro Fertilization (IVF);
- Gamete Intrafallopian Transfer (GIFT);
- Pronuclear Stage Tubal Transfer (PROST);
- Tubal Embryo Transfer (TET); and
- Zygote Intrafallopian Transfer (ZIFT).

Audiologist

A person skilled in the science of hearing, particularly the study of impaired hearing that cannot be improved by medication or surgical means.

Authorized Representative

For filing claims under the group health plans (Medical Plan, Dental Plan, Vision Plan, Health Savings Account and Health Care Flexible Spending Account), your authorized representative is a person you authorize in writing to act on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may act as your authorized representative.

Autism Spectrum Disorder

A condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Basic Annual Earnings

Eligible compensation for life, accidental death and dismemberment and business travel accident insurance, which is your current annualized salary including lump sum merit, sales incentives and shift differentials looking back on the preceding 12 months (or to date of hire if shorter) from the first of the pay-date month as determined by the provider, excluding overtime and other extra pay. This does not include overtime, bonuses, Incentive Plan payments, moving allowances, educational allowances, noncash payments or overseas allowances.

Basic Life Insurance

An NXP-funded program that provides a benefit to your beneficiary (or beneficiaries) if you die.

Behavioral Health Program

Program available to all NXP Medical Plan participants for the treatment of psychiatric, emotional and/or chemical dependency disorders.

Beneficiary

- **Primary Beneficiary:** The person, trust or estate you choose to receive the proceeds from your life insurance, business travel accident insurance and/or the 401(k) Retirement Plan account following your death.
- **Contingent Beneficiary:** Designated to receive the benefit if no primary beneficiary is living at the time the benefit becomes payable.

You may not designate your will as your beneficiary.

For the Dental Plan, beneficiary means you and your covered dependent(s) or legal representative of either and anyone to whom the rights of you or your covered dependent(s) may pass.

Benefits

Your right to payment for covered health services that are available under the Plan.

Biofeedback

A treatment method that uses monitoring instruments to feedback physiological information to patients, enabling them to learn to adjust their thinking and other mental processes to control bodily processes such as blood pressure, temperature, gastrointestinal functioning and brain wave activity.

Board Certification

A national test for physicians indicating that they are certified to practice the specialty for which the test is taken.

Brand Name Drug

The trademark name of a prescription drug.

Business Travel Accident Insurance

Insurance coverage that provides benefits if you have an accident while traveling on NXP business and that accident results in the loss of life, limb(s), eyesight, speech or hearing.

Care Management

See **Prior Authorization**

Case Management

Medical case management assistance that the UnitedHealthcare Advocate provides to NXP Medical Plan participants. Reach Case Management through your UnitedHealthcare Advocate by calling UnitedHealthcare at 844-210-5428.

Cellular Therapy

Administration of living whole cells into a patient for the treatment of disease.

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS) is a federal agency that administers the nation's major healthcare programs including Medicare, Medicaid and CHIP. CMS collects and analyzes data, produces research reports and works to eliminate instances of fraud and abuse within the healthcare system.

Certain Network Facilities

- A hospital, as defined in 1861(e) of the Social Security Act;
- A hospital outpatient department;
- A critical access hospital, as defined in 1861(mm)(1) of the Social Security Act;
- An ambulatory surgical center, as described in Section 1833(i)(1)(A) of the Social Security Act; and
- Any other facility specified by the UnitedHealthcare.

Child and Children

Your children by birth, adoption or pending adoption or legal guardianship; stepchildren who live with you; foster children legally placed by a licensed agency and grandchildren you legally adopt or for whom you are the court-appointed guardian. The term also includes the children of your domestic partner. See **Section 152 Dependent**, for information on IRS Section 152 and dependents.

Child(ren) Life Insurance

Optional life insurance for which you make contributions. Child(ren) life insurance pays benefits for the loss of life of a dependent child.

Claim

Request for a Plan benefit made according to the Plan's reasonable procedure for filing benefit claims. All claims except urgent care claims must be in writing and contain the information described in **Filing Claims**. Urgent care claims may be made orally.

Claims Administrator

NXP or the entity designated to administrate claims under the applicable portion of this Plan. See the table in **Claims Administrator** for the contact information for the Claims Administrator for specific benefits under the Plan.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law that extends group medical, dental and vision plan coverage to eligible employees, former employees and their qualifying spouses and dependent children and Health Care Flexible Spending Account participation to you, in certain circumstances. COBRA requires employers to offer covered individuals 18, 29 or 36 months (for the Health Care Flexible Spending Account, through end of calendar year) of continued coverage (offset, in some cases, by periods of coverage already provided) for a contribution based on the cost of the coverage plus a 2% administration fee (or a 50% administration fee for a qualifying 11 -month disability extension).

Coinsurance

A plan's benefit, expressed as a percentage of eligible expenses, that you are required to pay for certain covered services; e.g., a medical plan pays 80% of covered expenses and you pay the other 20%. Coinsurance is sometimes referred to as "benefit level."

Congenital Anomaly

A physical developmental defect that is present at the time of birth, and that is identified within the first 12 months of birth.

Copayment

An amount you pay directly to the provider for covered expenses at the time you receive services. **Note:** You pay the lesser of your copayment or the actual amount of the eligible expense for the covered service. Copayments are not included in the annual deductible or out-of-pocket maximum.

Cosmetic Dentistry

Cosmetic surgery or procedures for purely cosmetic reasons.

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function.

Covered Dependent

An eligible dependent whom an employee has enrolled in medical, pharmacy, dental, vision and/or spouse/domestic partner and/or child(ren) life insurance coverage.

Covered Expense

For the Medical Plan, covered expense means medical, dental (under certain circumstances), vision and hearing services and supplies described as covered by this Plan.

For the Dental Plan, covered expense means the program allowance for a dentally necessary covered service incurred by you or your covered dependent(s).

