NXP 2024

Summary Plan Description

NXP USA, Inc. Post-Employment Health Plan

Retirees and Terminated Disabled Participants Effective January 1, 2024

Introduction

You have benefits available to you through the NXP USA, Inc. Post-Employment Health Plan, depending on your status as a retiree or Terminated Disabled Participant (TDP). You also may have investment and distribution options through the NXP 401(k) Retirement Plan. If you are a TDP (or were disabled and receiving Long-Term Disability Plan benefits at the time of your retirement), you may have some life insurance and disability benefits as well. This book provides you with useful information to help you make decisions and take full advantage of the benefits available to you as a NXP retiree/TDP.

This is your official Summary Plan Description (SPD) for the NXP USA, Inc. Post-Employment Health Plan, as described in and required under the Employee Retirement Security Act (ERISA).

> ***If You Are a Terminated Disabled Participant (TDP)***
>
> There are some differences in the Post-Employment Health Plan between the retiree and TDP provisions. Watch for shaded boxes like this one throughout for important information that is provided specifically for TDPs. If you have any questions, call the NXP Benefits Service Center at 888-375-2367.

This SPD is divided into the following sections:

- **Participation** section on page 20 includes information about who is eligible for the benefits described in this SPD, how to enroll, when coverage begins, when you can make changes as well as when coverage ends. You will also find information about continuing some coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Health and wellness section includes:
  - **Medical** coverage (page 52) , including behavioral health and prescription drug;
  - Wellness Programs/Activity Center (page 158) ;
  - **Dental** coverage (page 161) ; and
  - **Vision** coverage (page 187).
- A **claims and appeals** section on page 202 includes information about how benefits are coordinated and your privacy rights.
- A **plan information** section on page 247 with other important information and your ERISA rights.
- A **definitions** section on page 254 with explanations of terms and phrases commonly used throughout this SPD.
- An **index** on page 292 to help you put your finger on the exact information you need.
- A handy **contact information** reference on page 293, 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 benefits, 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 information.

Keep this SPD handy and refer to it often as your resource for information on the many benefits of the NXP post-employment package.

NXP Post-Employment Benefits

The chart below lists the various Plans available.

In this chart, an eligible dependent is your dependent who, on your last day of employment, was *eligible* for coverage under the corresponding plan for active employees (e.g., the Employee Medical Plan corresponds to the Post-Employment Medical Plan), but who was not necessarily covered by that Plan.

Plan/Program	What It Is	Who Is Eligible	
		Retiree	**TDP**
Post-Employment Medical Plan Includes Behavioral Health Benefits	Pre-65 retiree medical coverage, including all coverage options	You and your eligible dependents, up to you or your dependents' respective 65th birthday, if you meet the eligibility requirements	You and your eligible dependents, up to you or your dependents' respective 65th birthday, if you enroll yourself and your dependents when you first become a TDP
Post-Employment Prescription Drug Program Included as part of Post-Employment Medical Plan	Pre-65 retiree benefit program through which you purchase prescription drugs through approved retail and mail order network pharmacies	You and your eligible dependents, up to you or your dependents' respective 65th birthday, if enrolled in the Post-Employment Medical Plan	You and your eligible dependents, up to you or your dependents' respective 65th birthday, if enrolled in the Post-Employment Medical Plan
Aon Retiree Health Exchange*	Health insurance plans offered for retirees and their dependents who are age 65 and older	You and your eligible dependents, age 65 and older, if you meet the eligibility requirements	Not available to TDPs or their dependents
Wellness Programs/Activity Center	Onsite Activity Centers designed to give NXP retirees the opportunity to be active and healthy	You and your spouse/domestic partner if you enroll yourself	Not available to TDPs or their dependents

Plan/Program	What It Is	Who Is Eligible	
		Retiree	**TDP**
Post-Employment Dental Plan	Plan that provides coverage for preventive and diagnostic dental services, dental treatment, orthodontia and other covered treatment	You and your eligible dependents, up to you or your dependents' respective 65th birthday, if you meet the eligibility requirements	You and your eligible dependents, up to you or your dependents' respective 65th birthday, if you enroll yourself and them when you first become a TDP
Post-Employment Vision Plan	Plan provides coverage for routine vision care services, including vision examinations, eyeglasses and contact lenses	You and your eligible dependents, up to you or your dependents' respective 65th birthday, if you meet the eligibility requirements	You and your eligible dependents, up to you or your dependents' respective 65th birthday, if you enroll yourself and them when you first become a TDP
Disability Income Plan	Income replacement plan for those who are disabled	Not available to retirees or their dependents	You, as a TDP, for as long as you remain disabled and receiving long-term disability benefits
Life Insurance Benefits	Payment by NXP of your Basic and Supplemental Life Insurance premiums	Not available to retirees or their dependents	You, as a TDP, for as long as you remain disabled and receiving long-term disability benefits

Note: *The Disability Income and Group Life Insurance Benefit Plans are not described in this document.* Refer to the *NXP Benefits: Health, Wellness, Life, Savings and More Summary Plan Description, U.S. Benefits* for more information about these Plans.

** Post-65 Retiree Coverage as of January 1, 2016*

Before January 1, 2016, the Plan provided post-65 coverage through a company-sponsored plan
through Humana. All company-sponsored post-65 retiree coverage ended on December 31, 2015.

Effective on and after January 1, 2016, all eligible retirees and dependents age 65 or older have the option to enroll in individual coverage through the Medicare marketplace. Through the Medicare marketplace, most post-65 NXP retiree health care participants are able to purchase coverage that is comparable to that previously covered through the company-sponsored plan; and in some cases, more comprehensive. As an added benefit, each participant can select from a wider choice of plans and pick the one that best meets his or her needs.

To help you choose the right Medicare marketplace plan for you and your dependents, NXP provides you with access to the Aon Retiree Health Exchange™. The Aon Retiree Health Exchange is a leading Medicare service that helps retirees navigate the individual Medicare marketplace with unbiased, licensed and certified Benefits Advisors who work one-on-one with you. Your Benefits Advisor helps you explore your health plan options and enroll in the one that best meets your health and financial needs. You just pay for the coverage that you choose. Your Benefits Advisor is also available to provide ongoing support after enrollment.

Transition Assistance: To ease the transition, NXP contributed to a Health Reimbursement Account (HRA). An HRA is an account that can be used to help reimburse certain eligible health care expenses and health care premiums. NXP made an HRA contribution for 2016 and 2017. There is no HRA contribution after December 31, 2017.

Advocacy Services

A majority of benefits and billing issues can be resolved with a phone call to UnitedHealthcare. When you call, your Advocate will help you and your family with all types of health and retirement benefit issues – whether it is to help you understand your benefits, help you with an insurance claim or help you research and locate treatments or medications – simply call UnitedHealthcare at 844-210-5428.

NXP 2024 Post-Employment Plan Summary Plan Description

This SPD represents general information regarding provisions of the NXP Post-Employment 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 Plan Administrator and Plan 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, including raising the costs or premiums for any of the benefits under the Plans. You will be notified of any changes.

This SPD describes the Plans, as each has been amended to date. Please see the prior Freescale or Motorola SPD and Summaries of Material Modifications (SMMs) for information concerning Plan provisions that applied before January 1, 2017. SMMs or new SPDs will be provided to advise you of changes in the Plans, as required by ERISA.

NXP will provide without charge to any participant in the 401(k) Retirement Plan a copy of the NXP 401(k) Retirement Plan document and any other documents required to be delivered pursuant to Rule 428(b) under the Securities Act or ERISA. Requests should be directed to the attention of: Benefits Department, NXP, Inc., 6501 West William Cannon Drive, Mail Drop OE 331, Austin, TX 78735, phone 888-375-2367.

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Participation

This section includes information about:

- *Who is eligible*
- *Enrolling for coverage*
- *Paying for coverage*
- *When coverage begins*
- *When you can change your coverage*
- *When coverage ends*
- *When and how and when you can continue certain coverage after it would otherwise end; and*
- *Additional information about survivor coverage as well as Medicare.*

Eligibility

NXP offers comprehensive health coverage to eligible former NXP retirees, Terminated Disabled Participants (TDPs) and their eligible dependents. This section summarizes the eligibility requirements and coverage options for the Post-Employment Health Plan.

Effective January 1, 2016, a retiree does not include former employees and covered dependents age 65 or older and former employees and covered dependents eligible to enroll in Medicare, regardless of their NXP USA, Inc. Post-Employment Plan and Medicare enrollment status.

Protection Against Use of Genetic Information

The Post-Employment Health Plan does 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

Health Benefits Retiree Eligibility

People retire at different ages and with varying years of service; two factors that are used in determining eligibility for retiree benefits. You may be eligible for retiree health benefits, which include medical, dental and/or vision coverage, if you meet specific age and service requirements when you retire.

Age and Service Requirements

As of December 2, 2007, there are no new participants in the Plan. That means that no employee or former employee will become eligible for post-employment medical, dental or vision benefits after December 2, 2007.

To be eligible for post-employment retiree medical, dental and/or vision coverage, you must have met the Plan's age and service requirements **on or before December 2, 2007.**

Only full, complete years of age and service (on U.S. payroll) as of December 2, 2007, are counted.

You are eligible as a retiree for Post-Employment Health Plan coverage if, ***on or before December 2, 2007***:

- You were a retiree (or spouse/domestic partner of a retiree) eligible for and receiving retiree health benefits; or
- Your combined age and service equaled at least 75 (for example, you were age 49 with 26 years of service); or
- You were:
  - Age 55 with 20 or more years of service;
  - Age 56 with 18 or more years of service;
  - Age 57 with 16 or more years of service;
  - Age 58 with 14 or more years of service;
  - Age 59 with 12 or more years of service;
  - Age 60 or older with at least 10 years of service; or
- You were an employee age 55 or older on March 31, 1989, and you retired at age 65 or older.

If you meet the above age and service requirements:

- On or before December 1, 1992, you are considered a grandfathered retiree; or
- After December 1, 1992, you are considered a non-grandfathered retiree.

If You Are Hired by NXP

If you terminated employment and you and your eligible dependents enroll in the Post-Employment Health Plan, and you are later re-employed by NXP, your Post-Employment coverage ends if you become covered under the active plans. When your NXP employee coverage ends, you and your eligible dependents may again enroll in the Post-Employment Health Plan, if available.

Health Benefits Terminated Disabled Participant (TDP) Eligibility

You are eligible for post-employment retiree medical, dental and/or vision coverage as a Terminated Disabled Participant (TDP) if you:

- Are a former employee of Freescale/Motorola SPS;
- Terminated employment due to disability, according to the NXP Medical/FMLA Leave Procedure;
- Were eligible for coverage under the Medical, Dental or Vision Plan until your termination of employment;
- Continue to be entitled to disability benefits from the NXP Disability Income Plan; and
- Are younger than age 65.

As a TDP, coverage is only available for your spouse/domestic partner and dependents who were covered under the corresponding Plan for active employees at the time your employment terminated.

Disability Income Benefits Eligibility

As a former employee of NXP, certain disability and life insurance benefits remain available to you if:

- You:
  - Are a TDP; or
  - Retire under NXP Medical/FMLA Leave Procedure, while receiving disability benefits under the NXP Disability Income Plan; and
- You continue to be eligible for disability benefits under the Plan.

> **Note:** The Disability Income Plan is not described in this document. Refer to the *NXP Benefits: Health, Wellness, Life, Savings and More Summary Plan Description, U.S. Benefits* for more information about this Plan.

Dependent Eligibility

When you are covered by the NXP Post-Employment Health Plan as a retiree or TDP, you may enroll your eligible dependents younger than age 65 in the Plan. Eligible dependents are not automatically enrolled; you must enroll your eligible dependents younger than age 65 at the same time you first enroll.

If you defer or decline coverage for yourself, your dependents may not be covered. The NXP Benefits Service Center may require documentation to verify your dependents' relationship or eligibility when you enroll them and/or at any time they are covered.

Eligible Dependents

For retirees, if an individual was not eligible for dependent coverage under the NXP Employee Health Benefit Plan as a dependent when you retired, the individual is not eligible for dependent coverage under the Post-Employment Health Plan.

To be an eligible dependent of a*:*

- **Retiree,** your spouse/domestic partner or child must be younger than age 65 and have been *eligible for dependent coverage* under the NXP Medical, Dental or Vision Plan on your last day of employment (actual coverage by that plan is not required).
- **TDP,** your spouse/domestic partner or child must be younger than age 65 and have been *actually covered* under the NXP Medical, Dental or Vision Plan on your last day of employment.

However, your child who is born or adopted within 10 months of your last day of employment at NXP is also an eligible dependent.

In addition to the above, your dependents must meet the criteria below to be covered by the Post-Employment Health Plan.

For medical (including behavioral health and prescription drug), dental and/or vision coverage for eligible dependents under age 65, you may enroll as a covered dependent:

- Your legally recognized spouse* claimed as your federal tax dependent;
- Your same-sex or opposite-sex domestic partner;

> * *For tax purposes, the Plan uses federal 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 married and unmarried children through the end of the month in which they reach age 26;

> Your children include your:
> - Children by birth, adoption, 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).

- A child who is over age 25 who is:
  - Incapable of working because of mental or physical disability that began before age 26; and
  - Financially supported by you.

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. Children age 19 and older who are eligible for health coverage from another source, such as from their employer, but not from your spouse's employer, **are not** eligible dependents.

Your siblings, parents, in-laws, ex-spouses, grandparents or grandchildren are not eligible dependents. In addition, a dependent who is already covered by an NXP Plan is not an eligible dependent.

Domestic Partner Eligibility Rules

Eligible dependents under the Post-Employment Health Plan include your domestic partner as well as your 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 your domestic partner's) 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. Legally wed same-sex couples are 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 Post-Employment Health Plan, you and your partner must register in accordance with applicable city, county or state laws. The NXP Benefits Service Center may request documentation and/or an affidavit.

An affidavit can be requested from the NXP Benefits Service Center.

In the absence of domestic partner registration, you and your partner must meet all these additional requirements:

- 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 is married to another person under statutory or common law and neither of you are in another domestic partnership.

TDPs: Your spouse/domestic partner or child must be younger than age 65 and have been eligible and actually covered under the NXP Medical, Dental or Vision Plan on your last day of employment at NXP.

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 are 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 the **Section 152 Dependent** section on page 288 for more information.

For domestic partners and their children who do not qualify as your Section 152 dependents, you must include as reportable income the value of any medical, dental and vision coverage that NXP provides for them.

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

Different rules may apply for state income tax purposes.

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.

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.

No Pre-Existing Conditions Exclusions

The Post-Employment Medical Plan does not have a "pre-existing condition" restriction.

Enrolling for Coverage

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

Your Retiree Enrollment Options

If you are an eligible retiree, you have three choices for health coverage when you retire from NXP:

- **Elect COBRA Continuation Coverage:** You may continue your coverage through COBRA for eligible programs of the NXP Employee Health Benefit Plan for up to the allowable COBRA coverage period (typically 18 months). You must pay for COBRA coverage; see the current **Summary Plan Description** for information on how to elect COBRA continuation coverage.

  You cannot defer enrollment. If you want coverage under the Post-Employment Health Plan, you must enroll at retirement. This applies to anyone eligible for NXP retiree benefits, including if anyone offered benefits under any NXP severance agreement.