Covered Health Service(s)

For the Medical Plan, health care services, including supplies or pharmaceutical products, that UnitedHealthcare determines to be:

- Medically necessary;
- Described as a covered health service in **What's Covered**;
- Not excluded in **What's Not Covered**;

Provided for the purpose of preventing, diagnosing or treating sickness, injury, mental illness and substance -related and addictive disorders or their symptoms; and

- Consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines; for this definition:

Scientific evidence means the results of controlled clinical trials or other studies published in -peer reviewed, medical literature generally recognized by the relevant medical specialty community; and.

- Prevailing medical standards and clinical guidelines means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines and national specialty society guidelines;

- Not provided for the convenience of the covered person, physician, facility or any other person; and
- Provided to a covered person who meets the Plan's eligibility requirements.

Covered Pay

For the Disability Income Plan, see **Your Covered Pay Determines Your Benefits**.

Custodial Care

For the Medical Plan, custodial care means services non-skilled care services that are:

- Non-health-related, such as help with daily living activities (e.g., eating, dressing, bathing, transferring and ambulating); or
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Delta Dental

Dental benefits administrator responsible for dental claims processing, customer service and appeals.

Delta Dental PPO Provider

A dental provider who contracts with Delta Dental and agrees to accept the Delta Dental PPO contracted fee as payment in full for covered services under the Plan.

Delta Dental Premier Provider

A dental provider who contracts with Delta Dental and agrees to accept the Delta Dental Premier contracted fee as payment in full for covered services provided under the Plan.

Dental Services

Services provided by a dentist for the necessary maintenance of dental hygiene or treatment of dental disease or other covered dental conditions.

Dentally Necessary/Dental Necessity

Services covered by the Dental Plan that are within several categories of dental services that a provider provides because they are necessary and within the standards of generally accepted dental practice standards. Claims will be processed according to standard processing policies.

Dentist

An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and is operating within the scope of that license.

Designated Virtual Network Provider

A provider or facility that has entered into an agreement with the Claims Administrator or with an organization contracting on the Claims Administrator's behalf to deliver covered health care services through live audio with video technology or audio only.

Dependent Care Flexible Spending Account (DCFSA)

An account to which you can contribute before -tax dollars that are later used to reimburse you for eligible dependent care expenses.

Diagnostic Testing

A series of tests, invasive or noninvasive, used to determine a particular diagnosis.

Disability Management Program

A program designed to effectively manage short-term disabilities and return NXP employees to work as soon as they are able.

Domestic Partner

Your domestic partner is a person who has lived with you for at least six months, is not a blood relative of yours, is not legally married or in another domestic partner relationship and is at least 18 years old.

To be eligible for domestic partner coverage under the NXP benefit plans, the following eligibility requirements must be met:

- You and your domestic partner are registered as domestic partners according to applicable city, county or state laws; or
- In the absence of domestic partner registration, all of the following requirements must be met (the NXP Benefits Service Center may request documentation and/or an **affidavit**):
  - You and your domestic partner are at least 18 years of age and have lived together for at least six months;
  - You and your domestic partner are not related to one another to a degree that would prevent marriage under the law of the state in which you reside; and
  - Neither you nor your domestic partner are married to another person under statutory or common law and neither of you are in another domestic partnership.

An affidavit can be requested from the NXP Customer Service Center or downloaded from **nxp.com/docs/en/brochure/COMMONLAW_AFFIDAVIT.pdf**.

Durable Medical Equipment

Medical equipment that:

- Is ordered or provided by a physician for outpatient use primarily in a home setting;
- Is used for medical purposes;
- Is not consumable or disposable (except as needed for the effective use of covered durable medical equipment);
- Is not of use to a person in the absence of a disease or disability;
- Serves a medical purpose for the treatment of a sickness or injury; and
- Is primarily used within the home.

Eligible Expenses

Eligible expenses for covered services are determined by UnitedHealthcare, according to UnitedHealthcare's reimbursement policy guidelines (or as otherwise required by law). UnitedHealthcare develops the reimbursement policy guidelines, per UnitedHealthcare's discretion, following evaluation and validation of all provider billings according to one or more of the following methodologies:

- Per the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association and/or the Centers for Medicare and Medicaid Services (CMS);
- As reported by generally recognized professionals or publications;
- As used for Medicare; or
- As determined by medical staff and outside medical consultants per other appropriate source or determination that UnitedHealthcare accepts.

Emergency

Sudden and, at the time, unexpected onset of a change in a person's condition that, if immediate medical care were not received, could reasonably be expected to result in loss of life or limb, significant impairment to bodily function or permanent dysfunction of a body part, as determined by UnitedHealthcare in its sole and complete discretion. Examples include heart attack, loss of breathing, unconsciousness, poisoning, severe bleeding and broken bones.

For the Medical Plan, emergency services include Emergency Room (ER) treatment (and stabilization services) for conditions that reasonably appear to constitute an emergency, based on the presenting symptoms, the Plan follows the prudent layperson ER policy in the Balanced Budget Act of 1997.

Under this Act, emergency services are for an emergency medical condition, which is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

The symptoms related to the medical emergency usually occur suddenly and are severe in nature. When emergency services are given in a facility's ER, the Plan will cover the care received (and stabilization services) provided the situation meets the criteria described above.

For the Dental Plan, emergency means the necessary procedures for treatment of pain and/or injury. Services include emergency procedures for treatment to the teeth and supporting structures.

Emergency Health Services

Relating to an emergency, as defined by the Plan, emergency health services include:

- An appropriate medical screening examination (as required under the Social Security Act or as would be required for an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate the emergency; and
- Any further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, as are required under the Social Security Act or as would be required for an independent freestanding emergency department, to stabilize the patient (regardless of the hospital department in which further exam or treatment is provided).

Emergency health services include items and services otherwise covered under the Plan when provided by an out-of-network provider or facility (regardless of the hospital department in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an inpatient stay or outpatient stay that is connected to the original emergency unless:

- The attending emergency physician or treating provider determines the patient is able to travel using non-medical transportation or non-emergency medical transportation to an available network provider or facility located within a reasonable distance taking into consideration the patient's medical condition;
- The provider furnishing the additional items and services satisfies notice and consent criteria per applicable law;

- The patient is in such a condition, as determined by UnitedHealthcare, to receive information as stated above and to provide informed consent per applicable law;
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law; or
- Any other conditions as specified by UnitedHealthcare.

The above conditions do not apply to unforeseen or urgent medical needs that arise when the service is provided regardless of whether notice and consent criteria have been satisfied.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, which establishes certain rights and protections for participants as well as rules for employers to qualify benefit plans for special tax considerations.

Expense Incurred

The actual fee charged for an incurred expense by a covered person.

Experimental or Investigational Care

For the Medical Plan, medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare makes a determination about coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not as appropriate for the proposed use for any of the following:
  - AHFS Drug Information (AHFS DI) for therapeutic uses;
  - Elsevier Gold Standard's Clinical Pharmacology for indications;
  - DRUGDEX System by Micromedex for therapeutic uses and has a strength recommendation rating of Class I, IIa or IIb; or
  - National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of Evidence 1, 2A or 2B;

- Subject to review and approval by any institutional review board for the proposed use. (devices that are FDA approved under the Humanitarian Use Device exemption are not experimental or investigational);
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial as listed in FDA regulations, regardless of whether the trial is actually subject to FDA oversight;
- Only obtainable for outcomes for the given indication, within research settings, except:

– Clinical trials for which benefits are available as described in **Clinical Trials** ; and

– UnitedHealthcare, as the Claims Administrator determines, considers an otherwise experimental or investigational service to be a covered health service for that sickness or condition if:

  - You are not a participant in a qualifying clinical trial, as described in **Clinical Trials**; and
  - You have a sickness or condition that is likely to cause death within one year of the request for treatment.

Before the consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

Explanation of Benefits (EOB)

A statement delivered by mail or electronically to the participant or provider itemizing services performed and benefit information related to those services.

Fertility Solutions

A program administered by UnitedHealthcare or its affiliates that is available to you through the Plan's medical benefits. The Fertility Solutions program provides:

- Specialized clinical consulting services to employees and covered dependents to educate on infertility treatment options; and
- Access to specialized network facilities and physicians for infertility services.

Freestanding Facility

An outpatient, diagnostic or ambulatory center or independent laboratory that performs services and submits claims separately from a hospital.

Generic Drug

A chemical copy of a brand name prescription drug.

Gene Therapy

Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gestational Carrier

A female who becomes pregnant fertilized egg (embryo) implanted in her uterus for to carry a fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Genetic Counseling

Counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of genetic testing to help you make informed decisions about genetic testing; and
- Interpretation of the genetic testing results to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when covered health services for genetic testing require genetic counseling.

Genetic Testing

Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or provide information to guide the selection of treatment of certain diseases, including cancer.

Health Care Flexible Spending Account

An account to which you can contribute before-tax dollars that are later used to reimburse you for eligible medical, dental or vision expenses that you and your eligible dependents incur. If you are eligible, you may participate in the Health Care Flexible Spending Account regardless of whether you enroll in medical, dental or vision coverage through NXP.

Home Health Agency

A program or organization authorized by law to provide health care services in the home.

Health Savings Account (HSA)

A tax-advantaged savings account, available with a corresponding High Deductible Health Plan, used to accumulate funds to pay for eligible expenses for you and your eligible dependents.

High Deductible Health Plan (HDHP)

A health plan that meets federal requirements about minimum deductible and maximum out-of-pocket costs.

Home Health Care

Care provided in the home as an alternative to extended hospitalization. Services must be prescribed by a physician, provided by a licensed agency and pre-approved by your UnitedHealthcare Advocate.

Home Health Care Provider

A registered nurse (RN), a licensed practical nurse (LPN), a licensed vocational nurse (LVN), a home health care aide or a medical social worker.

Home Nursing Care

Nursing services prescribed in writing by a physician and provided by a graduate licensed registered nurse or by a licensed practical nurse if the services are the same as those provided by a registered nurse. Home nursing care cannot be provided by someone who ordinarily resides in your home. Custodial care expenses are not included in home nursing care.

Hospice

An organization or facility that cares for the terminally ill. Hospice programs deal with the physical and psychological aspects of the illness.

Hospital

An institution that:

- Is operated as required by law;
- Is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons (care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of physicians); and
- Has 24-hour nursing services.

A hospital is not mainly a place for rest, custodial care or care of the age or a nursing home, convalescent home or similar institution.

Illness/Injury

A disease, disorder or condition affecting any structure or function of the body that requires treatment by a physician or other medical care provider. For a female patient, illness/injury also includes childbirth, pregnancy or any related medical condition.

Incurred Expense

An expense is considered incurred at the time the service is provided and not when an invoice for the service is issued or when the invoice is paid.

Independent Freestanding Emergency Department

A health care facility that:

- Is geographically separate and distinct and licensed separately from a hospital under applicable law; and
- Provides emergency health services.

Ineligible Providers

Providers whose services are not covered by the NXP Medical Plan, including but not limited to:

- Acupuncturist (except when provided by a physician if performed as a form of anesthesia in connection with a covered surgical procedure and to treat an illness, injury or to alleviate chronic pain);
- Certified Doula;

- Certified Herbalist;
- Certified Holistic Health Practitioner;
- Certified Massage Therapist/Practitioner;
- Certified Operating Room Technician;
- Certified Oral Facial Myologist;
- Certified Surgical Technologist;
- Christian Science Practitioner;
- Doctor of Oriental Medicine;
- Emergency Medical Technician;
- Holistic Nurse;
- Homeopathic Doctor;
- Hypnotherapist;
- Myotherapist;
- Naturopathic Doctor;
- Non-Nurse Midwife; and
- Registered Kinesiotherapist.