- **Enroll in the Post-Employment Health Plan:** You may enroll in the NXP Post-Employment Health Plan by calling the NXP Benefits Service Center at 888-375-2367 within 30 days of your retirement. No health statement or physical examination is required, and there are no pre-existing exclusions. Your coverage begins on the first day of the month after your retirement date.

  If you take no action when you retire from NXP you will have no coverage.

  If you retire from NXP at age 65 or older and want coverage under an individual Medicare marketplace plan, you must enroll; you cannot elect COBRA or defer coverage and enroll later. You may enroll through the Aon Retiree Health Exchange.

Post-Employment Health Plan Enrollment

To be eligible for NXP Post-Employment Health Plan medical coverage, you must enroll in the Plan before you reach age 65.

If you retire before age 65, you will lose your eligibility for the NXP Post-Employment Health Plan if you:

- Elect COBRA coverage or defer Post-Employment Health Plan coverage; and
- Do not enroll in the Post-Employment Health Plan before your 65th birthday.

If you retire at age 65 or older, NXP provides you with access to the Aon Retiree Health Exchange, a Medicare service that will help you navigate the individual Medicare marketplace. Your Benefits Advisor will help you explore your health plan options and enroll in the one that best meets your health and financial needs.

To learn more about your eligibility at and after retirement and how to enroll, call the NXP Benefits Service Center at 888-375-2367.

TDP Enrollment

The NXP Disability Income Plan is a closed plan, which means there are no new enrollments allowed into the plan.

Importance of Maintaining Coverage

Once ***you***, the NXP retiree, enroll for the Post-Employment Health Plan, you cannot cancel coverage and re-enroll later. Once Post-Employment Health Plan coverage ends for any reason, neither you nor your dependents are eligible for this coverage at

If Your Spouse/Domestic Partner or Child Works at NXP

No one may be covered by any NXP Rewards plan as both a retiree or employee, and a dependent, and no eligible dependent may be enrolled by more than one eligible retiree, TDP or employee. If you are an eligible retiree or TDP and your spouse/domestic partner is an eligible employee or retiree, you have these enrollment options for the Post-Employment Health Plan:

- One of you may enroll as an employee/retiree and the other enrolls as a dependent; or
- You may each enroll separately as an employee/retiree, and only one of you may enroll your eligible children as dependents.

When an NXP employee is married to or in a domestic partnership with another NXP employee, at the time either spouse/domestic partner retires and chooses not to enroll in the Post-Employment Health Plan, he or she may elect, within 30 days of the retirement date or when coverage may begin, to be covered as a dependent under the active spouse's/domestic partner's health coverage (Employee Medical, Dental and/or Vision Plans). The active spouse/domestic partner is allowed to enroll the retiree as a spouse/domestic partner at that time as a **Qualified Status Change** (see page 33) through the NXP Benefits Service Center.

If the second spouse/domestic partner above is not eligible for coverage under the Post-Employment Health Plan when his or her employment ends, the first spouse/domestic partner has 30 days after coverage ends under the NXP health plan(s) for active employees (or another plan offering creditable coverage) to enroll in the Post-Employment Health Plan as a retiree provided they are eligible for the Post-Employment Health Plan. The first spouse/domestic partner may also enroll the second as his or her dependent.

Enrolling Eligible Dependents

Eligible dependents are not automatically enrolled in the Post-Employment Health Plan. If you want your dependents to be covered, you must enroll your eligible dependents at the same time you first enroll for the Plan.

For retirees, if you die before you enroll in the Post-Employment Health Plan, but after you become eligible, then your dependents who were *eligible* for dependent coverage under the NXP Medical, Dental or Vision Plan (including COBRA coverage elected after your death) may enroll in the Post-Employment Health Plan within 30 days after the later of your death or when the active plans' coverage ends

In some cases, eligible dependents may instead continue coverage under COBRA.

Marriage/Domestic Partnership Rules

- **Retirees:** If you have an eligible spouse/domestic partner at retirement who is younger than age 65, that spouse/domestic partner is eligible for the Post-Employment Health Plan.
- **Retirees:** If you get married or establish a domestic partnership after retirement, that spouse/domestic partner *is not* eligible for the Post-Employment Health Plan.

Contact the NXP Benefits Service Center for details.

Divorce/End of Domestic Partnership

Your ex-spouse/domestic partner is not eligible to remain on the Post-Employment Health Plan after your marriage or domestic partnership ends, even if your divorce decree states you must provide health coverage for your ex-spouse/domestic partner. 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 the **Medical, Dental and Vision COBRA Continuation Coverage** section on page 41).

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 under the corresponding NXP Post-Employment Health Plan (medical, dental and/or vision coverage) if your divorce decree states that your former spouse 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 (QMCSO, as described on page 19) *and* the children were eligible (if you are a retiree) or covered (if you are a TDP) under the corresponding Employee Medical, Dental and/or Vision Plan at the time of your retirement or termination, as applicable.

Your Responsibilities – Enrolling and Certifying Your Dependents

It is your responsibility to ensure that you and the dependents you enroll are eligible for coverage according to Post-Employment Health Plan terms and conditions. When you enroll your dependents, or change your benefit elections, you represent that these individuals meet the definition of an eligible dependent under the applicable NXP Post-Employment Health 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 dependents to no longer meet the definition of an eligible dependent.

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

- Obligate you to reimburse the appropriate NXP Post-Employment Health 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 dependent's coverage prospectively or retroactively or refuse to cover your 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 dependent(s).

Paying for Coverage

Health Benefits

If you enroll in the Post-Employment Health Plan, you make a monthly after-tax contribution toward the cost of coverage for you and your covered dependents.

You are responsible for paying your contributions. When you receive your first bill, be sure to check it carefully to ensure you are being billed for the coverage option you choose. Your first payment is due at the end of the month in which your coverage begins. Please be aware that no benefits are paid for claims during a month in which your contributions are outstanding. You may avoid this problem by having your contributions automatically deducted from your bank account each month via direct debit.

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 Post-Employment Medical and Dental Plans.

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

Cost-Sharing and Contributions for Coverage

You and NXP share the cost of pre-65 post-employment medical coverage; NXP makes a contribution toward your coverage, and you pay the rest. The contribution for coverage each year is determined by NXP and communicated during annual enrollment. If you started employment with Motorola before January 1, 2002, and you met the age and service requirements for retiree health benefits as of December 2, 2007, NXP currently makes coverage available to you and shares with you the cost of the Plan's coverage and its administration. **Remember**: After December 2, 2007, no employee or former employee will become eligible for post-employment medical, dental and vision benefits.

For pre-65 Post-Employment Medical Plan coverage, NXP's share of claims costs will not exceed, on an annual basis:

- Single Coverage: $5,890
- Family Coverage: $10,690

When the company's costs reach the maximum, you absorb a greater share of the projected costs. Although the maximum affects the portion of the expenses you pay, it does not limit the benefits available to you as a retiree or TDP, as long as retiree coverage is provided.

Note: The company's share of claims costs has reached or will reach these limits in the next few years.

Note: Any contribution increase is based on the Plan's total medical cost inflation. When NXP's costs reach the maximum described above, your contribution will absorb a greater share of the projected costs.

NXP determines the cost sharing and contribution maximum each plan year based on claim data analyzed by the third-party administrator. NXP determines, in its sole discretion, whether the maximum NXP contribution has been attained. NXP also reserves the right in its discretion to modify contribution levels and/or plan design.

Annual Review of Contribution Amount for Retirees

As a retiree, each year, your contribution amount is reviewed and is subject to change. Your contribution increase (if any) depends on when you met the age and service requirements:

If you:	When you are under age 65:
• Retired on or before December 1, 1992; or • Met the age and service requirements on or before December 1, 1992 ...then you are eligible for grandfathered coverage, and	Your contribution increase is based on Plan's total medical cost inflation
• Met the age and service requirements after December 1, 1992, but before December 3, 2007 ...then you are eligible for non-grandfathered coverage, and	Your contribution increase is based on Plan's total medical cost inflation

Annual Review of Contribution Amount for TDPs

Each year, your contribution amount is reviewed and is subject to change. Your contribution increases (if any) depends on:

- When your employment terminated (either before or after January 1, 2002); and
- The Plan's total medical cost inflation.

Paying for Life Insurance Coverage

After your disability retirement or TDP status begins, NXP pays the full cost of your Basic and Supplemental Life Insurance coverage, if you previously elected them, for the period specified under Plan terms.

Call the NXP Benefits Service Center at 888-375-2367 or refer to the *NXP Benefits: Health, Wellness, Life, Savings and More Summary Plan Description, U.S. Benefits* for more information about the Group Life Insurance Benefit Plan.

When Coverage Begins

Retiree Coverage

Coverage under the Post-Employment Health Plan for you and your eligible dependents starts on the first day of the month following your retirement date, if you are eligible, younger than age 65 and you enroll within 30 days of your last day of employment.

If you are eligible and age 65 or older, you have access to post-65 retiree medical coverage through the Aon Retiree Health Exchange. If you enroll at age 65, coverage is effective the first of the month in which you turn age 65 (or the first of the previous month if your birthday falls on the first of the month), if you enroll. This replaces coverage under the pre-65 coverage options in the Post-Employment Medical Plan, which are for participants under age 65 only.

TDP Coverage

Coverage under the NXP Post-Employment Health Plan for you and your eligible dependents starts on your termination date if you are eligible and you enroll within 30 days of your last day of employment.

Coverage Outside the United States

If You Move Outside of the United States

Post-Employment Health Plan coverage is available only if you live in the U.S. or a U.S. territory (e.g., Puerto Rico, Guam). If you move your primary residence outside the U.S., your coverage ends on the last day of the month in which you move.

If You Vacation Abroad

While you are traveling or vacationing outside of the U.S. for a period of 60 days or less, your Post-Employment Health Plan coverage continues for emergency care expenses only.

If you are eligible age 65 or older and eligible for Medicare, you have access to retiree medical coverage through the Aon Retiree Health Exchange. Note that Medicare rarely pays for hospital admissions outside of the U.S. and, in most instances, does not cover other medical services performed outside of the U.S. Separate rules apply see your carrier's *Evidence of Coverage* booklet for details.

When You Can Change Your Coverage

You can drop coverage for yourself and/or your dependents at any time. Your coverage will end on the last day of the month of your request.

Annual Enrollment

Each year, you have an opportunity to change your pre-65 medical, dental and/or vision coverage option for the following year. When you elect a coverage change during annual enrollment, your change is effective the following January 1. Your annual coverage elections remain in force during the year unless you change your elections according to the provisions below.

> If you are age 65 or older, you will also have the opportunity to review and adjust your individual Medicare marketplace plan annually, if needed.

Qualified Status Changes and Special Enrollment

If you experience a qualified status change that affects eligibility, you may be eligible to change your Post-Employment Medical option. If you are a:

- Retiree, you may add or drop Post-Employment Medical, Dental or Vision coverage for a dependent who was an *eligible* dependent (but not necessarily covered) under the Employee Medical, Dental or Vision Plan at the time you retired.
- TDP, you may drop Post-Employment Medical, Dental or Vision coverage for a covered dependent (you may not add coverage for yourself or a dependent due to a qualified status change).

You must log on to **nxp.bswift.com** or call the NXP Benefit Service Center at 888-375-2367 within 30 days of the event to make the change.

> To enroll an eligible dependent when that dependent's other group health coverage ends or changes as described above, you must provide evidence of creditable coverage from your dependent's previous insurance carrier within 30 days of the loss of that other coverage. Your eligible dependent's coverage becomes effective the date the NXP Benefits Service Center approves his/her enrollment application.

Qualified status changes include:

- Your divorce, dissolution of a domestic partnership, legal separation or annulment;
- Death of your spouse/domestic partner or dependent;
- For retirees, a change in employment status by your spouse/domestic partner or eligible dependent that affects eligibility for other group health coverage, 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 spouse's/domestic partner's or dependent's health coverage.
- Beginning or ending a dependent's eligibility due to age, incapacity or other similar circumstance;
- A change in the place of residence of your eligible dependent that affects medical coverage (e.g., moving to or from a network location);
- You, your spouse/domestic partner or eligible dependent enrolls in or loses coverage under Medicare (Parts A and B) or Medicaid; or
- Any other event recognized under applicable law and regulations as a reason to change plan elections.

Note: Your spouse's or domestic partner's self-employment is not considered employment for these qualified status changes.

A change in coverage election due to a qualified status change is effective the date of the event.

You must provide updated information to the NXP Benefits Service Center regarding your spouse, domestic partner or eligible dependents, including the specific date on which any of your dependents ceases to be an eligible dependent.

HIPAA Special Enrollment – For Retirees Only (Not Applicable to TDPs)

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to enroll your eligible dependents under the Post-Employment Medical Plan, even if they were not previously enrolled, when you acquire a new dependent or when your dependents lose coverage under another group health plan for any of the following reasons:

- 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
- 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 Post-Employment Health Plan coverage within 60 days after your eligible child:

- Loses coverage under a Medicaid plan or state CHIP plan due to a loss of eligibility; or

- Becomes eligible for a government subsidy of the cost of coverage for the Post-Employment Health Plan 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 who was eligible for dependent coverage (if you are a retiree) or who was actually covered as a dependent (if you are a TDP) under the Employee Medical Plan at your retirement or termination, you may change your Medical Plan election 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 contact:

- **By Phone:** 888-375-2367; or
- **By Mail:**
  NXP Benefits Service 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 lose coverage under any group health coverage sponsored by a governmental or educational institution;
- Your spouse or dependent who was an *eligible* dependent (but not necessarily covered) under the Employee Medical, Dental, or Vision Plan on the date you retired or terminated (as applicable) 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.

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.

When Coverage Ends

Retiree and TDP Coverage

Termination of Former Employee Coverage

As a former employee, you cease to be a participant and your coverage under the Plan ends on the earliest of:

- The last day of the month for which you paid a required contribution to the Plan for coverage if you have discontinued payments for any reason;
- The date you become re-employed by NXP and become eligible for coverage under the NXP Employee Medical Plan;
- The last day of the month before you attain age 65 (or on the last day of the previous month if your 65th birthday falls on the first day of the month);
- The last day of the month before you become eligible for Medicare;
- 90 days after the Plan Administrator requires repayment from you or your covered dependent of amounts subject to reimbursement under any welfare plan, overpayments or mistaken payments from any welfare plan, unless you or your covered dependent repays such amounts or sets up a payment schedule for the amounts, as approved by the Plan Administrator (in its sole discretion);
- The date of your death; or
- The date the Plan ends or the effective date of an amendment eliminating your coverage.

> In addition to the above, coverage may also end on the last day of the month in which you move your primary residence abroad (except as determined by NXP and as described in this document, as it may be changed from time to time).

Following termination of coverage as described above, you may be entitled to elect to extend Plan coverage through COBRA (see the **Medical, Dental and Vision COBRA Continuation Coverage** section on page 41).

Dental and Vision Coverage Only

Unless your coverage ends as described above, your coverage under the Post-Employment Dental Plan and the Post-Employment Vision Plan ends on the first of the month in which you turn age 65 (or the first of the previous month if your birthday falls on the first of the month).

For example, if you turn 65 on June 12, your Post-Employment Dental Plan and Post-Employment Vision Plan coverages end on May 31. In this example, you do not have Post-Employment Dental Plan or Post-Employment Vision Plan as of June 1.