Infertility

A disease (an interruption, cessation or disorder of body functions, systems or organs) of the reproductive tract that prevents the conception of a child or the ability to carry a pregnancy to delivery.

Intensive Outpatient Treatment

A structured outpatient treatment program, consisting primarily of counseling and education for:

- Mental health services, which may be freestanding or hospital-based, that provides services for at least three hours per day, two or more days per week.
- Substance-related or addictive disorders services that provides 9 to 19 hours per week of structured programming for adults or 6 to 19 hours per week for adolescents.

Intermittent Care

Skilled nursing care that is provided for either fewer than seven days each week or eight hours each day for a period of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Kaiser Permanente

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on location. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-278-3296.

Leave of Absence

There are five types of leaves of absence available to eligible NXP employees:

- **Medical Leave:** For your own serious health condition or as necessitated by a workplace injury or illness or for the illness or qualifying serious health condition of a family member;
- **Parental Leave:** To care for a child after the birth, foster care placement or adoption of the child;
- **Leave under the Family and Medical Leave Act (FMLA):**
  - For the birth of a son or daughter and to care for such son or daughter;
  - For the placement of a child with you for adoption or foster care;
  - To care for a spouse, child or parent with a serious health condition;
  - For your own serious health condition that makes you unable to perform the functions of your position;
  - To attend to qualifying exigencies that have arisen from the fact that your spouse, child or parent who is a covered military member is on or has been notified of an impending call to covered active duty in the armed forces; or
  - To care for a covered service member with a serious injury or illness and you are the spouse, child, parent or next of kin of the covered service member.
- **ADA Leave:** For your own serious health condition when you are not yet or no longer eligible for FMLA leave;

- **Personal Leave:** To attend to personal matters; and
- **Military Service Leave:** If you are called to active duty or temporary active duty by the U.S. armed forces or you are on temporary training duty with the U.S. armed services.

Life Insurance

Death benefit protection that provides benefits to your beneficiary following your death or to you following the death of a covered dependent. Life insurance benefits include Basic Life, Supplemental Life, Accidental Death and Dismemberment, Business Travel Accident, Spouse/Domestic Partner and Child(ren) Life Insurance.

Limited Use Health Care Flexible Spending Account

An account to which you can contribute before-tax dollars that are later used to reimburse you for eligible dental and vision expenses that you and your eligible dependents incur. This account is only available if you are enrolled in Medical Plan 1.

Long-Term Disability Plan Benefit

Percentage of base salary paid to an eligible employee who is under a doctor's care, continuously unable to engage in your *own* or *any* reasonable occupation due to a medically determinable physical or mental impairment and satisfies the other requirements under the Disability Income Plan. Benefits begin after you qualify for and receive payment of 180 days of Short-Term Disability Plan benefits. Duration of benefits depends on the employee's age when he or she became disabled, how long he or she continues to be disabled and, in some cases, the primary cause of the disability.

Manipulative Treatment (Adjustment)

A form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion;
- Reduce pain; and
- Increase function.

Maternity Services

UnitedHealthcare Advocate service that provides NXP Medical Plan participants with risk screenings, prenatal education and information to help ensure a healthy delivery.

Maximum Contract Allowance

Reimbursement under the Dental Plan against which Delta Dental calculates payment and a participant's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the maximum contract allowance for services provided by a:

- PPO provider is the lesser of the provider's submitted fee or the Delta Dental PPO contracted fee;
- Premier provider is the lesser of the provider's submitted fee or the Delta Dental Premier provider contracted fee; or
- Non-Delta Dental provider is the lesser of the provider's submitted fee or the program allowance.

Medically Necessary

Health care services that are, as determined by UnitedHealthcare or a UnitedHealthcare designee:

- Provided according to generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, service site and duration
- Considered effective for the sickness, injury, mental illness, substance-related addictive disorders, disease or symptoms;
- Not mainly for your, your doctor's or other health care provider's convenience;
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the sickness, injury, disease or symptoms.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare has the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, is determined by UnitedHealthcare.

UnitedHealthcare develops and maintain clinical policies that describe the generally accepted standards medical practice scientific evidence, prevailing medical standards and clinical guidelines supporting UnitedHealthcare's determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time) are available through **myuhc.com** or by calling UnitedHealthcare at 844-210-5428. They are also available to physicians and other health care professionals on **UHCprovider.com**.

Member Identification Number

Unique identifier provided to each NXP Plan participant that replaces the Social Security Number.

Mental Health Care Services

Covered health services for the diagnosis and treatment of mental health or psychiatric categories that are listed in the *Mental and Behavioral Disorders* section of the current edition of the *International Classification of Diseases* or current edition of the *Diagnostic and Statistical Manual of Mental Disorders* used by the American Psychiatric Association. The fact that a condition is listed in the current edition of one of these documents does not mean that treatment for the condition is a covered health service.

Mental Health/Substance-Related and Addictive Disorders Designee

The organization or individual, designated by UnitedHealthcare, that provides or arranges mental health care services and substance -related and addictive disorders services.

Mental Illness

Mental health or psychiatric diagnostic categories that are listed in the *Mental and Behavioral Disorders* section of the current edition of the *International Classification of Diseases* or current edition of the *Diagnostic and Statistical Manual of Mental Disorders* used by the American Psychiatric Association. The fact that a condition is listed in the current edition of one of these documents does not mean that treatment for the condition is a covered health service.

Mental/Nervous/Alcohol/Drug-Related Condition

Conditions subject to the 24-month maximum disability benefit under the Disability Income Plan.

Network

For the Medical Plan, when used to describe a provider of health care services, this means a provider that has a participation agreement (either directly or indirectly) with UnitedHealthcare or with a UnitedHealthcare affiliate to participate in the UnitedHealthcare network. This does not include providers who have agreed to discount charges for covered health services. The UnitedHealthcare affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain covered health services, but not all covered health services, or to be a network provider for only some of UnitedHealthcare's products. In this case, the provider will be a network provider for the covered health services and products included in the participation agreement and an out-of-network provider for other covered health services and products. The participation status of providers change from time to time.

Network Hospitals

A group of hospitals that have met quality criteria and agree to charge negotiated rates to NXP Medical Plan participants for services.

Network Provider

A physician, dentist or other health care provider who participates in a network, has met specific quality standards and has agreed to accept the allowed amount.

Neuropsychological Testing

The administration and interpretation of standardized tests to assess an individual's cognitive functioning.

Non-Delta Dental Provider

A dental provider who is not a PPO or Premier provider and is not contractually bound to abide by Delta Dental's administrative guidelines.

Non-Occupational Illness

An illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is provided that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that illness under such law.

Non-Occupational Injury

An accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Non-Preferred Drug

A brand name drug that is not on the Preferred Drug List (PDL) under the Prescription Drug Program. You pay a larger share of the cost of non-preferred drugs than for generic or preferred drugs.

NXP Benefits Service Center

The benefits administrator responsible for NXP Welfare Plan eligibility, appeals and customer service.

NXP Health Plans

- NXP Employee Medical Plan;
- Post-Employment Benefits Plan Health Plan;
- Post-Employment Benefits Plan Employee Dental Plan; and
- NXP Pre-Tax Contributions and Health Care Flexible Spending Account Plan.

NXP Medical Plan

An NXP medical benefits plan that features coverage for most medical services, preventive care, a network of physicians and hospitals, well-baby care and more.

NXP Welfare Plans

NXP Employee Medical Plan, NXP Employee Dental Plan, NXP Employee Vision Plan, NXP Disability Income Plan, NXP Pre-Tax Contributions and Health Care Flexible Spending Account Plan, NXP Adoption/Assistance Program, NXP Dependent Care Flexible Spending Account Plan and Post-Employment Benefits Plan.

Ophthalmologist

A medical physician who specializes in the diagnosis and medical and surgical treatment of diseases and defects of the eye.

Optometrist

A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing corrective lenses and other optical aids.

Opt Out

Electing not to enroll in medical (including behavioral health and prescription drug), dental and/or vision coverage. NXP employees who opt out pay no contributions for coverage.

Orthodontia

A dental specialty that involves the correction of abnormally positioned teeth.

Out-of-Area

A term that describes participants who live in, or travel to, an area in the U.S. outside of the designated U.S. network areas.

Out-of-Network Benefits

How benefits are paid for covered health services provided by out-of-network providers. See **Medical Plan Benefits Summary** for out-of-network coverage information.

Out-of-Network Provider

A physician or other health care provider who is not a part of a network and who has not agreed to charge the negotiated network fee schedule. If you live in a network area and use an out-of-network provider, the Plan pays a reduced (out-of-network) level of benefits or no benefits.

Own Occupation

For Short-Term and Long-Term Disability Plan benefits, the occupation that you are routinely performing when your disability period begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed for your specific employer or at your location or worksite and without required to your specific reporting relationship.

Physician

A licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatry (DPM) or Doctor of Dental Surgery (DDS), to the extent that each provides services within the scope of his or her license.

Post-Service Claim

Request for a plan benefit for which prior authorization is not required and payment is being requested for medical care already provided.

Preferred Drug List

List of medications health care experts have selected to be preferred drugs. The Medical Plan pays a higher level of coinsurance for preferred drugs than non-preferred drugs.

Preferred Drugs

Drugs clinical experts select to be placed on the Preferred Drug List. Drugs on the PDL cost participants less than non-preferred drugs. Preferred drugs have met rigorous clinical and therapeutic criteria.

Prescription Drug Product

A medication or product that has been approved by the FDA that can, under federal or state law, be dispensed only according to a prescription order or refill. This includes a medication that due to its characteristics is generally appropriate for self-administration or administration by a non-skilled caregiver. For this Plan, this includes:

- Inhalers (with spacers);
- Insulin;
- Certain injectable medications administered in a network pharmacy;
- Diabetic supplies, including:
  - Standard insulin syringes with needles;
  - Glucose blood testing strips;
  - Glucose urine testing strips;
  - Ketone testing strips and tablets;
  - Lancets and lancet devices;
  - Insulin pump supplies, including infusion sets, reservoirs, glass cartridges and insertion sets; and
  - Glucose meters, including continuous glucose monitors; and
- Certain vaccines/immunizations administered in a network pharmacy.

Prescription Drugs

Brand name and generic drugs prescribed by a physician and dispensed by a pharmacist in a retail pharmacy or through a mail order service.

Pre-Service Claim

Request for a plan benefit for which the Plan requires the claimant to get approval of the benefit in advance of receiving the care.

Pre-Treatment Estimate

For the Dental Plan, a review by Delta Dental of a dentist's planned treatment and expected charges, including diagnostic charges, before providing the services. By asking for a pre-treatment estimate before receiving any prescribed treatment, you have an estimate up front of what Delta Dental will pay and the difference, which you will need to pay. Pre-treatment estimate requests are not required; however, your provider may file a claim form before beginning treatment, showing the services to be provided to you. The benefits will be paid when the treatment is actually performed. A pre-treatment estimate is effective for 365 days.

Primary Care Physician

A physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Primary Residence

The place you primarily reside, as reported to the Plan Administrator.

Primary Provider

The following are generally considered NXP Medical Plan network primary providers:

- Family practitioner;
- General practitioner;
- Internist;
- Nurse practitioner, but only when billed by a primary physician's office;
- Obstetrician/gynecologist; and
- Pediatrician.