TDP Coverage

Your coverage under the Post-Employment Health Plan ends on the earliest of:

- The last day of the month before you reach age 65 (this date does not apply if you are eligible to receive income benefits from the NXP Disability Income Plan at age 65 or older);
- The last day of the month in which you are no longer entitled to receive income benefits from the NXP Disability Income Plan;
- The last day of the month in which you cease to be disabled;
- The last day of the month in which you move your primary residence abroad;
- The last day of the month in which you enter the military service of any country, except as may otherwise be required by law;
- The last day of the month for which you paid a contribution if you have discontinued payments for any reason;
- The date you become re-employed by NXP and eligible for coverage under the NXP Employee Medical Plan;
- The date of your death (your covered dependents may continue their coverage under COBRA, see page 24); or
- The date the Plan ends or the effective date of an amendment eliminating your coverage.

Basic and Supplemental Life Insurance

In general, your Basic and Supplemental Life Insurance ends when you are no longer an active employee. The following information describes when continuation coverage ends if you are disabled. Refer to the *NXP Benefits: Health, Wellness, Life, Savings and More Summary Plan Description, U.S. Benefits* for more information about when Basic and Supplemental Life Insurance ends.

If you became disabled before age 60, your Basic and Supplemental Life Insurance continuation coverage ends on the earliest of:

- Your age 65;
- The date you are no longer disabled;
- The date your coverage ends under the NXP Disability Income Plan; or
- The date the Plan ends or the effective date of an amendment eliminating your coverage.

If you became disabled at age 60 or older, your Basic and Supplemental Life Insurance continuation coverage ends on the earliest of:

- Five years after the onset of your disability;
- Age 70;
- The date you are no longer disabled;
- The date your coverage ends under the NXP Disability Income Plan; or
- The date the Plan ends or the effective date of an amendment eliminating your coverage.

Dependent Coverage

Your covered dependent will cease to be a participant and his or her coverage under the Plan ends at 11:59 p.m. on the earliest of:

- The last day of the month before the dependent attains age 65 (or on the last day of the previous month if the 65th birthday falls on the first day of the month);
- The last day of the month before the dependent becomes eligible for Medicare;
- The last day of the month in which the dependent enters the military service of any country, except as may be otherwise required by law;
- The last day of the month in which a spouse or domestic partner enters the military service of any country other than the U.S.;
- 90 days after the Plan Administrator requests repayment from a dependent (or any former employee or other covered dependent enrolled in family coverage with the dependent) of amounts that are subject to reimbursement under any welfare plan, overpayments or mistaken payments from any welfare plan, unless the dependent (or former employee or other covered dependent enrolled in family coverage with the dependent) repays the amounts or sets up a payment schedule for repayment that is approved by the Plan Administrator, in its sole discretion;
- The date of the dependent's death;
- The day the Plan terminates or the effective date of an amendment eliminating coverage for the dependent;
- For a retiree's dependent, the date:
  - On which the retiree's coverage ends, other than by reason of death, attainment of age 65 or becoming eligible for Medicare;
  - After the retiree's death, attainment of age 65 or becoming eligible for Medicare, the dependent either becomes covered by another group health plan that does not contain any applicable limitations for pre-existing conditions or ceases to qualify as a dependent; or
  - The last day of the month in which the dependent moves his or her primary residence abroad;
- For a TDP's dependent, the last day of the month:
  - The TDP loses coverage; or
  - In which the dependent moves his or her primary residence abroad; or
- For a former employee's dependent, the:
  - Date the former employee becomes reemployed by the Company if the former employee and the dependents are eligible for coverage under the Medical and/or Dental Plan; or
  - Last day of the month in which the former employee elects to end a dependent's coverage.

For TDPs, unless your spouse's/domestic partner's coverage ends earlier as described above, your spouse's/domestic partner's coverage and/or eligibility under the Post-Employment Medical Plan, Post-Employment Dental Plan and Post-Employment Vision Plan ends on the first of the month in which he or she turns age 65 (or the first of the previous month if the birthday falls on the first of the month). For example, if he/she turns 65 on June 12, his/her Post-Employment Medical Plan, Post-Employment Dental Plan and Post-Employment Vision Plan coverages end on May 31.

For retirees, unless your spouse's/domestic partner's coverage ends earlier as described above, his/her coverage under the Post-Employment Medical, Post-Employment Dental Plan and Post-Employment Vision Plan ends on the first of the month in which he/she turns age 65 (or the first of the previous month if the birthday falls on the first of the month). For example, if he/she turns 65 on June 12, his/her Post-Employment Medical, Post-Employment Dental Plan and Post-Employment Vision Plan coverages end on May 31.

In some cases, dependents may continue coverage under COBRA, see page 37.

> You must notify the NXP Benefits Service Center within 30 days when any of your dependents ceases being an eligible dependent.

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. 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.

> The coverage history notice is not the same as the Medicare Prescription Drug Coverage (Part D) Creditable Coverage notice.

Coverage History Notice for Dependents

One 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 notice is not sent to a dependent who lives with you. If a dependent's last known address is different from yours, a separate 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.

Medical, Dental and Vision COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows your covered dependents to continue medical, dental and vision care coverage under the Post-Employment Health Plan in certain situations when coverage would otherwise end. When your covered dependent loses coverage due to one of these qualifying events, he/she may choose COBRA continuation coverage for up to 36 months:

- You die;
- You divorce or become legally separated, or your domestic partnership ends;
- Your child or the child of your domestic partner no longer meets the Plan's definition of a dependent;
- Your domestic partner no longer meets the Plan's definition of a dependent;
- 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 dependents must be covered by the Plan at the time of the COBRA qualifying event to be eligible for continuation coverage. Your covered spouse/domestic partner may also elect COBRA coverage for a child who becomes an eligible child while COBRA coverage is in effect.

COBRA allows your dependents to continue medical, dental and/or vision care coverage in certain situations when coverage would otherwise end. 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 make a decision 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.

You are responsible for reporting a qualifying event to UnitedHealthcare at 866-747-0048 within 60 days for your dependent to choose continued coverage under COBRA.

Deciding Whether to Continue Coverage

You are responsible for notifying UnitedHealthcare within 30 days after the date your dependent loses coverage under the Post-Employment Health Plan due to a qualifying event. UnitedHealthcare sends you a notice and election form within 14 days of receiving notification of the qualifying event. Your dependents 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. If no election is made, their COBRA option is deemed waived. In this case, your dependent's medical, dental and vision coverage ends on the last day of the month in which the qualifying event occurred.

Each family member losing coverage (qualified beneficiary) has an independent right to elect COBRA continuation coverage. Covered retirees or TDPs may elect COBRA on behalf of their covered spouses/domestic partners, and parents may elect COBRA on behalf of their covered children.

To continue medical, dental and/or vision coverage, your covered dependents must pay the full cost of coverage, plus an additional 2% fee for administrative costs. No benefits are payable under COBRA until the first premium payment is received.

The first payment (due within 45 days of the election) must include your dependents' 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 the monthly contribution within 30 days of the due date, coverage is permanently cancelled as of the last day of the month for which a contribution was paid.

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

When Continuation Coverage Ends

Continuation coverage ends when any of the following events occurs:

- Your covered dependent reaches the end of the applicable maximum COBRA period for coverage;
- A monthly contribution is not paid within 30 days of its due date;
- Upon written request to cancel coverage;
- Your covered dependent becomes entitled to Medicare;
- Your covered dependent becomes covered under another group medical, dental or vision plan that does not contain a pre-existing condition rule;
- NXP ceases to provide any post-employment group health coverage; or
- The date the Plan ends or the effective date of an amendment eliminating this coverage.

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

Moving Your Primary Residence Outside of the United States

If you move your primary residence outside of the U.S., your and your dependents' participation in the Post-Employment Health Plans ends as of the last day of the month during which you move.

Other Continuation Rights

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

Additional Information

Survivor Coverage

When you die, your survivors should call the NXP Benefits Service Center at 888-375-2367 to review their enrollment options.

> The NXP Benefits Service Center is a primary resource for answering your questions on eligibility, coverage and benefits. Call 888-375-2367.

Retirees

If you are either *covered by or eligible for* the Post-Employment Health Plan when you die, your eligible dependents who were either *covered or eligible* for dependent coverage under the Post-Employment Health Plan will remain eligible to enroll, either at your death or in the future, so long as they meet the Plan's eligibility requirements. When they enroll, they must make the required contributions and continue to meet all the other requirements of the Plan.

TDP

If you are a TDP receiving benefits under the NXP Disability Income Plan, but you **are not** covered by the Post-Employment Health Plan at the time of your death, no Post-Employment Health Plan coverage is available to your surviving eligible dependents, even if you were eligible for coverage at the time of your death.

Since survivor benefits are offered to covered dependents of *retirees*, if you are a TDP eligible for *retiree* coverage when you die, your eligible dependents may qualify for survivor benefits as described above.

The Plan and Medicare

Retirees

Before you or your covered family member reach age 65, you should take steps to enroll in Medicare. Aon Retiree Health Exchange coverage requires you to be enrolled for Medicare before you can apply for coverage. To prevent a gap in coverage, contact the Social Security Administration (SSA) at least three months before you turn 65 to start the Medicare enrollment process.

TDPs

NXP TDP coverage ends at age 65. This is when most people in the U.S. begin Medicare coverage. To avoid a gap in your medical coverage, you should begin the Medicare enrollment process at least three months before you turn 65 by contacting the nearest SSA office.

Social Security Request for Employment Information Form

The NXP Benefits Team can assist in completing the verification request from the SSA. Please email the NXP Benefits Team at usbenefits.office@nxp.com to coordinate the completion and signing of the SSA form.

Post-65 Coverage

All company-sponsored post-employment medical, prescription drug, dental and vision coverage ends when you reach age 65 and become Medicare-eligible. To supplement your Original Medicare coverage, NXP offers eligible Post-65 retirees the option to enroll in individual Medicare insurance coverage through the Aon Retiree Health Exchange as outlined below.

Medical and Prescription Drug Coverage

Anyone who uses health care knows that costs keep climbing. At the same time, more choices are becoming available on the open market for individuals to find coverage that suits their needs.

To provide NXP Medicare-eligible retirees and their dependents with coverage options, NXP offers you the opportunity to enroll in individual Medicare insurance coverage through the Aon Retiree Health Exchange. The Aon Retiree Health Exchange is a Medicare coordinator that will work with you to explore your coverage options and prices.

If you were eligible for NXP Post-Employment Medical Plan, you or your dependent are age 65 or older and eligible for Medicare Parts A and/or B, you can enroll in an individual Medicare insurance option through the Aon Retiree Health Exchange.

Original Medicare

There are two parts to Original Medicare benefits:

- Part A benefits are for hospitalization; and
- Part B benefits are for other medical expenses.

The Medicare program has various coverage options:

- Original Medicare (Parts A and B), which is a fee-for service plan offered by the federal government;
- Medicare Supplement (Medigap) policies, which is private insurance that pays in addition to Original Medicare coverage;
- Medicare Advantage plans (Part C), which is private insurance plans that replace Original Medicare coverage; and
- Medicare Prescription Drug plans (Part D), which are private insurance plans offering prescription drug coverage to Medicare beneficiaries.

> You cannot be covered by an individual Medicare insurance option offered through the Aon Retiree Health Exchange and a separate Medicare Supplement, Medicare Advantage or Prescription Drug Plan.

For most retirees, Medicare Parts A and B provide some coverage for hospital and medical costs. However, there is no limit on the amount of money you could have to pay annually out of your own pocket.

Aon Retiree Health Exchange Coverage Options

Through the Aon Retiree Health Exchange, you can find an individual insurance plan that meets the needs of you and your dependents and supplements your Medicare benefits to protect you from unexpected medical costs.

Generally, there are two options:

- Medicare Supplement plans; and
- Medicare Advantage plans.

Some Medicare Advantage plans offer extra coverage, such as dental, vision and/or hearing benefits. Most Medicare Advantage plans include Medicare prescription drug coverage, which means you do not have to purchase separate prescription drug coverage. Your Benefits Advisor will help you decide what type of plan is right for you and your Medicare-eligible dependents.

You have flexibility to choose the coverage that fits the individual needs of you and your dependents. For example, your spouse may need a higher level of benefits or a more robust prescription drug plan than you do (or vice versa). Individual insurance plans give you the option to choose the plan or plans that best meet the unique needs of you and your eligible dependents.

Depending on where you live, you may have several types of plans available to you. Insurers generally cover many more individuals than most group health plans, and that means they can offer more competitive pricing to you.

Individual Medicare insurance options offered through the Aon Retiree Health Exchange are not company-sponsored plans. Therefore, all premiums, benefits, claims and appeals processes and administrative procedures are determined by the insurance company. You must contact your insurer for specific information about your plan.

Monthly Premiums

You are responsible to pay your individual insurance plan premiums directly to your insurance company. By law, individual insurance purchased through the Aon Retiree Health Exchange cannot cost more than if you bought it on your own.

If you move your primary residence outside the U.S., you and your dependents' participation in your individual Medicare insurance option may end; contact your insurer for additional information.

When You Are Medicare-Eligible

When you reach age 65 and become eligible for Medicare, your eligible spouse/domestic partner and eligible dependents under age 65 are not affected and may continue coverage under the Post-Employment Plan's pre-65 medical coverage.

As an eligible retiree, before you become eligible for Medicare, you will receive an education package from the Aon Retiree Health Exchange at your home address. The education package will include:

- Information about making an appointment with a Benefits Advisor and how to prepare for that appointment. You must make an appointment to speak with a personal Benefits Advisor. Your appointment will take one to two hours, depending on whether you and your dependent share the appointment.
  - Before your telephone appointment with an Aon Retiree Health Exchange Benefits Advisor, make sure you are enrolled in both Medicare Parts A and B, and have your Medicare card available for the appointment. The Aon Retiree Health Exchange will need your Medicare Parts A and B eligibility dates, which can be found on your Medicare card.

- If you are not already enrolled in Medicare Part B, contact the Social Security Administration today at **ssa.gov** or by calling 800-772-1213 (TTY use 711 Relay). You must be enrolled in Medicare Part B to enroll in an individual Medicare insurance plan.
- A Medicare Insurance Guide to help you learn more about the basics of Medicare, including the types of insurance plans available to supplement your Medicare benefits.

- The Aon Retiree Health Exchange website address and phone number.
  - Use the Aon Retiree Health Exchange website to set up your account and provide information about your medical needs, preferences (such as if you prefer to pay more for coverage and less when you get care, or vice versa) and the prescription drugs you and your dependents currently take. This information will help your Benefits Advisor determine which plans might be a good match for your preferences and needs.

When Your Eligible Dependent is Medicare-Eligible

When your eligible dependent reaches age 65, he or she may enroll in individual Medicare coverage through the Aon Retiree Health Exchange. Your dependent does not need to select the same coverage option as you.

Remember, coverage is available only for your spouse/domestic partner and dependents who:

- Were eligible for coverage under the NXP Employee Benefits Plan when you retired; and
- Continue to be eligible dependents as outlined in the Eligible Dependents section of this document.

Dual Coverage

The following provisions apply to a former Freescale or NXP employee who married to or in a domestic partnership with another former Freescale or NXP employee when either spouse/domestic partner retires at age 65 or older.

If you or one of your dependents is not Medicare-eligible, the non-Medicare-eligible individual may be covered under an NXP Post-Employment pre-65 medical option until turning age 65 and becoming eligible for Medicare, provided eligibility is not otherwise lost under the Plan.

When the first spouse/domestic partner retires, if he or she chooses not to enroll individual Medicare coverage through the Aon Retiree Health Exchange, he or she may elect, within 30 days of his or her retirement date, to be covered as a dependent under the active spouse's/domestic partner's medical coverage (NXP Employee Medical Plan). The active spouse/domestic partner is allowed to enroll the retiree as a spouse/domestic partner at that time.

When the second spouse/domestic partner retires at age 65 or older, both individuals must enroll in individual Medicare coverage through the Aon Retiree Health Exchange.

For more details on dual coverage and coordination of benefits, see the **Coordination of Benefits** section on page 227.

If you have questions about your eligibility, please call the NXP Benefits Service Center at 888-375-2367.

Personal Benefits Advisor

The Aon Retiree Health Exchange features specially trained and licensed Benefits Advisors who will help you compare, choose and enroll in the health care coverage that meets your needs – at no cost to you.

You will be assigned a Benefits Advisor who will work with you every step of the way to guide you through the Medicare insurance marketplace in your area so you can find the right coverage at the right price.

Your Benefits Advisor provides:

- Knowledgeable guidance and recommendations about local individual insurance options.
- One-on-one assistance to help you enroll in the plan you choose.
- Ongoing support to help you if you move or your health or financial picture changes.

Your Benefits Advisor will ask you questions to get to know you and understand your needs and preferences. He or she will then help you decide what plans meet your needs and budget based on the insurance options available in your area. Once you choose a plan, your Benefits Advisor will work with you to complete your application, either by telephone or online, and to fill out any forms that might be required. Aon Retiree Health Exchange Benefits Advisors receive no special compensation to enroll you in a specific plan, so you can be sure they will help you make an objective choice that's right for you.

When Coverage Begins

If you enroll through the Aon Retiree Health Exchange before age 65, coverage will begin on the first day of the month in which you reach age 65 (or on the first day of the previous month if your birthday falls on the first day of the month).

If you first become eligible for NXP Post-Employment Health Plan coverage after reaching age 65, then you will have the opportunity to enroll in an individual Medicare insurance option through the Aon Retiree Health Exchange as described in your enrollment materials.

> Pre-65 coverage under the Post-Employment Medical, Dental and Vision Plan ends on the first of the month in which you turn age 65 (or the first of the previous month if your birthday falls on the first of the month). For example, if you turn 65 on June 12, your coverages end on May 31. In this example, you do not have Post-Employment Medical, Dental or Vision Plan coverage as of June 1.

NXP Post-Employment Health Plan

NXP offers retirees and TDPs a variety of health benefits under the Post-Employment Health Plan, including the:

- **Post-Employment Medical Plan** (see page 52), which includes behavioral health benefits;
- **Post-Employment Prescription Drug Program** (see page 140);
- **Post-Employment Dental Plan** (see page 161); and
- **Post-Employment Vision Plan** (see page 187).

All of these plans provide coverage for losses from **non-occupational illnesses and/or injuries** (see page 280). In addition, the Post-Employment Medical Plan includes preventive care coverage.

> Refer to the **Participation** section (beginning on page 20) for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

The NXP Post-Employment Health Plan is available to help you and your family once your employment with NXP ends. If you and your eligible dependents are younger than age 65 and meet the eligibility requirements, you have the option of enrolling in the following Post-Employment Health Plans:

- Post-Employment Medical Plan;
- Post-Employment Dental Plan; and/or
- Post-Employment Vision Plan.

Post-Employment Medical Plan

Post-Employment Medical Plan benefits are only available to you and your eligible dependents younger than age 65. Contact the NXP Benefits Service Center for more information at 888-375-2367 or online at **nxp.bswift.com.**

Medical Benefits Summary

	$750 Option		$1,500 Option	
	Deductible In-Network	**Out-of-Network**	**Deductible In-Network**	**Out-of-Network**
Deductible • Individual • Family	$750 $1,500	$2,250 $4,500	$1,500 $3,000	$4,500 $9,000
Coinsurance	80%	60%	70%	50%
Physician • PCP • Specialist	$20 $40	60% 60%	$20 $40	50% 50%
Virtual Care Services	$20	Not available	$20	Not available
Emergency Care • ER Visit	$100 copay before 70%	$100 copay before 70%	$100 copay before 70%	$100 copay before 70%
Out-of-Pocket • Individual • Family	$4,000 $8,000	$12,000 $24,000	$5,000 $10,000	$15,000 $30,000
Prescription				
Retail • Generic • Preferred Brand • Non-Preferred Brand	$5 70% covered with $75 max 50% covered with $100 max		$5 50% covered with $100 max 50% covered with $100 max	
Mail • Generic • Preferred Brand • Non-Preferred Brand	$10 70% covered with $175 max 50% covered with $250 max		$10 50% covered with $250 max 50% covered with $250 max	
Maximum • Annual Maximum Benefit	$6,000		$12,000	

*If you are covered medical options and live in an area where network providers are not available, you are considered "out-of-area" and benefits are paid at the network level. However, the amounts you pay are based on a percentage of the allowed or recognized amount, as applicable, rather than the network fee, plus any amount exceeding the allowed or recognized amount.

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** on page 43.

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** on page 44 for more information). For some out-of-network coverage the Plan pays based on the recognized amount; see the definition of **recognized amount** on page 179.

Prescription Drug Annual Benefit Maximum: The prescription drug annual benefit maximum is the most the Plan will pay for covered prescription drug benefits each year. See the **Prescription Drug Annual Benefit Maximum** section on page 95 for more information.

Medical Plan Features

Contributions

You and NXP share the cost of your medical coverage under the Post-Employment 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 partner:

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

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

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

Cost Sharing

Annual Deductible

The annual deductible is the specific amount of eligible medical expenses you must pay each year before the Plan begins paying benefits for most covered expenses.

The Plan's coverage options include both individual and family annual deductibles:

- **Individual Deductible:** Once you or a covered dependent meet the individual annual deductible, the Plan begins to pay for most covered expenses for you or your covered dependent, as applicable.
- **Family Deductible:** The family deductible is a combined annual amount for all family members. Once two or more covered individuals amounts combined meet the family deductible, the Plan begins to pay for most covered expenses for all covered family members. However, to meet the family deductible, no more than the individual annual deductible amount for any one family member applies. The family deductible does not need to be met before the Plan begins to pay benefits for the individual (you or your covered dependent) that met their individual annual deductible.

> Amounts applied to your annual deductible are calculated based on eligible expenses or, for certain covered health services, the recognized amount, as applicable.

There are separate network (where applicable) and out-of-network deductibles. Network (where applicable) and out-of-network annual deductibles do not cross apply, which means covered expenses applied to the network deductible do not also apply toward meeting the out-of-network deductible, and vice versa.

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 the NXP Employee Medical Plan to this Plan in the year that your employment ends.

Copayments

A copayment is a flat dollar amount you pay for some services. Copayments do not apply toward your annual deductible or annual out-of-pocket maximum.

Under the medical options, you pay a copayment for network provider office visits. Once you pay your copayment, the Plan pays covered expenses, up to the allowed or recognized amount, as applicable; other benefit provisions may apply.

> For out-of-area participants, a single copayment applies to office visits with any provider (primary and specialist).

Separate copayment amounts apply to primary and specialty provider office visits. As stated above, this does not apply to out-of-area participants. 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.

Coinsurance

Once the annual individual and/or family deductible is met (where required), you and the Plan share the cost for most covered expenses; this percentage is known as coinsurance.

> Medical options, there are two coinsurance percentages – one for network charges and one for out-of-network charges.

If you use a network provider, the Plan's benefit is 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.

If you use an out-of-network provider and live in a network location, the Plan's benefit is the out-of-network coinsurance percentage. If you are an out-of-area participant, the Plan has only one coinsurance percentage. The out-of-network 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 are not applied to the out-of-pocket maximum.

Annual 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 you meet the annual out-of-pocket maximum, the Plan pays 100% of the allowed or recognized amount for the remainder of the calendar year.

The Plan's coverage options include both individual and family annual out-of-pocket maximums:

- **Individual Out-of-Pocket Maximum:** Once you or a covered dependent meet the individual annual out-of-pocket maximum, the Plan begins to pay 100%. The individual annual out-of-pocket maximum applies to each covered person.
- **Family Out-of-Pocket Maximum:** The family out-of-pocket annual maximum is combined for all family members covered under the Plan. Once two or more covered individuals amounts combined meet the family out-of-pocket annual

maximum, the Plan begins to pay 100% for all covered family members. To meet the family out-of-pocket maximum, no more than the individual out-of-pocket annual maximum for any one family member applies. The family out-of-pocket maximum does not need to be met before the Plan begins to pay benefits for the individual (you or your covered dependent) that met their individual out-of-pocket annual maximum.

There are separate network and out-of-network out-of-pocket maximums. Network and out-of-network maximums do not cross apply, which means covered expenses applied to the network maximum do not also apply toward meeting the out-of-network maximum, and vice versa.

Covered expenses that apply toward meeting the out-of-pocket annual maximum include amounts you pay toward meeting your deductible and coinsurance amounts during that year.

Not all expenses you pay count toward meeting your out-of-pocket maximum. The following expenses do not apply:

- Copayments and expenses to which the copayment is applied;
- Contributions;
- Expenses that are not paid or prior authorization benefit reductions when prior authorization is not obtained;
- Amounts greater than maximum benefits;
- Amounts you pay for prescription drugs; and
- Any expenses not covered by the Plan.

In addition, if you are covered under the medical plan options, the out-of-network out-of-pocket annual maximum excludes amounts you pay that are over the allowed or recognized amount.

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 NXP Post-Employment Health Plan in the year that your employment ends.

Lifetime Maximum

The Plan has a $5,000,000 per person aggregate lifetime maximum. This maximum includes network and out-of-network benefits you and/or your dependents received under any current or former NXP, Freescale or Motorola medical plan. This does not include amounts you pay, such as your deductible.

Key Terms

Emergency Services: The Plan covers Emergency Room (ER) treatment and stabilization services) for conditions that reasonable 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** on page 43.

Medically Necessary: Medical care determined in the sole and complete discretion of 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

Coverage Options

The Pre-65 Post-Employment Medical Plan provides various coverage options for you to choose, based on your personal circumstances.

If you do not choose a coverage option when you first enroll, you will automatically be enrolled in the $750 Deductible option.

$750 Deductible Option

The $750 Deductible option, also known as the Pre-65 UnitedHealthcare $750 Deductible option, lets you pay lower contributions while still enjoying the security of comprehensive medical coverage.

- **Network:** You pay only a copayment for office visits. For all other covered expenses, you must meet the network deductible before the Plan begins to pay. After you meet the network deductible, you pay 20% coinsurance for most other covered network services. When your 20% share (and your deductible amounts) reaches the out-of-pocket maximum, the Plan pays 100% coinsurance for most covered network expenses for the remainder of the year.
- **Out-of-Network:** You must meet the out-of-network deductible before the Plan begins to pay. After you meet the out-of-network deductible, the Plan pays 60% coinsurance (based on the allowed or recognized amount, as applicable) for most other covered out-of-network services. When your 40% share (and your deductible amounts) reaches the out-of-network out-of-pocket maximum, the Plan pays 100% coinsurance for most out-of-network covered expenses for the remainder of the year.

$1,500 Deductible Option

The $1,500 Deductible option, also known as the Pre-65 UnitedHealthcare $1,500 Deductible option, lets you pay lower contributions while still enjoying the security of comprehensive medical coverage.

- **Network:** You pay only a copayment for office visits. For all other covered expenses, you must meet the network deductible before the Plan begins to pay. After you meet the network deductible, you pay 30% coinsurance for most other covered network services. When your 30% share (and your deductible

amounts) reaches the out-of-pocket maximum, the Plan pays 100% coinsurance for most covered network expenses for the remainder of the year.

- **Out-of-Network:** You must meet the out-of-network deductible before the Plan begins to pay. After you meet the out-of-network deductible, the Plan pays 50% coinsurance (based on the allowed or recognized amount, as applicable) for most other covered out-of-network services. When your 50% share (and your deductible amounts) reaches the out-of-network out-of-pocket maximum, the Plan pays 100% coinsurance for most out-of-network covered expenses for the remainder of the year.

Out-of-Area Coverage

You are considered an out-of-area participant if you do not live in an area where network providers are available. Out-of-area coverage is available under medical options. If you are not sure if you live in a network area, contact the NXP Benefits Service Center.

If you are an out-of-area participant, you and your covered dependents may go to any eligible provider or hospital you want and still be eligible for the higher (network) level of benefits (provided you request prior authorization. See **Prior Authorization**, on page 66 for more information. However, the Post-Employment Health Plan pays its coinsurance based on the allowed or recognized amount, as applicable. If you are able to travel to a network location for care, you may reduce your out-of-pocket costs by using a UnitedHealthcare network provider. You will save money because the provider charges will be based on the allowed or recognized amount. The amounts you pay will be a percentage of the allowed or recognized amount, plus any amount exceeding the allowed or recognized amount.

If you are unsure whether you live in a network area, contact the NXP Benefits Service Center.

If You Transfer from One Coverage Option or Plan to Another

Note: If you transfer mid-year from the NXP Medical Plan for active employees to this Plan, benefit deductibles and maximums start over. This means that when you transfer to the NXP Post-Employment Health Plan, you will be required to meet a 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.

Health Care Networks

Health care networks are an integral part of the Post-Employment Medical Plan. With the medical plan options, you must use providers in the Plan's 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 administrator and agree to charge the allowed amount.

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.

Air 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 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 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.

Additional Information

Get the most value out of your benefits by using UnitedHealthcare's Cost Estimator Tool to help decide whether to get care in-network or out-of-network. UnitedHealthcare's secure member website (**myuhc.com**) may contain additional information that may help you determine the cost of a service or supply.

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 (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.

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 benefit, you must use UnitedHealthcare network providers.

To find a behavioral health network provider:

- Go online to **myuhc.com** (requires registration); or
- Call UnitedHealthcare at 844-210-5428.

Out-of-Network Benefits

If you are covered under the medical plan options and choose to use the services of out-of-network providers, your coverage for these services is generally at the out-of-network level. You are responsible for paying all fees, plus any expenses that exceed the allowed or recognized amount, as applicable.

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 (and stabilization services) received 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 within 48 hours to receive the network benefit level. See **Prior Authorization**, for more information.

When Your Children Are Away at School

If your child attends school (for example, a child away at college) in an area with a NXP Post-Employment Medical Plan Network, then he/she should choose a provider in that network for non-emergency care. Under the medical plan options, 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 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 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 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); 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 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 healthcare provider 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 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;
- Air ambulance services; or
- Emergency ground ambulance transportation.

Virtual Care Services

When you are covered under a UnitedHealthcare medical plan, you have access to virtual care services. Virtual care for covered health services includes 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 through live audio with video 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.

Virtual care services cost significantly less than urgent care and emergency room visits. Plus, you can use virtual care services at your convenience, allowing you to avoid the hassle of sitting in a waiting room. Your cost when you use virtual care services is $20 per visit.

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.

Certain services, such as inpatient stays, certain tests, procedures and outpatient surgery require prior authorization. Prior authorization is a process that helps you and your physician determine whether the services being recommended are covered expenses under the Plan. It also allows the Plan to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

When you use network providers, in most cases, you do not need to prior authorize services provided by the network provider. Network providers are responsible for obtaining necessary prior authorization for you. Since prior authorization is the provider's responsibility, there is no additional out-of-pocket cost to you if a network provider does not prior authorize services.