Principal Sum

Your business travel accident and accidental death and dismemberment insurance coverage amount is known as the "principal sum."

Prior Authorization

UnitedHealthcare review and approval of a physician's recommendation for covered expenses, such as, but not limited to, certain equipment, treatment, outpatient surgeries, testing and non-emergency hospital admissions. Network providers are responsible for obtaining prior authorization for certain services. Getting prior authorization when required for out-of-network care is the participant's responsibility and provides the highest level of coverage under the Medical Plan.

Private Duty Nursing

Care provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Services must be for treatment, not for custodial care.

Program Allowance

For the Dental Plan, the maximum Delta Dental will reimburse for a covered procedure. Delta Dental sets the program allowance for each procedure through a review of proprietary data by geographic area. The program allowance may vary by the contracting status of the provider and/or the program allowance selected by NXP.

Provider

Any person or facility that provides covered health services under one of NXP's Plans. Providers may include hospitals, physicians, counselors or technicians.

Provider Network

A group of U.S. hospitals, physicians, specialists, ancillary providers, etc., that meet specific criteria and that agree to provide services at negotiated rates to participants covered by NXP Medical Plans that include the network.

Psychological Testing

The administration and interpretation of standardized tests to assess an individual's psychological/personality functioning.

Qualified Domestic Relations Order (QDRO)

A court order approved by the Plan and meeting the requirements of ERISA that requires all or a portion of the benefits payable from the Life Insurance Plan to be paid to someone else, usually a spouse or child for whom the participant has financial responsibility.

Qualified Medical Child Support Order (QMCSO)

A court order approved by the Plan that provides for health care coverage and allocation of responsibility for payment of costs for health care coverage for a child of the employee.

Recognized Amount

The amount that the deductible, copayment and/or coinsurance is based on for the following covered services when provided by out-of-network providers:

- Out-of-network emergency health services; and
- Non-emergency covered services received at certain network facilities by out-of-network physicians when those services are either ancillary services or non-ancillary services that have not satisfied specified notice and consent criteria (network facilities are limited to hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgical centers and any other specified facilities as defined by the UnitedHealthcare.

The amount is based on either:

- An *All Payer Model Agreement,* if adopted;
- State law; or
- The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider is calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the recognized amount to determine cost sharing may be higher or lower than if cost sharing for those covered health services were determined based on the allowed amount.

Remote Physiologic Monitoring

The automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more remote physiologic monitoring devices. Remote physiologic monitoring must be ordered by a licensed physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented and ongoing relationship. Remote physiologic monitoring may not be used while the patient is inpatient at a hospital or other facility. Use of multiple devices must be coordinated by one physician.

Residential Treatment

Treatment in a facility established and operated as required by law that provides mental health care services or substance-related and addictive disorders services that:

- Provides a program of treatment, approved by UnitedHealthcare's mental health/substance-related and addictive disorders designee, under the active participation and direction of a physician and, approved by UnitedHealthcare's mental health/substance-related and addictive disorders designee; and
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least:
    - Room and board;
    - Evaluation and diagnosis;
    - Counseling; and
    - Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a hospital is considered a hospital.

Residential Treatment Center

A facility with 24-hours-a-day, voluntary, short-term supervised level of care provided to children, adolescents or adults with behavioral health illnesses previously not responsive to short-term interventions and/or those requiring crisis stabilization as an alternative to inpatient hospitalization. For treatment of alcoholism and substance use disorder, the facility must provide detoxification services and licensed behavioral health provider and/or substance use disorder professionals onsite 24-hours-a-day.

Resource & Referral Program

A service designed to provide NXP employees with information, resources and referrals on work and personal issues, as well as child care and elder care referral. Sometimes referred to as the NXP EAP program.

Routine Office Visit

Visits with a physician or other provider covered under the medical plan in the physician's or provider's office or outpatient facility.

Section 152 Dependent

Under the provisions of Section 152 of the Internal Revenue Code that would apply under Plan terms, an individual is your "Section 152 dependent" if he or she is a "qualifying child" or a "qualifying relative."

Generally, a "qualifying child" is a person who:

- Is your child or legal ward;
- Has the same principal place of abode as you for more than one-half of the taxable year;
- Either has not attained age 19 at the close of the taxable year or is a student who has not attained age 24 at the close of the year; and
- Does not provide more than 50% of his or her own support in the calendar year.

To be a "qualifying child," the child must be your son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister or a descendant of any such individual. An eligible foster child is treated as your child (an "eligible foster child" means a person who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction).

Generally, a "qualifying relative" is a person:

- Who is either your child or a person who has the same principle abode as you and who is a member of your household;
- Whose gross income for the calendar year is less than the exemption amount for the year;
- For whom you provide over 50% of his or her support in the calendar year; and
- Who is not a qualifying child of yours or any other person for the year.

Short-Term Disability Benefit

Percentage of base salary paid for up to 180 calendar days to an eligible employee who is under a physician's care and continuously unable to perform the essential duties of his or her usual occupation due to a medically determinable physical or mental impairment.

Short-Term Disability Buy-Up

A program that enables you to increase your benefit coverage under the Short-Term Disability Plan by an additional 15%. You pay for this increased level of coverage through before-tax payroll deductions.

Sickness

Physical illness, disease or pregnancy, this includes mental Illness, substance-related and addictive disorders, regardless of the cause or origin of the mental Illness, substance-related and addictive disorder.

Skilled Nursing Facility

An institution licensed to provide professional nursing services 24-hours-a-day, under the supervision of a physician or registered nurse. It must meet local licensing requirements and it must qualify as a skilled nursing facility under Medicare or be accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities. It may also be a rehabilitation hospital or the part of a hospital designed for skilled or rehabilitation services. It is not an institution providing only minimal or custodial care or that primarily provides behavioral health care.