When you use out-of-network providers, you are responsible for requesting prior authorization when required. If you do not prior authorize when required, your benefits may be reduced, or the Plan may not pay any benefits. To request prior authorization, call UnitedHealthcare at 844-210-5428 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. (Note: If Medicare is your primary coverage, Medicare pays before this Plan and you are not required to get prior authorization before receiving covered services and, therefore, there is no reduction.)

> 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.

Prior Authorization Process

Regardless of the coverage option you have chosen, certain types of care, including behavioral health care, require prior authorization. Before being hospitalized or receiving certain other medical services or supplies there are certain prior authorization procedures that must be followed. You, a member of your family, a

hospital staff member or the attending physician, must request prior authorization before any of the services or supplies that require prior authorization are received.

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 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
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.

UnitedHealthcare will provide a written notification to you and your physician of the prior authorization decision. If your prior authorized expenses are approved, the approval is good for 60 days, provided you remain enrolled in the Plan.

When you have an inpatient facility admission, UnitedHealthcare will notify you, your physician and the facility about your prior authorized length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician or the facility will need to contact UnitedHealthcare as soon as reasonably possible, but no later than the final authorized day. UnitedHealthcare will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If prior authorization determines that the stay or services and supplies are not covered expenses, the notification will explain why and how UnitedHealthcare's decision can be appealed. You or your provider may request a review of the prior authorization decision (see the Claims and Appeals section beginning on page 125 for more information).

When 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 network facilities for non-emergency medical and behavioral health care.

Prior authorization is required for the following inpatient and outpatient medical care:

- Ambulance (non-emergency), including any affiliated non-emergency ground ambulance transport in conjunction with non-emergency air ambulance transport;
- Applied behavioral analysis;
- Clinical trials;
- Congenital heart disease;
- Durable medical equipment (more than $1,000);
- Habilitative services;
- Home health care;
- Intensive outpatient programs for mental disorders and substance use disorders;
- Mental health care and substance-related and addictive disorders services;
- Neuropsychological testing;
- Obesity surgery;
- Outpatient detoxification;
- Outpatient hospice care;
- Partial hospitalization program care for mental disorders and substance use disorder;
- Pregnancy (inpatient stay for the mother and/or the newborn if 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);
- Private duty nursing care;
- Prosthetics (more than $1,000);
- Psychiatric home care services;
- Psychological testing;
- Sleep apnea surgery;
- Sleep studies;
- Stays in a hospital;
- Stays in a residential treatment facility for treatment of mental disorders and substance use disorder;
- Stays in a skilled nursing facility;
- Stays in a rehabilitation facility;

- Stays in a hospice facility;
- Therapeutic treatments (dialysis, intensity modulated radiation therapy and MR-guided
  focused ultrasound);
- Transcranial Magnetic Stimulation (TMS); and
- Transplant (network); 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.

In an Emergency

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

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 UnitedHealthcare's decision.

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

If You Do Not Request Prior Authorization

If you do not obtain prior authorization when required, a prior authorization benefit reduction will be applied to the benefits paid. This means UnitedHealthcare will reduce the amount paid towards your coverage or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary prior authorization before receiving services from an out-of-network provider. Your provider may prior authorize your treatment for you; however, you should verify with UnitedHealthcare before the procedure, that the provider has obtained prior authorization. If your treatment is not prior authorized, the benefit payable may be significantly reduced or your expenses may not be covered.

The following chart illustrates the effect on your benefits if necessary prior authorization is not obtained:

If Prior Authorization Is:	Then Expenses Are:
Requested and approved	Covered
Requested and denied	Not covered (this may be appealed)
Not requested, but would have been covered if requested	Covered after a prior authorization benefit reduction (50%) is applied
Not requested, and would not have been covered if requested	Not covered (this may be appealed)

It is important to remember that any additional out-of-pocket expenses incurred because the prior authorization requirement was not met do not count toward your deductible or out-of-pocket maximum.

Chronic Condition Management Program

If you or a covered family member suffers from a chronic condition, the Post-Employment Medical Plan 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 UnitedHealthcare at 844-210-5428.

Behavioral Health Program

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

Behavioral Health Benefits Summary	
Mental Health Benefit	**Description**
Covered Expenses	Charges made for treatment of mental disorders by behavioral health providers provided in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office. Not all types of services are covered; see the **What's Not Covered** section on page 101.
	Under the Pre-65 Post-Employment Medical Plan section on page 47 for more information.
	The Plan covers behavioral health telemedicine when you get your internet-based consult through an authorized vendor or provider who conducts behavioral health telemedicine consultations. Telemedicine may have different cost sharing. For uncertified treatment, the program's coinsurance is 50% of allowed amount for covered treatment and you pay the remaining charges.
Inpatient Treatment	Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.
Partial Confinement Treatment	Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.
Outpatient Treatment	Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility. Outpatient mental health treatment also includes: • Electro-Convulsive Therapy (ECT); and • Substance use disorder injectables.

Behavioral Health Benefits Summary	
Substance Use Disorder Benefit	**Description**
Covered Expenses	Charges made for treatment of substance use disorders by behavioral health providers. Not all types of services are covered; see the **What's Not Covered** section for more information.
	The Plan covers behavioral health telemedicine when you get your internet-based consult through an authorized vendor or provider who conducts behavioral health telemedicine consultations. Telemedicine may have different cost sharing. For uncertified treatment, the program's coinsurance is 50% of the allowed amount for covered treatment and you pay the remaining charges.
Inpatient Treatment	Covered expenses room and board at the semi-private room rate, and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriate licensed by the state Department of Health, or its equivalent. Covered expenses include treatment in a hospital for medical complications of substance use disorder (medical complications include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis). Treatment in a hospital is covered only when the hospital does not have a separate treatment facility section.
Partial Confinement Treatment	Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of substance use disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.
Outpatient Treatment	Covered expenses include charges for treatment received for substance use disorders while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive alcohol or drug abuse. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

When You Use a Network Provider

If you use a 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. ***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

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, where applicable. You are responsible for all remaining charges, including amounts above the allowed 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 a percentage (depending on your option) of allowed or recognized amount for covered medical services. For office visits, you pay your copayment and the Program pays the rest, up to the allowed or recognized amount for that service. You are responsible for paying any amounts above the allowed or recognized 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 Claims** table beginning on page 202). ***You are responsible for getting prior authorization for out-of-network care when it is required.*** Contact UnitedHealthcare at 844-210-5428 to request prior authorization.

What's Covered

The Post-Employment 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 prior authorization requirements whenever applicable to receive the highest benefit possible.

Failure to follow the guidelines for prior authorization when required reduces your benefit.

Voluntary Health Screenings

Preventive Care

The Post-Employment Medical Plan emphasizes preventive care and encourages you and your covered dependents to take advantage of voluntary screenings. These can be done at your primary providers' office and are covered as an office visit.

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;
- Preventive care and screenings for women, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- 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 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.

Maternity Coverage

NXP offers maternity benefits and the **Maternity Support Program** to all Post-Employment Medical Plan participants. The Maternity Support Program is a confidential, no-cost service provided by UnitedHealthcare. It is part of NXP's commitment to providing the highest quality care to expectant mothers and their babies.

> You should contact UnitedHealthcare at 844-210-5428 to enroll in the Maternity Support Program as soon as the pregnancy is confirmed.

The Plan includes these services as part of its routine maternity coverage:

- Charges made by a freestanding facility licensed in the jurisdiction to provide prenatal care, delivery and immediate postpartum care within 24 hours after the delivery;
- Services and supplies provided for prenatal care, delivery of a child or children, and postpartum care within 24 hours after the delivery;
- Charges by the operating physician for performing the obstetrical procedure, related pre- and post-operative care and administration of an anesthetic;
- Services of any other physician for administration of a general anesthetic, not a local anesthetic; and
- Routine nursery care for a newborn, while the mother is hospitalized for maternity care.

If you are covered under a medical option that covers out-of-network care, any ***out-of-network*** maternity admission requires **prior authorization**. Contact UnitedHealthcare at 844-210-5428 to have your out-of-network admission prior authorized. ***Network providers will handle prior authorization for you***.

While your benefits may be reduced for an uncertified out-of-network admission, the Plan will not:

- Reduce benefits for any maternity hospital stay for a covered mother or newborn child to less than 48 hours for vaginal delivery, or 96 hours for cesarean section;
- Require you to demonstrate that a hospital stay for childbirth is medically necessary; or
- Require an attending provider to complete a certificate of medical necessity to cover any part of a 48-hour (or 96-hour) maternity hospitalization.

The length of stay is decided between the physician and the mother.

Important Note: Contact UnitedHealthcare at 844-210-5428 for detailed information regarding what you should do if your doctor discontinues his/her participation in the provider network during your pregnancy.

Using a Midwife

You may choose to use the services of a midwife, rather than a physician, for your maternity care. The midwife must be a licensed or certified nurse midwife (LNM,

CNM) for you to receive benefits for his or her services. If the midwife is not a licensed or certified nurse midwife, the Plan will pay no benefits for the care, you will be responsible for all charges.

For you to receive the highest level of benefit, you should use a midwife whose charges are billed through a network provider (if you live in a network area).

Transplantation Services

Organ transplants are covered under all options of the Post-Employment Medical Plan.

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 the time 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 care 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.

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

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

See the **Transplants** section on page 76 for more information about what this benefit does not cover.

Additional Post-Employment Medical Plan Covered Expenses

Acupuncture

Acupuncture treatment 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.

Alcohol, Drug Treatment

Treatment of alcoholism or drug addiction is covered as part of behavioral health benefits; see the **Behavioral Health Program** section beginning on page 71 for details.

Allergy Treatment

Physician-prescribed testing, treatment and injections for allergies.

Ambulance Services

Covered expenses include charges made by a professional ambulance for ground or Air Ambulance transportation:

- To the first hospital where treatment is given in a medical emergency;
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition;
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition (transport is limited to 100 miles); and
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to transport you safely and adequately to or from inpatient or outpatient medically necessary treatment.

For out-of-network services, you must obtain prior authorization as soon as possible before any out-of-network non-emergency air ambulance services. See **Prior Authorization** on page 66 for more information. (**Note:** If Medicare is your primary coverage, Medicare pays before this Plan and you are not required to get prior authorization.)

Ambulatory Surgery (Outpatient)

Professional services and facility fees for outpatient surgery. Prior authorization is required. See **Prior Authorization**, on page 66 for more information.

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 or recognized 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. 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 (coverage for network only).

> 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** on page 66 for more information.

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**, on page 66 for 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 **Centers for Medicare and Medicaid Services (CMS)** (see page 227);
  - 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 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)** (see page 162);
  - A cooperative group or center of any of the entities described above or 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 care service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries that are ordered by a physician 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. 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**, on page 66 for more information.

You can call UnitedHealthcare at 844-210-5428 for more 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 the **What's Covered** section on page 73 in the **Post-Employment Prescription Drug Program** section, starting on page 47.

Convalescent Home, Skilled Nursing Home, Inpatient Rehabilitation

Medically necessary care in a convalescent home or skilled nursing home, including:

- Room and board (up to the semi-private room rate or up to private room rate if it is needed due to an infectious illness or a weak or compromised immune system);
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a skilled nursing facility (not including charges made for private or special nursing or physician's services); and
- Medical supplies.

Confinement must be in lieu of a hospital stay, and you or your covered dependent must be under the regular care of a physician. Limited to 120 days per calendar year.

Dental Implants

Coverage only when medically necessary to correct an injury to sound natural teeth. Most dental implant requests do not meet the criteria for medical necessity under the Post-Employment Medical Plan. Implants are medically necessary only in cases of major trauma, gross deformity resulting in debilitating impairment related to food ingestion, with the potential for malnutrition and other life-threatening medical circumstances.

No coverage for any related post-operative dental services such as crowns, dentures, abutments, connector bars, precision attachments or dental prostheses. Prior authorization is required. See **Prior Authorization**, on page 66 for more information.

Dental Services (Accidental Only)

Benefits for treatment of accidental injury are limited to the following:

- 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

Diabetes self-management and training/diabetic eye exams/foot care includes 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.

Diabetic self-management items include supplies for the management and treatment of diabetes, based upon your medical needs. Items include:

- Insulin pumps (subject to all the conditions of coverage stated in the **Durable Medical Equipment (DME), Orthotics and Supplies** section on page 82;
- 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 the **Diabetes Services** section on page 63;
- 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 devices and tracheo-esophageal 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 the **What's Not Covered Under the Pre-65 Post-Employment Medical Plan** section on page 74.

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 care service for which benefits are available under the applicable medical/surgical covered health care service categories of this Plan)*;*
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a covered health care 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 the **What's Not Covered Under the Pre-65 Post-Employment Medical Plan** section on page 74.

Prior authorization is required for rental or purchase of $1,000 or more, see **Prior Authorization**, for more information.

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.

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. See the **Vision Benefits** section beginning on page 118 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, described on page 122, the Post-Employment Medical Plan benefit is secondary.

Gastric Bypass

If medically necessary, gastroplasty, lap banding, and bypass that is approved pursuant to procedures maintained by UnitedHealthcare. Prior authorization is required, see **Prior Authorization**, for more information.

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 well-being 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 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 that 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 that is capable of being demonstrated, UnitedHealthcare may request a treatment plan that includes:

- Diagnosis;
- Proposed treatment by type, frequency, and expected duration of treatment;
- Expected treatment goals; and
- Frequency of treatment plan updates.

Habilitative services provided in your home by a home health agency are provided as described in the **Home Health Care** section on page 67. Habilitative services provided in your home other than by a **Home Health Agency** (see page 171) are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described in the **Durable Medical Equipment (DME), Orthotics and Supplies** section on page 63.

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 aid 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

Covered expenses include charges made by a home health care agency for home health care when the care is given under a home health care plan or to you in your home while you are homebound. Home health care expenses include charges for:

- Part-time or intermittent care by an R.N. or an L.P.N. if an R.N. is not available;
- Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an R.N. or L.P.N.;
- Physical, occupational and speech therapy;
- Part-time or intermittent medical social services by a social worker when provided in conjunction with and in direct support of care by an R.N. or L.P.N.;
- Medical supplies, prescription drugs and lab services by or for a home health care agency to the extent they would have been covered under the Plan if you had a hospital stay;
- Skilled behavioral health care services provided in the home by a behavioral health provider when ordered by a physician and directly related to an active treatment plan of care established by the physician, provided:
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications;
  - The services are in lieu of a continued confinement in a hospital or residential treatment facility or receiving outpatient services outside of the home;
  - You are homebound because of illness or injury;
  - The services provided are not primarily for comfort or convenience or custodial in nature;
  - The services are intermittent or hourly in nature; and
  - The services are not for applied behavior analysis;
- Benefits for home health care visits are payable up to any home health care maximum. Each visit by a nurse, behavioral health provider or therapist is one visit. In figuring any visit maximums, each visit from a:
  - Nurse or therapist of up to 4 hours is one visit; and
  - Behavioral health provider of up to one hour is one visit;
    - This maximum does not apply to care given by an R.N. or L.P.N. when care is:
  - Provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
  - Needed to transition from the hospital or skilled nursing facility to home care.
    - When the above criteria are met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs. The Plan does not cover custodial care, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Hospice Benefits

Covered expenses include charges made by the following provided to you for hospice care when given as part of a hospice care program:

- ***Facility Expenses:*** The charges made by a hospital, hospice or skilled nursing facility for:
  - Room and board and other services and supplies provided during a stay for pain control and other acute and chronic symptom management; and
  - Services and supplies provided to you on an outpatient basis;
- **Outpatient Hospice Expenses:** Covered expenses include charges made on an outpatient basis by a hospice care agency for:
  - Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
  - Part-time or intermittent home health aide services to care for you up to eight hours a day; and
  - Medical social services under the direction of a physician, including, but not limited to:
    - Assessment of your social, emotional and medical needs and your home and family situation;
    - Identification of available community resources; and
    - Assistance provided to you to obtain resources to meet your assessed needs;
  - Physical and occupational therapy;
  - Consultation or case management services by a physician;
  - Medical supplies;
  - Prescription drugs;
  - Dietary counseling; and
  - Psychological counseling.
- Charges made by the providers below if they are not an employee of a hospice care agency and the agency retains responsibility for your care:
  - A physician for a consultation or case management;
  - A physical or occupational therapist;
  - A home health care agency for:
    - Physical and occupational therapy;
    - Part time or intermittent home health aide services for your care up to eight hours a day;

- Medical supplies;
- Prescription drugs;
- Psychological counseling; and
- Dietary counseling.

Hospital – Inpatient

Only semiprivate hospital room and board are covered, as well as other inpatient services for medical care and treatment. Must be medically necessary based on diagnosis. (If you have a private room, you pay the difference unless medically necessary due to a contagious illness or immune system problem, or if it is the only room available.) Prior authorization is required, see **Prior Authorization**, for more information.

Hospital – Outpatient

Charges made by a hospital for outpatient treatment, such as outpatient surgery. Prior authorization is required in some cases, see **Prior Authorization**, for more information.

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 allowed or 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

Coverage includes limited infertility benefits for you and/or a covered spouse/domestic partner, but not a dependent child. Coverage includes the diagnosis and treatment of the underlying medical condition relating to infertility.

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.
- Prior authorization is required, see **Prior Authorization**, for more information.

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 Treatment

Non-surgical treatment of obesity by a physician, licensed or certified dietician, nutritionist or hospital for outpatient weight management services, including an initial medical history and physical exam, diagnostic tests given or ordered during the first exam and prescription medications.

Network provider hospital and physician charges for surgical treatment of morbid obesity are also covered; out-of-network provider surgical benefits are not covered. Morbidly obese means having a Body Mass Index that is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes. Coverage includes expenses incurred within a two-year period (beginning with the date of the first morbid obesity surgical procedure) for:

- One morbid obesity surgical procedure including complications directly related to the surgery;
- Pre-surgical visits;
- Related outpatient services; and
- One follow-up visit.

This benefit does not include coverage for:

- Surgical benefits provided by out-of-network providers;
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Exercise programs, exercise or other equipment; and
- Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity or for weight reduction, regardless of the existence of comorbid conditions (except as specifically listed as covered).

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 and speech therapy are limited to $3,500 per calendar year.

Oral Surgery

Surgery for the treatment of fractures or dislocations of the jaw or the cutting procedures of the mouth, excluding procedures for the teeth or gums.

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. Prior authorization is required, see **Prior Authorization**, for more information.

Note: Orthodontic treatment and crowns associated with TMJ treatment are not covered under this benefit.

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.

Physician's Fees

Charges for visits for the treatment of an accident, illness, specialist consultation or covered preventive services.

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 $3,500 per calendar year.

Prescription Medicine

Charges for drugs prescribed by a physician and dispensed in an inpatient setting, outpatient hospital or surgical center. If the network or out-of-network 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 (see page 97 for details).

Private Duty Nursing (Skilled Nursing Care)

Outpatient nursing care when the attending physician states in writing that the nursing care is necessary; covered up to a maximum of 120 eight-hour shifts 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.

Radiation Therapy and Chemotherapy

Coverage for radiation therapy (X-ray, radium and radioactive isotope treatment) and chemotherapy. If the network or out-of-network 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 (see page 97 for details).

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition;
- Improvement or restoration of physiologic function; and
- 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** (see page 164) 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 care service. Contact UnitedHealthcare at 844-210-5428 for more information about benefits for mastectomy-related services.

Respiratory Therapy

Respiratory therapy prescribed by a physician.

Routine Physical Exams

Coverage for exams beyond required or voluntary screenings or diagnostic lab services and X-rays. Includes adult and pediatric physical exams. Exams by a school physician or school nurse are not covered.

Sleep Studies

Diagnostic testing for the determination of sleep disorders. Prior authorization is required, see **Prior Authorization**, for more information.

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 $3,500 per calendar year.

Sterilization

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

Surgeon's Fees (Physician Services)

Charges by the operating surgeon for an operation in or out of the hospital, in a physician's office, or in an outpatient treatment facility (such as a surgicenter), including performing the surgical procedure, pre-operative and post-operative visits and consultations with another physician to obtain a second opinion before surgery. **Note:** Special payment rules apply to secondary, ancillary and bilateral surgical procedures.

Surgical Assistant

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

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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. The lifetime maximum is two 12-week cycles of treatment per person.

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.

Urinary Catheters

External, 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.

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 and Hairpieces

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. Excludes physiologic changes as a part of the aging process or hereditary factors. If medical criteria are met, maximum benefit of $500, limited to one wig.

What's Not Covered Under the Pre-65 Post-Employment Medical Plan

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 Post-Employment 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 NIH.

NXP Post-Employment Health Plan

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 the **Dental Services (Accidental Only)** section on page 62; 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 the **Dental Services (Accidental Only)** section on page 62;
- 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 the **Dental Services (Accidental Only)** section on page 62;
- Dental braces (orthodontics); and
- Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a **congenital anomaly** (see page 164).

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 are covered DME as described in the **Durable Medical Equipment (DME), Orthotics and Supplies** section on page 63;

- 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 tracheo-esophageal voice devices for which benefits are provided as described in the **Durable Medical Equipment (DME), Orthotics and Supplies** section on page 63;
- 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 the **Clinical Trials** section on page 59.

Foot Care

- Routine foot care. Examples include:
- The cutting or removal of corns and calluses.
- Nail trimming, nail cutting or nail debridement;
- Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic or peripheral vascular disease
- Treatment of flat feet;
- Treatment of subluxation of the foot;
- Shoes;
- Shoe orthotics;
- Shoe inserts; and
- Arch supports.

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 the **Durable Medical Equipment (DME), Orthotics and Supplies** section on page 63 (this does not apply to supplies for the administration of medical food products); and
      - Diabetic supplies for which benefits are provided as described in the **Diabetes Services** section on page 63; and
      - Urinary catheters and related urologic supplies for which benefits are provided as described in **Urinary Catheters** on page 74;
- Tubings and masks except when used with DME as described in the **Durable Medical Equipment (DME), Orthotics and Supplies** section on page 63;

- 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

These exclusions apply to services described in the **Behavioral Health Program** section on page 52.

- Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases (ICD)*, Mental and Behavioral Disorders Section or the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of 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 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 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;
  - 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** on page 64); 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 and 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** (see page 164), 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 the **Reconstructive Procedures** section on page 71;
- 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 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** (see page 164) or autism spectrum disorder;
- Habilitative services for maintenance/preventive treatment;
- Outpatient cognitive rehabilitation therapy except as medically necessary following a post-traumatic brain injury or cerebral vascular accident or stroke;
- 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;
- Manipulative treatment (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);

- 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** (see page 164), 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 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 in the **Reconstructive Procedures** section on page 71;
- Helicobacter pylori (H. pylori) serologic testing; and
- Sex transformation operations and related services.

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** (see page 170) 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

- Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment;
- The following services related to a **gestational carrier** (see page 170) or **surrogate** (see page 183):
  - Fees for the use of a gestational carrier or surrogate;
  - Insemination or invitro fertilization procedures for surrogate or transfer of an embryo to gestational carrier; and
  - Pregnancy services for a gestational carrier or surrogate who is not covered under the Plan;
- Donor, gestational carrier or surrogate administration, agency fees or compensation;
- The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs) or embryos (fertilized eggs):
  - ***Known Egg Donor (altruistic donation; i.e., friend, relative or acquaintance):*** The cost of donor eggs, including 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):*** The cost of donor eggs, including 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):*** The cost of sperm collection, cryopreservation and storage (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):*** The cost of procurement and storage of donor sperm (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 all reproductive materials; examples include eggs, sperm, testicular tissue and ovarian tissue;
- The reversal of voluntary sterilization;
- Health care services and related expenses for surgical, non-surgical or drug-induced pregnancy termination; this exclusion does not apply to treatment of a molar pregnancy, ectopic pregnancy or missed abortion (commonly known as a miscarriage);
- In vitro fertilization regardless of the reason for treatment;
- Assisted Reproductive Technology (ART) procedures done for non-genetic disorder sex selection or eugenic (selective breeding purposes); and
- Pre-Implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer to increase the chance for conception.

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;
- If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected;
- 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 in the **Transplantation Services** section on page 57;
- Health care services connected with the removal of an organ or tissue from you for a 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 in order 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 care 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 UnitedHealthcare's discretion. This exclusion does not apply to ambulance transportation for which benefits are provided as described in the **Ambulance** section on page 58.

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 Benefits** section on page 68;
- 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; or
  - 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 care 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 care service of this Plan as described in the **What's Covered** section on page 54;
  - Not otherwise excluded by the Plan, as described in the **What's Not Covered Under the Pre-65 Post-Employment Medical Plan** section on page 74;
- 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 the **Clinical Trials** section on page 59;
- 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 or recognized 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 care service: When a service is not a covered health care service, all services related to that non-covered health care 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 care service; and
- For this exclusion, a complication is an unexpected or unanticipated condition that 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 requires hospitalization.

NXP Post-Employment Health Plan

Medical Program Compliance

Maternity or Newborn Infant Coverage

Per the Newborns' and Mothers' Health Protection Act of 1996, the Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the 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, your provider is not required to get authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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)

The ACA imposes various mandates and restrictions related to providing group health benefits to employees. However, many of these mandates, such as a restriction on lifetime and annual dollar limits, do not apply to plans that cover fewer than two participants who are current employees, such as a stand-alone retiree medical plan. The Plan is structured as a stand-alone retiree medical plan and is not subject to many of the ACA mandates and restrictions. If you have any questions about how the ACA applies to this Plan, contact the Plan Administrator.

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 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 begins on page 145.

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

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.

NXP Post-Employment Health Plan

Post-Employment Prescription Drug Program

As part of the Post-Employment Medical Plan, available to you and your eligible dependents younger than age 65, you and your covered dependents fill your covered prescriptions through the Post-Employment 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 pre-65 Post-Employment Medical Plan participants are eligible to use the Post-Employment Prescription Drug Program. There is no need to enroll for these benefits.

Prescription Drug Benefits Summary

All prescriptions must be filled at a network pharmacy and all benefits are based on negotiated fees. All maintenance prescriptions taken in 90-day supplies must be filled at a CVS retail pharmacy or through the home delivery service.

$750 Deductible Option		$1,500 Deductible
Retail Pharmacy (up to a 30-day supply)		
Generic drugs	You pay $5 copayment	You pay $5 copayment
Preferred drugs	You pay 20% up to $75	You pay 30% up to $100
Non-preferred drugs	You pay 50% up to $100	You pay50% up to $100
Home Delivery Service or Pick Up at CVS Retail Pharmacy* (90-day supply)		
Generic drugs	You pay $10 copayment	You pay $10 copayment
Preferred drugs	You pay 30% up to $175	You pay 50% up to $250
Non-preferred drugs	You pay 50% up to $250	You pay 50% up to $250
Maximums		
Annual Benefit Maximum**	$6,000	$50,000

* All maintenance prescriptions taken in 90-day supplies must be filled at a CVS retail pharmacy or through the home delivery service.

** Once the prescription drug annual benefit maximum has been met, you are responsible for 100% of prescription costs for the remainder of the year.

NXP Post-Employment Health Plan

Prescription Drug Plan Features

Here is how the Program works:

- **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.

Prescription Drug Annual Benefit Maximum

The Plan includes a limit on the amount of prescription drug expenses that will be covered by the Plan each year; this is known as the annual benefit maximum. A prescription drug annual benefit maximum applies to all options. Once the Plan pays prescription drug benefits equal to the prescription drug annual benefit maximum applicable to your coverage option, you are responsible for 100% of prescription costs for the remainder of the year.

If you have medical coverage under the $750 Deductible option, the prescription drug annual benefit maximum paid by NXP for each covered individual each calendar year (combined NXP cost of retail and home delivery prescriptions) is $6,000.

If you have medical coverage under the $1,500 Deductible Option, the prescription drug annual benefit maximum paid by NXP for each covered individual each calendar year (combined NXP cost of retail and home delivery prescriptions) is $32,000.

The prescription drug annual benefit maximum calculation begins when you are first covered by the Post-Employment Health Plan. For example, if you terminate employment in August and are first covered under the Post-Employment Health Plan in September, your annual benefit maximum begins on September 1 and is applicable through December 31 of the year you terminate employment.

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:

- Aspirin products for males age 45-79 and females age 55-79 to prevent cardiovascular disease;
- Contraception (hormonal, emergency and barrier products) for females; and
- Folic acid supplements for females who may become pregnant.

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. 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 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.

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 fee 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.

Mail order 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.

For questions about home delivery benefits, contact CVS Caremark at 877-

505-8360. ***Steps to Follow***

Your physician may contact CVS Caremark by either telephone or fax to submit your home delivery prescription.

Physician Orders by Telephone

Ask your doctor to call CVS Caremark Home Delivery 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

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 from your provider 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
- 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 home delivery, 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, but 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. The price difference you pay does not apply to any limit on your share of covered expenses.

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;
- 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 CVS Caremark at 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 home delivery (available through retail only);
- Anorexiants;
- Anti-wrinkle agents (e.g., Renova);
- Any retail cost of drugs above the negotiated network charge;
- 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 6;
- Hair growth stimulants or other medicines for treatment of hair loss;
- Medical devices;
- Mifeprex;
- Norplant;
- Nutritional supplements;
- Over-the-counter (OTC) medications that can be purchased without a prescription, except preventive health services medications, such as aspirin, folic acid, iron and Vitamin D;
- 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**.

Wellness Programs/Activity Center

NXP provides eligible retirees and TDPs with the opportunity to use special health programs.

Work Site Wellness Programs

Watch for information at the nearest NXP location about on-site wellness programs that may be available to you. All eligible NXP, former Freescale retirees and TDPs are encouraged to take advantage of work site wellness programs when they are available to them.

- **Educational Classes:** Information includes healthy eating, physical activity, resilience and a variety of other topics throughout the year through the NXP Activity Centers.

Enrollment in an NXP Activity Center

If you terminate employment and meet the eligibility requirements for retiree health care benefits, you will be eligible to join the Activity Center as a retiree and pay the applicable membership rate.

> **If You Are a TDP**
>
> Activity Centers are not available to TDPs or their dependents. If you are a member of an NXP Activity Center when your employment terminates, your membership ends on the date of your termination. If your spouse/domestic partner has a paid membership in an Activity Center, his or her membership also ends on the date of your termination. NXP will refund the unused membership for your spouse/domestic partner. If you have any questions, contact your nearest NXP Activity Center.