Specialty Pharmaceutical Product

Pharmaceutical products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spouse/Domestic Partner Life Insurance

Optional life insurance for which you make contributions. Spouse/domestic partner life insurance pays benefits for the loss of life of a spouse/domestic partner. Your after-tax contribution amount to pay for this benefit depends on the level of coverage selected, your spouse/domestic partner's age and their tobacco use status.

Social Security Offset

Any Social Security benefit paid to you for the same period that you receive benefits under the Disability Income Plan. This amount is offset from your Disability Plan benefit.

Specialty Provider

For the NXP Medical Plan, a health provider other than a **primary provider**. Examples of specialty providers include cardiologists, neurologists, dermatologists and podiatrists.

Spouse

An individual who is legally married to an employee, including a common-law spouse, and including an individual who is an employee's spouse under the law of the state or country in which the employee married if that state or country recognizes that marriage. An individual separated from the employee under a legal separation decree is still considered a spouse.

> For tax purposes, the Plans follow federal law to recognize a person as your spouse. If you are legally married in a state or country that recognizes same-sex spouses, your same-sex spouse is eligible for coverage as your spouse.

Step Therapy Program

A special feature of NXP's prescription drug coverage, this Program requires patients to try a generic drug for at least 30 days before providing benefits for certain brand name prescription drugs.

Substance-Related and Addictive Disorders Services

Covered health services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the *Mental and Behavioral Disorders* section of the current edition of the *International Classification of Diseases* or current edition of the *Diagnostic and Statistical Manual of Mental Disorders* used by the American Psychiatric Association. The fact that a disorder is listed in the current edition of one of these documents does not mean that treatment of the disorder is a covered health service.

Supplemental Life Insurance

Life insurance coverage in addition to your Basic Life Insurance. You make contributions to pay for this coverage, which provides additional benefits to your survivors if you die while covered. Your after-tax contribution amount to pay for this benefit depends on the level of coverage selected, your age and your tobacco use status.

Surrogate

A female who becomes pregnant, usually by artificial insemination or transfer of a fertilized egg (embryo) to carry the fetus for another person. When the surrogate provides the egg, the surrogate is biologically (genetically) related to the child.

Taxable Income

Income subject to federal and some state income taxes.

Temporomandibular Joint Disorder (TMJ)

A combination of three symptoms that consist of pain in the muscles of mastication and jaw joints, clicking in the jaw joints and limitation in jaw movements. Lesser symptoms may include dislocation and/or locking of jaw joints and sensory changes in hearing.

Terminated Disabled Participant (TDP)

A former employee of NXP, Freescale or Motorola SPS who:

- Terminated employment due to disability according to NXP, Freescale or Motorola SPS's Medical Leave Policy;

- Was eligible to be covered under the Medical Plan, Dental Plan or Vision Plan until December 31, 2016, and has terminated employment;
- Continues to be entitled to disability benefits under the NXP Disability Income Plan; and
- Is younger than age 65.

Therapeutic Donor Insemination (TDI)

Insemination with a donor sperm sample to conceive a child.

Timely Applicant

An employee and/or an employee's eligible dependent who applies for dental coverage within 30 days of the eligibility date.

Tobacco Non-Users Discount

A discount applied to the contribution for employees and spouses/domestic partners required for coverage under the NXP Medical and Life Insurance Plans.

Uniformed Service

Service in the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, full-time National Guard Duty, the commissioned corps of the Public Health Service Act and any other category of persons designated by the President in time of war or emergency and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

UnitedHealthcare

Medical, behavioral health and disability administrator responsible for claims processing, customer service and appeals.

UnitedHealthcare Advocate

A service that UnitedHealthcare maintains to provide prior authorization, disease management, case management, utilization review, network information and other services to NXP Medical Plan participants. Contact a UnitedHealthcare Advocate by calling UnitedHealthcare at 844-210-5428.

Unproven Services

Health services, including medications and devices, regardless of FDA approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well conducted randomized controlled trials or cohort studies in the prevailing published peer reviewed medical literature.

Well conducted randomized controlled trials are when two or more treatments are compared to each other and the patient is not allowed to choose which treatment is received.

Well conducted cohort studies from more than one institution are where patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence for certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

If you have a life threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), UHC or the Plan Sponsor may, its discretion, consider an otherwise unproven service to be a covered health care service for that sickness or condition. Before this consideration, UHC or the Plan Sponsor must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

Urgent Care

Care for medical situations of a serious but non-life-threatening nature, for which the patient needs immediate treatment.

Urgent Care Claim

Any claim for medical care for which the applicable periods for UnitedHealthcare to make non-urgent care determinations could:

- Seriously jeopardize the claimant's life or health or his or her ability to regain maximum function; or
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject him or her to severe pain that cannot be adequately managed without the care or treatment.

U.S. Inpatriate

U.S. Inpatriates are employees of NXP or a participating entity that are transferred from their home country to the U.S. for an extended assignment as determined by NXP Global Mobility. A U.S. Inpatriate is an NXP employee on the payroll of an NXP entity based in the United States, regardless of where the employee actually performs work. The benefits described in this SPD, except the medical (including behavioral health and prescription drug), dental and vision benefits, apply to you if you are a U.S. Inpatriate on U.S. payroll. See the **NXP Benefits** chart for details on eligibility.

U.S. Expatriate

U.S. Expatriates are employees of NXP or a participating entity that are on short-term or long-term assignment outside the U.S. as determined by NXP Global Mobility. A U.S. Expatriate is defined as an NXP employee on the payroll of an NXP entity based in the United States, regardless of where the employee actually performs work. The benefits described in this SPD, except the medical (including behavioral health and prescription drug), dental and vision benefits, apply to you if you are a U.S. Expatriate on U.S. payroll. See the **NXP Benefits** chart for details on eligibility.