If you are not a member of an NXP Activity Center as an NXP or former Freescale employee, you may enroll at any time after your retirement, if you meet the eligibility requirements for retiree health care benefits; payment is due immediately upon enrollment. Contact the nearest Activity Center for the current monthly rate. You may pay by cash, check or credit card to the Activity Center where you originate your membership.

You are responsible for paying any additional expenses such as locker rental, individual or group classes or personal training.

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 nearest NXP Activity Center.

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 areas where one is located.

You and/or your spouse/domestic partner may enroll and pay the applicable membership rate at selected locations if you:

- Are eligible for retiree health care benefits upon retirement; and
- Are a spouse/domestic partner of another NXP or former Freescale employee who remains an NXP Activity Center member.

Your membership ends on your last day of employment if you:

- Were a member of an Activity Center as an NXP or former Freescale employee; and
- Are not eligible for retiree health care benefits when you retire.

If your spouse/domestic partner is also a member at the Activity Center, NXP will refund any paid months beyond the month of termination, but not for any remaining days in the month of termination.

NXP Post-Employment Health Plan

Dental Benefits

Regular dental care is important to maintaining good health. Regardless of your medical choice, you can choose cost-effective dental coverage through the Dental Plan. The Plan is offered to all eligible retirees and their eligible dependents under age 65.

Dental Benefits Summary

Dental Carrier	Delta Dental
Annual Deductible	**Individual:** $200 **Family:** $600
Annual Maximum Benefit	$2,000 per person in combined diagnostic and preventive, basic and
Diagnostic and Preventive Services	Plan pays 100% of contracted fees (PPO and Premier providers) or program allowance (non-Delta providers), no
Basic Services	Plan pays 80% of contracted fees (PPO and Premier providers) or program allowance (non-Delta providers), after
Major Services	Plan pays 50% of contracted fees (PPO and Premier providers) or program allowance (non-Delta providers), after
Orthodontic Services	Plan pays 50% of contracted fees (PPO and Premier providers) or program allowance (non-Delta providers), no deductible, 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 program allowance, as defined on page 179.

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 800-471-0236.

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 services and orthodontic services before the Dental Plan begins paying benefits.

A separate $200 deductible applies to each covered person in your family. The $600 family deductible is a combined amount for all family members. However, to meet the family deductible, no more than $200 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 the NXP Employee Dental Plan to this 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
- 50% for orthodontic services, no deductible.

You pay the remaining amount, including amounts above the program allowance, when you use a non-Delta Dental provider.

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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 does not include benefits you received in the year you left NXP under the NXP Employee Dental Plan. Your annual maximum benefit starts over when you enroll in this Plan.

Orthodontic Services

You do not need to satisfy the Dental Plan deductible before you receive benefits for orthodontic services. The Plan pays a percentage of covered expenses, up to the annual maximum and orthodontic lifetime maximum. 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, Freescale or Motorola 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; 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.

NXP Post-Employment Health Plan

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 the **What's Not Covered** section beginning on page 115), you are responsible for paying 100% of that expense.
>
> Contact the Delta Dental Customer Service Center at 800-471-0236 for detailed information about covered dental services.

Following are some examples of covered services. If you have any questions about what expenses are covered, call the Delta Dental Customer Service Center at 800-471-0236.

Diagnostic and Preventive Services

You are encouraged to see your dentist for diagnostic and preventive dental 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 provider) for diagnostic and preventive services. These benefits are not subject to the Dental Plan's deductible.

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.
Cleanings (routine prophylaxis)	• Routine cleanings, including scaling in the presence of generalized moderate or severe gingival full-mouth inflammation; limited to

X-Rays	• Bitewing X-rays:
	  ◦ Limited to two sets 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

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
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

Diagnostic and Preventive Services	What's Covered/Limits
Space Maintainers	· For fixed or removable appliances to maintain a space created by the premature loss of a primary ● Limited to dependent children through age 13 ● Space maintainers are limited to the initial appliance and are a benefit for an enrollee to age 14; however, an exception is made if the removal ● A distal shoe space maintainer-fixed-unilateral is limited to children 8 and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral ● Recementation of space maintainer is limited to once per lifetime; and ● 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 following chart for examples of covered basic services.

Basic Services	What's Covered/Limits
Endodontics	● Endodontics is the treatment of diseases and injuries 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
Fillings	● Amalgam and resin-based composite restorations (fillings). 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

Basic Services	What's Covered/Limits
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
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

NXP Post-Employment Health Plan

Basic Services	What's Covered/Limits
Periodontics	· Periodontics is the treatment of gums and bones supporting teeth. · Full-mouth, periodontal maintenance in the presence of inflamed gums. · 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 24-month period; ● No more than two quadrants of scaling and root planing will be covered on the same date ● 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 ● 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, periradicular surgery, ridge ● 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 ● Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area; ● Periodontal surgery is subject to a 30 day wait following 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;
- 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; and
    - 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; and
- Denture repairs to partial or complete dentures, including rebase procedures and relining:
    - Denture repairs are not covered not more than once in any six-month period, except for fixed denture repairs, which are not covered more than twice in any 60-month period;
    - When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be covered;
    - The Dental Plan limits payment for dentures to a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six months after placement;

- 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 covered separately when performed on the same day as a denture, reline or rebase service; and
- Recementation of fixed partial dentures is limited to once in

a lifetime.

Orthodontic Services

The Dental Plan pays 50% 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, Freescale or Motorola 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 are provided in periodic payments and will continue as long as you are eligible.

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 stayplate.

Coverage does not include damage to the teeth that is 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, see limitations as age limits may apply; however, 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.

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 the Delta Dental Customer Service Center at 800-471-0236.

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.

You must cooperate with Delta Dental to protect the Dental Plan's recovery rights.

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 Post-Employment Health Plan

Vision Benefits

Routine eye care services are included in the Post-Employment Vision Plan for you and your covered dependents under age 65. Regardless of your medical plan choice, you can choose vision coverage. This Plan is offered to all eligible retirees and their eligible dependents under age 65.

Services include comprehensive eye examinations and prescription eyeglasses (lenses and frame) or contact lenses. To take advantage of the Vision Plan, you simply enroll yourself or yourself 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.

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 $10 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 $20 copayment for the Exam, Eyeglass Lenses, and Prescription Glasses are applied once per year	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
Eyeglass Frames	Once every calendar year	• Your $20 copayment for the Exam, Eyeglass Lenses, and Prescription Glasses are applied once per year • Plan pays up to $250 allowance ($270 retail 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	Plan reimburses up to $70 after your copayment

Service	Frequency	VSP Network Doctor or Retail Chain*	Out-of-Network
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
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 Retirees 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

NXP Post-Employment Health Plan

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
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
Glasses and Sunglasses	Not applicable	• Extra $20 to spend on featured frame brands (go to **www.vsp.com/offer** for details) • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP providers within 12 months of a Well	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.

NXP Post-Employment Health Plan

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 Pre-65 Post-Employment 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/potical-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 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 retiree's/TDP'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 beginning on page 118 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** chart on page 118).

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
P.O. Box 385018
Birmingham, AL 35238-0518

Be sure to write the retiree's/TDP's name and birth date, the 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 the **Vision Benefits Summary** chart on page 118 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.

NXP Post-Employment Health Plan

Claims and Appeals

This section provides information on:

- *How to file claims (beginning on page 126);*
- *The **appeals** process* (beginning on page 132)*;*
- *How your benefits are **coordinated** with other plans (beginning on page* 139)*; and*
- *Your **privacy** rights* (beginning on page 145)*.*

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.

If you are age 65 or older and covered under an individual Medicare plan through the Aon Retiree Health Exchange, claims and appeals procedures are not described in this document. Contact your carrier for information specific to your plan.

Plan/Program	Information Needed and Deadline	Claims Administrator	Initial Decision
Post-Employment (including Behavioral Program)	**Network Care:** You are not required to file a claim using a network provider **Out-of-Network Care*:** If your provider does not the claim for you, you must submit an itemized bill that includes: • Date of service • Description of service, with CPT code if • 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	**NXP Post-Employment 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
Post-Prescription Drug Program	If your provider does not submit the claim for 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 TDP/retiree's identification number on the statement **Deadline**: One year from date service is	**NXP Post-Employment Medical Plan CVS Caremark** P.O. Box 52116 Phoenix, AZ 85072-2116	Within 30 days** claim is received

Plan/Program	Information Needed and Deadline	Claims Administrator	Initial Decision
Post-Dental Plan	Claims for benefits must submitted on a standard Delta Dental claim form. If your provider does not submit a claim for you, you can request a claim form Delta Dental. The form must be completed and signed by the provider and patient (or the parent or guardian if the **Deadline**: One year from date service is	**NXP Post-Employment Dental Plan Delta Dental Insurance Company** P.O. Box Alpharetta, GA 30023-1809	Within 30 days after claim is received
Post-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 TDP/retiree's name and either birth date or the last four digits of Security number **Deadline**: One year from date service is	**VSP** 3333 Quality Drive, Rancho Cordova, CA 95670-7985	Within 30 days** claim is received

Group Health Plans

As identified in the preceding charts, the following special rules apply to expedite claims under the NXP Post-Employment Health Plans (the Post-Employment Medical Plan, Post-Employment Dental Plan and Post-Employment Vision Plan), depending on the type of claim involved. Any reference in this section to "you" includes your authorized representative (see page 161). The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

Complaints

If you are dissatisfied with service you receive from the Plan or want to complain about a
provider, contact UnitedHealthcare within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. UnitedHealthcare will review the information and provide you with a written response within 30 calendar days of receipt of the complaint unless additional information is needed and it cannot be obtained

Urgent Care Claim

An urgent care claim is any claim for medical care or treatment in which a delay in treatment could:

- Jeopardize your life;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

The Claims Administrator will notify you of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, the Claims Administrator will notify you within 24 hours of receipt of the claim. You have 48 hours after receiving the notice to provide the Claims Administrator with the additional information. The Claims Administrator will notify you within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the physician to provide the Claims Administrator with the information.

If you do not follow Plan procedures for filing a claim, the Claims Administrator will notify you within 24 hours following your failure to comply.

Pre-Service Claim

A pre-service claim is any claim for care or treatment that requires approval before the care or treatment is received.

The Claims Administrator will notify you of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. The Claims Administrator may determine that due to matters beyond its control an extension of this 15 calendar day claim determination period is required. An extension of no longer than 15 additional calendar days, will be allowed if the Claims Administrator notifies you within the first 15 calendar day period. If this extension is needed because the Claims Administrator needs additional information to make a claim determination, the notice of the extension will specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide the Claims Administrator with the required information.

Post-Service Claim

A post-service claim is any claim that is not a pre-service claim.

The Claims Administrator will notify you of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. The Claims Administrator may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. An extension, of no longer than 15 additional calendar days, will be allowed if the Claims Administrator notifies you within the first 30 calendar day period. If this extension is needed because the Claims Administrator needs additional information to make a claim determination, the notice of the extension will specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide the Claims Administrator with the required information.

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.

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.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

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 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 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.

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 be 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.

Claims and Appeals 131

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, 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.

For non-medical 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).

You will receive a decision on appeal in writing as detailed in the **Claim Decision** section beginning on page 130.

If you are age 65 or older and covered under an individual Medicare plan through the Aon Retiree Health Exchange, claims and appeals procedures are not described in this document. Contact your carrier for information specific to your plan.

Where and When to Submit Your Appeal

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 Austin, TX 78735	180 days from notification of denial
Post-Employment 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
Post-Employment 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
Post-Employment Dental Plan	**Delta Dental Insurance Company** P.O. Box 1809	180 days from notification of denial
Post-Employment Vision Plan	**VSP** 3333 Quality Drive, Rancho Cordova, CA 95670-7985	180 days from notification of denial

Post-Employment Medical Plan Appeals

You may submit an appeal if the Claims Administrator gives notice of an adverse benefit determination. This Plan provides for two levels of appeal. It will also provide an option to request an external review of the adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your level one appeal. Your appeal may be submitted verbally or in writing and should include:

- The patient's name and the identification number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

The notice of an adverse benefit determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call your Claims Administrator.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing verbal or written consent to the Claims Administrator.

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for benefits. If any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Level One Appeal

A level one appeal of an adverse benefit determination is provided by Claims Administrator personnel not involved in making the adverse benefit determination.

- **Urgent Care Claims (may Include concurrent care claim reduction or termination):** The Claims Administrator will make a determination within 36 hours of receipt of the request for an appeal.
- **Pre-Service Claims (may Include concurrent care claim reduction or termination):** The Claims Administrator will make a determination within 15 calendar days of receipt of the request for an appeal.
- **Post-Service Claims:** The Claims Administrator will make a determination within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If the Claims Administrator needs more information from your physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for benefits is incomplete, the Claims Administrator	24 hours
You must then provide completed request for benefits to the Claims	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
The Claims Administrator denies your request for benefits, you must appeal an adverse benefit determination no later	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

* You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for benefits.

Second Level Appeals

If the Claims Administrator upholds an adverse benefit determination at the first level of appeal, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

A level two appeal of an adverse benefit determination of an urgent care claim, pre-service claim or post-service claim will be provided by Claims Administrator personnel not involved in making the adverse benefit determination.

- **Urgent Care Claims (may Include concurrent care claim reduction or termination):** The Claims Administrator will make a determination within 36 hours of receipt of the request for a level two appeal.
- **Pre-Service Claims (may Include concurrent care claim reduction or termination):** The Claims Administrator will make a determination within 15 calendar days of receipt of the request for level two appeal.
- **Post-Service Claims:** The Claims Administrator will make a determination within 30 calendar days of receipt of the request for a level two appeal.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

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			
Type of Appeal	**Send Written Appeals**	**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
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

Exhaustion of Process

You must exhaust the applicable level one and level two appeal processes before you establish any litigation, arbitration or administrative proceeding regarding an alleged breach of this Plan or any matter within the scope of the appeals process.

Voluntary Appeals

You may file a voluntary appeal for external review of any final standard appeal determination that qualifies.

If you file a voluntary appeal, 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 benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Post-Employment Dental Plan Appeals

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

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 such 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 contract, 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 such individual. Delta Dental will send you a decision within 30 days after receipt of the appeal or grievance.

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

UnitedHealthcare may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with UnitedHealthcare's decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review:

- You must have received notice of the denial of a claim by UnitedHealthcare;
- Your claim must have been denied because UnitedHealthcare determined that the care was not necessary or was experimental or investigational;
- The cost of the service or treatment in question for which you are responsible must exceed $500; and
- You must have exhausted the applicable internal appeal processes.

The claim denial letter you receive from UnitedHealthcare will describe the process to follow if you want to pursue an external review, including a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to UnitedHealthcare within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

UnitedHealthcare will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form* and will follow UnitedHealthcare's contractual documents and Plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of UnitedHealthcare's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after UnitedHealthcare receives the request.

UnitedHealthcare, NXP and the Plan will abide by the decision of the External Review Organization, except where UnitedHealthcare can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you want to be reviewed by the External Review Organization to UnitedHealthcare. UnitedHealthcare is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about the external review process, call UnitedHealthcare at 844-210-5428.

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 on page 142.

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.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the Explanation of Medicare Benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

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 on page 144.

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 legal action.