Virtual Care Services

When you enroll in an NXP medical option administered by UnitedHealthcare, you have access to virtual care services, an added benefit that gives you 24/7 access to a national network of U.S. board-certified doctors. See **Virtual Care Services** , for more information.

Index

This section includes an index to help you find what you need in this SPD.

Contact Information

This section includes a convenient list of telephone numbers, websites and other resources for the various Plans described in this SPD.

Plan/Program	Telephone/Website	Address
Eligibility and Administration		
NXP Benefits Service Center	**Telephone:** 888-375-2367 **Website: NXP.bswift.com**	**NXP Benefits Service Center** 100 Half Day Road Lincolnshire, IL 60069-1475
Dependent Verification Center	**Telephone:** 888-375-2367 **Website: NXP.bswift.com**	Not applicable; online access only
Premium Payments (COBRA and non-COBRA)* * *Effective 10/1/20*	**Telephone:** 866-747-0048 **Email:** cobraKYoperations@uhc.com	**UnitedHealthcare** Attn: Benefit Services P.O. Box 740221 Atlanta, GA 30374-0221
Health Plans/Resources		
NXP Medical Plan • UnitedHealthcare Advocate and Nurses • Behavioral Health Program	**UnitedHealthcare Telephone:** 844-210-5428 Monday through Friday 8 a.m. to 8 p.m. (local time) **TDD:** 800-628-3323 **Website:** myuhc.com	**Claims:** **UnitedHealthcare** P.O. Box 30555 Salt Lake, UT 84130-0555
NXP Medical Plan • Kaiser Medical Plan	**Kaiser Permanente:** **Telephone:** 800-278-3296 **Website:** kp.org	The medical option, which is fully-insured, is only available in the Kaiser service area and is not described in this SPD.
Prescription Drug Program	**Telephone:** 877-505-8360 **TDD:** 800-231-4403 **Website:** Caremark.com **PrudentRx Solution (Medical Plan 2 and 3 Specialty Medications):** 800-578-4403	**Mail order prescriptions:** **CVS Caremark** P.O. Box 659541 San Antonio, TX 78265 **Claims:** **CVS Caremark** P.O. Box 52136 Phoenix, AZ 85072
Health Savings Account Administrator	**Telephone:** 844-697-4015 **Fax:** 888-211-9900 **Website:** https://netbenefits.com/	**Fidelity Investments** Attn: Retirement Distributions Fidelity Investments P.O. Box 770001 Cincinnati, OH 45277-0035
Employee Assistance Program	**Telephone:** 866-248-4094 **Website:** Live and Work Well.com (access code: NXP)	**UnitedHealthcare Live and Work Well** 151 Farmington Avenue Hartford, CT 06156

Plan/Program	Telephone/Website	Address
Flexible Spending Accounts – Health Care/Limited Use Health Care FSA and DCFSA	**Telephone:** 844-210-5428 **Website:** myuhc.com NXP.com/benefits	**Claims:** **Health Care Account Service** Center P.O. Box 981506 El Paso, TX 79998-1506 **Website:** Online submission and forms at myuhc.com
Dental Plan	**Telephone:** 800-521-2651 **Website:** deltadentalins.com	**Claims:** **Delta Dental Claims** P.O. Box 1809 Alpharetta GA 30023-1809
Vision Plan	**Telephone:** 800-877-7195 **TTY:** 800-428-4833 **Website:** VSP.com	**Claims:** **VSP** P.O. Box 385018 Birmingham, AL 35238-0518
Gym Reimbursement Program	**Telephone:** 888-375-2367 **Website:** NXP.com/benefits	**email:** hr.helpdesk.amr@nxp.com
Disability and Life		
Disability Income Plan	**Telephone:** 800-842-1718 **Fax:** 877-889-4885	**Claims:** **The New York Life Insurance Company of America** Disability Management Services P.O. Box 13480 Philadelphia, PA 19176
Life and Accidental Death and Dismemberment Insurance – Basic, Supplemental, Spouse/Domestic Partner and Child(ren)	**Telephone:** • ***Evidence of Insurability and Claims:*** 800-638-6420 • ***Conversion Applications:*** 877-275-6387	**Claims:** **MetLife Group Life Claims** P.O. Box 6100 Scranton, PA 18505-6100
Work/Life		
Adoption Assistance Program	**Telephone:** 888-375-2367 **Website:** NXP.com/benefits	**NXP Semiconductors** c/o bswift P.O. Box 150890 Grand Rapids, MI 49515-0890
Backup Care	**Telephone:** -- 877-242-2737 **Website:** clients.brighthorizons.com/NXP	Use registration code “NXP”
ID Watchdog Identity Theft Protection	**Telephone:** 866-513-1518 **Website:** idwatchdog.com/myplan/NXP	-

Plan/Program	Telephone/Website	Address
MetLife Legal Services Plan	**Telephone:** 800-821-6400 **Website:** legalplans.com	**Appeals:** **MetLife Legal Plans** Directory of Administration Eaton Center 1111 Superior Avenue Cleveland, OH 44114-2507
NXP PerkSpot	**Website:** nxp.perkspot.com	**New Hires:** Please allow two weeks for your information to be provided to PerkSpot.
Pet Insurance	**Telephone:** 800-438-6388 **Website:** metlife.com/mybenefits	Use employer name "NXP" and your employee ID
International SOS **Travel Assistance Program**	**Telephone:** 800-523-6586 **Fax:** 215-354-2338 **International:** +1-215-942-8226 **Website:** internationalsos.com/member-zone (log in with NXP corporate membership number)	**International SOS** 3600 Horizon Boulevard, Suite 300 Trevose, PA 19053 **NXP Corporate Membership Number:** 11BCPA000145
Tutoring	**Telephone:** 877-242-2737 **Website:** clients.brighthorizons.com/NXP	