NXP HIPAA Notice of Privacy Practices for Protected Health Information

The NXP Post-Employment Health Plan (Plan) is 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 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 that 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, for our own training programs, 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; and
  - 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 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 in the **Contacting Us** section that follows 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:

NXP Semiconductors, Inc.
Human Resources Department – HIPAA Privacy Inquiries
6501 William Cannon Drive West, OE 331
Austin, TX 78735

This Notice of Privacy Practices is effective September 9, 2014.

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 beginning on page 89.

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, Under Insured Motorist (UIM) 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.

This section is included to help provide useful information for you in learning about your ERISA rights and other important Plan information.

If you are age 65 or older and covered under an individual Medicare plan through the Aon Retiree Health Exchange, see your *Evidence of Coverage* booklet from your health carrier for specific information about your coverage.

Administrative Information

Employer and Plan Sponsor	NXP Semiconductors, Inc. 6501 William Cannon Drive West Austin, TX 78735
Employer Identification Number	20-0443182
Agent for Legal Service	Senior Vice President, Human Resources NXP Semiconductors, Inc. 6501 William Cannon Drive West Austin, TX 78735 512-895-2021 Service of legal process may also be made on NXP or Trustee, if any.
Plan Year	January 1 through December 31
Type of Plan	Retiree health and welfare plan and defined contribution plan providing benefits to retirees and certain terminated

Plan Name and Type	Number	Funding Administration	Plan or Third-Party Administrator	Effective Date
NXP Post-Employment Health Plan	580	Self-insured by NXP and claims administered by: **UnitedHealthcare** P.O. Box 30555 Salt Lake City, UT 84130-0555	NXP Semiconductors, Inc.	January 1, 2024
NXP Post-Employment Dental Plan	502	Self-insured by NXP and claims administered by **Delta Dental Insurance Company** P.O. Box 1809 Alpharetta, GA 30023	NXP Semiconductors, Inc.	January 1, 2024
NXP Post-Employment Vision Plan	502	Self-insured by NXP and claims administered by **VSP** 3333 Quality Drive Rancho Cordova, CA 95670	NXP Semiconductors, Inc.	January 1, 2024

Plan Administration

NXP and its delegates have the sole and complete discretionary authority to determine eligibility for Plan benefits and to construe Plan terms, including the making of factual determinations. NXP and its delegates have the discretionary authority to grant or deny Plan benefits. Plan benefits will be paid only if NXP or its delegates decide in their discretion that the applicant is entitled to them. NXP's and its delegates' decisions (except with respect to NXP) 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 final action, finding, interpretation, ruling or decision of NXP or its delegates 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.

NXP may delegate to other persons responsibilities for performing certain Plan Administrator duties under Plan terms and may seek expert advice, as NXP deems reasonably necessary under the Plan. NXP and its delegates are 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.

NXP and its delegates 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, vision, disability, etc.) are primarily funded by NXP and paid from NXP's general assets. Other portions of the Plan (e.g., life insurance) are fund 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 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 SPD upon written request to NXP. NXP 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. NXP 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 SPD 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 NXP 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 NXP'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 NXP 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 NXP, 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/agencies/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.

Accidental Injury

For the Post-Employment 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.

Adverse Benefit Determination

For the Post-Employment Medical Plan, a denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

The adverse benefit determination may be based on:

- Your eligibility for coverage;
- The results of any utilization review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not medically necessary.

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, Freescale and Motorola and your retirement, you participated in the Medical Plan and the Post-Employment Medical Plan, the sum of benefits paid under the Medical Plan and the Post-Employment Medical Plan (whether NXP, Motorola or Freescale) is your aggregate lifetime maximum benefit under any NXP health plan.

Air Ambulance

Medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane (as defined in *42 CFR 414.605*).

Allowed Amounts

Allowed amounts for covered health services incurred while covered health service 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.

Alternate Facility

A health care facility that is not a hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency health care services; and
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide **mental health care services** or substance-related and addictive disorder (see the **Behavioral Health Program** section) on an outpatient or inpatient basis.

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. 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.

Annual Benefit Maximum

For prescription drug benefits, this is the maximum amount of prescription drug benefits that the Plan will pay for each covered individual each year.

Annuity

Monthly benefit payments made to a retiree until his or her death. An annuity may also provide ongoing payments to a retiree's spouse or beneficiary following the retiree's death. These payments may be provided over a fixed period or until the beneficiary's death, depending on the type of annuity elected.

Appeal

For the Post-Employment Medical Plan, an oral or written request to UnitedHealthcare to reconsider an adverse benefit determination.

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 Post-Employment Medical Plan, Dental Plan and Vision Plan, 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.

Behavioral Health Program

Program available to all Post-Employment 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 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 Post-Employment 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.

Care Management

See **Prior Authorization**, for more information.

Case Management

Medical case management assistance that UnitedHealthcare provides to Post-Employment Medical Plan participants. Reach Case Management through UnitedHealthcare by calling 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. It 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 the **Section 152 Dependent** section on page 182 for information on IRS Section 152 and dependents.

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 the **Filing Claims** section beginning on page 126. 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 beginning on page 126 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 in certain circumstances. COBRA requires employers to offer covered individuals 18, 29 or 36 months 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). In the Post-Employment Health Plan, COBRA is generally available only to dependents for up to 36 months.

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."

Complaint

For the Post-Employment Medical Plan, any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension

For the Post-Employment Medical Plan, a request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination

For the Post-Employment Medical Plan, a decision to reduce or terminate a previously approved course of treatment.

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 a participant has enrolled in medical, pharmacy, dental and/or vision coverage.

Covered Expense

For the Post-Employment Medical Plan, covered expense means medical, dental (under certain circumstances), vision and hearing services and supplies described as covered by this Plan.

For the Post-Employment Dental Plan, covered expense means the program allowance for a dentally necessary covered service incurred by you or your covered dependent(s).

Covered Health Care Service(s)

For the Post-Employment Medical Plan, health care services, including supplies or pharmaceutical products that UnitedHealthcare determines to be:

- Medically necessary;
- Described as a covered health care service in the **What's Covered**;

- Not excluded as described in the **What's Not Covered Under the Pre-65 Post-Employment Medical Plan** section;
- Provided for 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.

Custodial Care

For the Post-Employment Medical Plan, custodial care means non-skilled care services that are:

- Non health-related services, 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.

Deductible or Annual Deductible

Amount that you are required to pay for certain covered expenses before the Post-Employment Medical or Dental Plan pays benefits.

Delta Dental

The Post-Employment Dental Plan 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

The Post-Employment Dental Plan provides benefits only for covered services and covers several categories of dental services when a provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims will be processed according to standard processing policies.

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.

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.

Diagnostic Testing

A series of tests, invasive or noninvasive, used to determine a particular diagnosis.

Domestic Partner

Your domestic partner is a person who has lived with you for at least six consecutive 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:
    - 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 is married to another person under statutory or common law and neither of you is in another domestic partnership.

Your domestic partner is eligible for dependent medical (including behavioral health and prescription drug), dental and vision coverage. The NXP Benefits Service Center may require documentation and/or an affidavit of your relationship. An affidavit can be requested from the NXP Benefits 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;
- Used for medical purposes;
- Not consumable or disposable except as needed for the effective use of covered durable medical equipment;
- 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
- 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 Post-Employment 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 Post-Employment 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 Post-Employment 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 regarding 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 the **Clinical Trials** section (see page 59);
  - UnitedHealthcare may, as UnitedHealthcare determines, consider an otherwise experimental or investigational service to be a covered health care service for that sickness or condition if:
    - You are not a participant in a qualifying clinical trial, as described in the **Clinical Trials** section (see page 59); and
    - You have a sickness or condition that is likely to cause death within one year of the request for treatment.

Before such a 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.

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.

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.

Geographic Area

For UnitedHealthcare medical expenses.

The geographic area is the area made up of the first three digits of the U.S. Postal Service zip codes. If UnitedHealthcare determines it needs more data for a particular service or supply, UnitedHealthcare may base rates on a wider geographic area, such as an entire state.

Gestational Carrier

A gestational carrier is a female who becomes pregnant fertilized egg (embryo) implanted in her uterus for carrying the fetus to term for another person. The carrier

does not provide the egg and is therefore not biologically (genetically) related to the child.

Home Health Agency

A program or organization authorized by law to provide health care services in the home.

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 aged, 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 Post-Employment 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 or Infertile

The condition of a presumably healthy covered person who is unable to conceive or produce conception as outlined in the **Infertility Treatment** section on page 69.

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 provide services for at least three hours per day, two or more days per week.
- Substance-related or addictive disorders services that provide 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 fewer:

- Seven days each week; or

- Eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

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 Support Program

UnitedHealthcare provides Post-Employment Medical Plan participants with risk screenings, prenatal education and information to help ensure a healthy delivery.

Maximum Contract Allowance

The reimbursement under the participant's Delta Dental plan against which Delta Dental calculates its payment and the 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, as determined by UnitedHealthcare or UnitedHealthcare's designee, that are:

- Provided according to generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, service site and duration;
- Considered effective for your sickness, injury, mental Illness, substance-related and addictive disorders, disease or its symptoms;
- Not mainly for your convenience or that of your doctor or other health care provider; and
- 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 your 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 of 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 to covered persons 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**.

Medicare

The Hospital and Supplementary Medical Insurance Plan established by Title XVIII of the Social Security Act of 1965, as then constituted or as later amended.

Medicare Allowable Rates

For UnitedHealthcare medical expenses.

Except as specified below, Medicare allowable rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. UnitedHealthcare updates their systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, UnitedHealthcare will determine the rate as follows:

- Use the same method CMS uses to set Medicare rates;
- Look at what other providers charge;
- Look at how much work it takes to perform a service; or
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

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 current edition of the "International Classification of Diseases" section on Mental and Behavioral Disorders or the *Diagnostic and Statistical Manual* of the American Psychiatric Association. The fact that a condition is listed in the current edition of the *International Classification of Diseases (ICD)*, Mental and Behavioral Disorders Section or the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association does not mean that treatment for the condition is a covered health care 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

Those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases (ICD)*, Mental and Behavioral Disorders Section or the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. The fact that a condition is listed in the current edition of the *International Classification of Diseases (ICD)*, Mental and Behavioral Disorders Section or the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association does not mean that treatment for the condition is a covered health care service.

Network

For the Post-Employment Medical Plan, 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 those providers who have agreed to discount charges for covered health services. UnitedHealthcare affiliates are those entities affiliated with the UnitedHealthcare through common ownership or control with UnitedHealthcare or with the 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 will change from time to time.

Network Hospitals

A group of hospitals that have met quality criteria and agree to charge an allowed amount to Post-Employment 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 provider or a 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 Plan eligibility, appeals and customer service.

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.

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

The description of how benefits are paid for covered health services provided by out-of-network providers. The **Medical Benefits Summary** shows the coverage for out-of-network benefits.

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-Employment Health Plan

NXP health benefits plan for certain retirees, TDPs and their dependents and survivors.

Post-Service Claim

For the Post-Employment Medical Plan, any claim that is not a pre-service claim.

Preferred Drug List

List of medications health care experts have selected to be preferred drugs. The Post-Employment Medical Plan's Prescription Drug Program 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

For the Post-Employment Medical Plan, any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Pre-Treatment Estimate

Applies Post-Employment 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 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. 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.

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 where indicated for out-of-network care is the participant's responsibility and provides the highest level of coverage under the Post-Employment 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 Post-Employment Dental Plan, the program allowance refers to 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 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 a covered participant.

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 treatment plan related to a chronic and/or acute health illness or condition. The treatment plan 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 Facility

A residential treatment facility for mental and/or substance use disorders is an institution that:

- Is credentialed by UnitedHealthcare or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC);
  - Committee on Accreditation of Rehabilitation Facilities (CARF);

    - American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or
    - Council on Accreditation (COA); or is credentialed by UnitedHealthcare;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of the care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above, for mental health residential treatment programs:

- A behavioral health provider must be actively on duty 24 hours a day, 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist.

In addition to the above, for chemical dependence residential treatment programs:

- The facility must have a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- The professional must be actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.

In addition to the above, for chemical dependence detoxification programs in a residential setting:

- An R.N. must be onsite 24 hours per day, 7 days a week; and
- Care must be provided under the direct supervision of a physician.

Routine Office Visit

Visits with a physician or other provider covered under the Post-Employment 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.

Sickness

Physical illness, disease or pregnancy; this includes substance-related and addictive disorder (See the **Behavioral Health Program** section on page 52).

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.

Specialty Provider

For the Post-Employment 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 a participant, including a common-law spouse, and including an individual who is a retiree's or TDP's spouse under the law of the state or country in which the retiree or TDP married if that state or country recognizes that marriage. An individual separated from the retiree or TDP under a legal separation decree is still considered a spouse.

> For tax purposes, the Plan follows 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 current edition of the *International Classification of Diseases (ICD)*, Mental and Behavioral Disorders Section or the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. The fact that a disorder is listed in the current edition of the *International Classification of Diseases (ICD)*, Mental and Behavioral Disorders Section or the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association does not mean that treatment of the disorder is a covered health care service.

Surrogate

A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for carrying 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/Motorola's Medical Leave Policy;
- Was eligible to be covered under the Post-Employment Medical Plan, Dental Plan or Vision Plan until the termination of employment;
- Continues to be entitled to disability benefits under the NXP Disability Income Plan; and
- Is younger than age 65.

Timely Applicant

A retiree, TDP or 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 retirees and spouses/domestic partners required for coverage under the Post-Employment Medical Plan.

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 an examination to determine the fitness of the person to perform any such duty.

UnitedHealthcare

The medical and behavioral health administrator responsible for claims processing, customer service and appeals.

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

For the Post-Employment Medical Plan, any claim for medical care or treatment in which a delay in treatment could:

- Jeopardize your life;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Index

This section includes an index to help you find what you need in this document.

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		
UnitedHealthcare Advocacy Services	**Telephone:** 844-210-5428	Not applicable
NXP Benefits Service Center	**Telephone**: 888-375-2367 **Website**: **nxp.bswift.com**	**NXP Benefits Service Center** 100 Half Day Road Lincolnshire, IL 60069-1475
Premium Payments (COBRA and non-COBRA)	**Telephone**: 844-210-5428 **Website**:http://www.nxp.bswift.com/ **myuhc.com**	**UnitedHealthcare** P.O. Box 30555 Salt Lake, UT 84130-0555
Health Plans/Resources		
NXP Post-Employment Medical Plan	**UnitedHealthcare** **Telephone:** 844-210-5428 Monday through Friday 8 a.m. - 8 p.m. local time **Website**: **myuhc.com**	**Claims**: **UnitedHealthcare** P.O. Box 30555 Salt Lake, UT 84130-0555
NXP Post-Employment Prescription Drug Program	**Telephone**: 877-505-8360 **TDD**: 800-231-4403 **Website**:	**Mail order prescriptions**: **CVS Caremark** P.O. Box 659541 San Antonio, TX 78265 **Claims**: **CVS Caremark** P.O. Box 52116 Phoenix, AZ 85072-2116
Medicare	**Telephone**: 800-638-6833 **Website**: **medicare.gov**	See your local SSA office
NXP Post-Employment Dental Plan	**Telephone**: 800-471-0236 **Website**: **deltadentalins.com**	**Delta Dental Claims:** P.O. Box 1809 Alpharetta, GA 30023
NXP Post-Employment Vision Plan	**Telephone**: 800-877-7195 **TTY**: 800-428-4833 **Website**:	**Claims**: **VSP** Attention: Claim Services PO Box 495918 Cincinnati, OH 45249-5918